Commissioning Diabetes and Kidney Care

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

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Charlie Tomson  Consultant in Renal Medicine, North Bristol NHS Trust
Hugh Cairns    Consultant in Renal Medicine, King’s College Hospital NHS Foundation Trust
Niru Goenka    Consultant in Diabetes and Endocrinology, Countess of Chester NHS Foundation Trust

And to Thoreya Swage who wrote this publication.
## Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning for Diabetes and Kidney Care</td>
<td>5</td>
</tr>
<tr>
<td>Features of Diabetes and Kidney Care Services</td>
<td>6</td>
</tr>
<tr>
<td>Diabetes and Kidney Care Services Intervention Map</td>
<td>8</td>
</tr>
<tr>
<td>Contracting Framework for Diabetes and Kidney Care Services</td>
<td>11</td>
</tr>
<tr>
<td>Standard Service Specification Template for Diabetes and Kidney Care</td>
<td>25</td>
</tr>
</tbody>
</table>
Commissioning for Diabetes and Kidney Care

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 and NHS Kidney Care 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 and kidney care services between commissioners and providers from which a contract for services can then be agreed.

This commissioning guide consists of:

- A description of the key features of good diabetes and kidney care
- A high level intervention map. This intervention map describes the key high level actions or interventions (both clinical and administrative) diabetes and kidney care services should undertake in order to provide the most efficient and effective care, from admission to discharge (or death) from the service.

It is not intended to be a care pathway or clinical protocol, rather it describes how a true ‘diabetes without walls’ service should operate going across the current sectors of health care.

The intervention map may describe current service models or it may describe what should ideally be provided by diabetes and kidney care services.

- A diabetes and kidney care contracting framework that brings together all the key standards of quality and policy relating to diabetes and kidney care
- A template service specification for diabetes and kidney care services that forms part of schedule 2 part 1 ,or section 1 (module B) of the Standard NHS Contract covering the key headings required of a specification. It is recommended that the commissioner checks which mandatory headings are required for each type of care as specified by the Standard NHS Contracts.

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

High quality diabetes and kidney care services should ensure:

• that people with diabetes have a regular assessment and review of renal function (including management of anaemia and bone conditions) as part of their diabetes assessment and care planning process
• that patients with chronic kidney disease and diabetes who require specialist care are seen in joint nephrology and diabetes services
• there is access to vascular services for vascular access for haemodialysis
• there is access to transplantation services which provide combined kidney and pancreatic transplantation as appropriate
• that there is regular training and development in basic diabetes competences for hospital staff caring for people who have renal conditions and diabetes
• that there is regular training and development for all health care professionals who provide diabetes care on the management of kidney conditions
• that there are monitored protocols for hospital staff on when to access diabetes specialist advice and intervention for people with diabetes who have renal conditions
• that there are monitored protocols in place to ensure that patients can continue to manage their diabetes themselves while in hospital (food and medication)

• that data items included in the National Renal Dataset are reported accurately and completely on all patients on Renal Replacement Therapy

In addition, the service should:

• be developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care and placing users at the centre of decisions about their care and support - “no decision about me without me” (Equity and Excellence: Liberating the NHS).
• be commissioned jointly by health and social care based on a joint health needs assessment which meets the specific needs of the local population, using a holistic approach as described by the generic model for the management of long term conditions
• 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
• deliver the outcomes for diabetes as determined by the NHS Outcomes Framework
• take into account the emotional, psychological and mental wellbeing of the patient
• 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
• ensure that the family/carers of 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
• 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 children and adult services and 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
• produce information on the outcomes of diabetes care including contributing to national data collections and audits
• have adequate governance arrangements, e.g. local mortality and morbidity meetings on diabetes care to learn from errors and improve patient safety
• take account of patient experience, including Patient Reported Outcomes Measures, in the development and monitoring of service delivery
• deliver the separate modules of care according to the best practice quality markers
• actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents

http://www.ic.nhs.uk/proms
Diabetes and Kidney Care Services

Intervention Map

1. **Health Needs Assessment**
   - See commissioning guidance on diagnosis and continuing care for people

2. **Diagnosis of diabetes**
   - See commissioning guidance on diagnosis and continuing care for people

3. **Management of chronic kidney disease including complications**
   - Treat hypertension, if present, according to agreed protocols

4. **Assessment of renal function**
   - E.g.: Blood pressure
   - Albumin/creatinine ratio
   - eGFR
   - Serum creatinine

5. **Evidence of chronic kidney disease?**
   - Yes
     - Referral to specialist care required?
       - Yes: Update care plan
       - No: Go to page 9

6. **Staging of chronic kidney disease**
   - Yes
     - renal function deteriorating?
       - Yes: Referral to specialist care required?
         - Yes: Update care plan
         - No: Go to page 9

7. **Advice on lifestyle**
   - E.g.: Smoking, diet (salt intake, etc.)

8. **Review of results of renal function tests**
   - Evidence of chronic kidney disease?
     - Yes
       - see NICE guidance on chronic kidney disease

9. **Update care plan**
   - Review date agreed
     - Yes
       - Go to page 9

10. **Go to page 9**
    - No
       - Update care plan

NHS Diabetes

Diabetes and kidney care

Chronic kidney disease: risk assessment

See commissioning guides for CYP, diagnosis and continuing care and older people.

Assessment for other possible complications of diabetes

Assessment of possible complications of diabetes

- Update care plan
- Frequency of review according to agreed protocols
- Update care plan
NHS Diabetes
Diabetes and kidney care
Specialist kidney care

From page 8

Nephrology assessment at joint renal/diabetes service

Renal Replacement Therapy planning required?

Yes

Go to page 10

No

Advice on lifestyle
- E.g. Smoking
- Exercise
- Diet

Advice on other risk factors for chronic kidney disease
- E.g. Chronic NSAID use etc

Appropriate medication

Management of complications of kidney disease

Review date agreed
- Update care plan

check:
- renal function
- blood pressure
- cardiovascular risk
- anaemia
- bone conditions
- glycaemic control
- check feet

Go to page 10
NHS Diabetes
Diabetes and kidney care
Specialist kidney care

Renal Replacement Therapy planning initiated

Assessment of cardiovascular risk
- arrangements for vascular access, if required
- patient education
- dialysis

Renal Replacement Therapy treatment options discussed

Continuing management of complications of kidney disease

Renal Replacement Therapy inappropriate?

Yes
See commissioning guide for End of Life Care

No

Renal Replacement Therapy option agreed and implemented
- dialysis
- transplant
- consider referral for simultaneous pancreas and kidney transplantation according to agreed protocols

Continued management of complications of diabetes
- update care plan

Management of chosen Renal Replacement Therapy option according to agreed protocols

Review of chosen Renal Replacement Therapy option according to agreed protocols
Introduction

This contracting framework sets what is required of clinically safe and effective services that are providing care for people with diabetes who need kidney care. The framework is designed to be read in conjunction with the high level patient intervention map, which describes the interventions and actions required along the patient pathway as well as entry and exit points, and the standard service specification template for kidney care services for people with diabetes.

The framework brings together the key quality areas and standards that have been identified by NHS Diabetes, NHS Kidney Care, 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.

**Diabetes and Kidney Care Services**

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

Care of people with diabetes who have renal complications 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 patients through the care planning process and that the nephrologist/diabetes physicians retain joint responsibility for overall patient care across the whole pathway and retain overall responsibility for the management of side effects and further 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.

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

This contracting framework focuses on people with diabetes, including children and young people and older people, who require care for the renal complications of diabetes. This contracting framework should also be read in conjunction with the diabetes commissioning guides for children and young people, prevention and risk assessment, diagnosis and continuing care, older people, End of Life Care and follow the principles for the effective commissioning of services for people with Learning Disabilities.

**Ensuring quality**

Commissioning Bodies should ensure that the diabetes and kidney care 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 and kidney care services, there should be retrospective evidence of systems being in place, implemented and working.

ii) For organisations new to the arena, the commissioner should reassure itself that the provider has the organisational attributes, governance arrangements, systems and processes set up to provide the platform for safe and effective delivery of diabetes and kidney care 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 Acute Services– bilateral (main clauses and schedules). (The cross references also apply to the clauses and schedules in the Standard NHS Contract for Community Services). This is to assist commissioners and providers in having an overview of how the elements link to the Standard NHS Contract. Some of the areas are open to interpretation and consequently the references are not exhaustive.
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Leadership</td>
<td>Clarity of the organisation’s purpose with explicit commitment to providing high quality services</td>
<td>Provider must have organisational structure that provides leadership for all professions and disciplines</td>
<td>There should be a designated clinical director with responsibility and accountability for diabetes and kidney care services</td>
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<td>A culture that demonstrates an open learning ethos</td>
<td>In particular, there must be a corporate clinical director with the responsibility and accountability for the clinical service</td>
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<td>An organisation that is legal and ethical in all its activities</td>
<td>There must be a learning framework in the organisation</td>
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<tr>
<td>Governance</td>
<td>Integrated Governance</td>
<td>An organisation that is guided by the principles of good governance:</td>
<td>Clear organisational and integrated governance systems and structures in place with clear lines of accountability and responsibilities for all functions. This includes interfaces and transitions between services</td>
<td>Quality Governance in the NHS. A guide for provider boards[4]</td>
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<td>- clarity of purpose</td>
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<td>- participation and engagement</td>
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<td>- rule of law</td>
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<td>- transparency</td>
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<td>- responsiveness</td>
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<td>- equity and inclusiveness</td>
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<td>- effectiveness and efficiency</td>
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<td>- accountability</td>
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<td>An organisation that accepts responsibility and accountability for all its actions</td>
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<tr>
<td>Governance</td>
<td>Clinical Governance</td>
<td>Explicit commitment to quality and patient safety</td>
<td>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</td>
<td>All sub-contractors must meet governance and leadership arrangements of the main provider organisation</td>
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<td>Patient focused with respect for the personal wishes of patients in all aspects of their care</td>
<td>e.g.</td>
<td>Commissioner, provider and NHS Litigation Authority must review the Clinical Negligence Scheme for Trusts arrangements /or other organisational / professional indemnity arrangements</td>
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<td>A commitment to innovation and continuous improvement</td>
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<td>The service should have in place written protocols and procedures defining clear lines of accountability and responsibility.</td>
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<td>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]</td>
</tr>
<tr>
<td>TOPIC</td>
<td>ELEMENTS</td>
<td>CHARACTERISTICS, SKILLS AND BEHAVIOURS</td>
<td>OUTPUTS</td>
<td>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
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<td>---------</td>
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| Governance | Clinical Governance | • Staff Development  
• Complaints Management  
• Patient and Public Involvement  
• Patient dignity and respect  
• Equality and diversity  
• Introducing new technologies and treatments  
• An externally accredited Quality Assurance system and internal error reporting involving all staff groups.  
CG systems should have clear and demonstrable links to other NHS systems with collaborative CG activities and sharing of experience and learning  
Provider should produce annual Clinical Governance reports as part of NHS CG reporting system  
Providers are required to agree Commissioning for Quality and Innovation schemes (CQUIN) for diabetes care, e.g. model CQUIN scheme proposed by the NHS Institute for Innovation and Improvement | In addition, the service is required to comply with the following:  
i. Guidance published by NICE  
• Early identification and management of chronic kidney disease in adults in primary and secondary care  
• Anaemia management in people with chronic kidney disease  
• The clinical effectiveness and cost effectiveness of patient education models for diabetes  
• Medicines adherence: involving patients in decisions about prescribed medicines and endorsing adherence  
The service is also required to comply with:  
clinical guidelines for Type 2 Diabetes Mellitus produced by the European Diabetes Working Party for Older People  
Renal Specific Management of Medicines  
Guidelines for LCP Drug Prescribing in Advanced Chronic Kidney Disease |
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
</table>
| Clinical quality | Workforce/staff               | 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 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:
  - Diabetes: registration with the GMC and evidence of further qualification in diabetes care or experience within diabetes clinic
  - Nephrology: registration with the GMC and evidence of further qualification in renal medicine
- Nurses:
  - Diabetes: registration with the NMC, further evidence of qualification in diabetes care or experience within diabetes clinic and an interest in nephropathy
  - Nephrology: registration with the NMC and further evidence of qualification in renal medicine or experience within nephrology clinic
- Dietitians:
  - Diabetes: registration with the HPC and further evidence of qualification in diabetes care or experience within diabetes clinic
  - Nephrology: registration with the HPC and further evidence of qualification in dietetics and renal medicine or experience within nephrology clinic
- Podiatrists:
  - Diabetes: registration with the HPC and further evidence of qualification in diabetes care or experience within diabetes clinic
Healthcare professionals involved in delivering care for people with diabetes who have renal complications are required to have the relevant competencies in the management of:
- diabetes
- Chronic Kidney Disease
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality</td>
<td>Workforce/staff</td>
<td>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</td>
<td>Provider to satisfy the commissioner that all staff have had documented competence assessment relative to all equipment used in contract.</td>
<td>All healthcare professionals involved in delivering care for people with diabetes who have cardiovascular complications are required to have the relevant competencies in using appropriate equipment e.g. blood glucose and ketone monitors, insulin delivery devices including insulin pumps etc.</td>
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</tbody>
</table>
|                           | Clinical staff competency in use of equipment  | Cross references to the Standard NHS Contract for Acute Services  
Main clauses: 11, 16, 17, 21, 26, 33 | Provider to satisfy the commissioner that all staff have had documented competence assessment relative to all equipment used in contract. |  |
|                           | Development                                   | Cross references to the Standard NHS Contract for Acute Services  
Main clauses: 11, 16, 19, 30, 48 | Provider to satisfy the 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          | Workforce/staff                               | 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 the 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 |  |
| Registration and licensing| Cross references to the Standard NHS Contract for Acute Services  
Main clauses: 4, 4A, 5, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 21, 26, 27, 29, 33, 34, 35, 36, 43, 48, 49, 52, 53, 54, 56, 60  
Schedule: 2, 3, 4, 5, 6, 8, 10, 12, 13, 15, 17, 19, 20 | The Provider is required to register with the Care Quality Commission to demonstrate that it 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:  
- Renal NSF 23  
- Older People's NSF 24  
- NSF for Children, Young People and Maternity Services 25  
- The Mental Health Strategy 26  
- Long Term Conditions NSF 27 | Compliance with Care Quality Commission Reviews |
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality</td>
<td>Outcomes Cross references to the Standard NHS Contract for Acute Services</td>
<td>Comprehensive understanding and commitment to delivering and improving outcomes of care</td>
<td>Compliance with the NHS Outcomes Framework²⁻³</td>
<td>Compliance with the Quality Standards for Diabetes, specifically²⁻³</td>
</tr>
<tr>
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<td>Main clauses: 4,4A,10,14,15,16,21</td>
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<td></td>
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<td></td>
<td>Schedule: 3 (part 5), 5 (parts 1,2,3), 12</td>
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<td></td>
<td>Patient pathway Cross references to the Standard NHS Contract for Acute Services</td>
<td>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</td>
<td>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.</td>
<td>The pathway should follow the principles set out by the Generic Long Term Conditions model³⁻⁴. This includes: • Stratifying the levels of need and risk • Case management • Personalised care planning • Supporting people to self care • Assistive technology The key elements of diabetes and kidney care services should include • Chronic kidney disease risk assessment and initial management • The early identification and management of cardiovascular complications of diabetes³⁻⁴ (see also the Commissioning Guide for cardiovascular services for people with diabetes)² • Specialist kidney care 1. Chronic kidney disease risk assessment and initial management • There should be agreed protocols for assessing the risk of: o diabetes o the effects of smoking o chronic kidney disease o hypertension (e.g. NHS Health Checks for 40 - 74 year olds²⁻³). • There should be agreed protocols for: o the management of chronic kidney disease o management of anaemia o management of bone conditions</td>
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<tr>
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<td>ELEMENTS</td>
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<td>OUTPUTS</td>
<td>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</td>
</tr>
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| 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  
v) There are arrangements for the management of out of hours care according to best clinical practice | o management of hypertension  
• when to refer for specialist renal/diabetes care  
• Every patient with chronic kidney renal/diabetes care should have a kidney care plan  
2. The early identification and management of cardiovascular complications of diabetes  
• there should be protocols in place to identify and manage the cardiovascular complications of diabetes as cardiac co-morbidity has a significant impact on renal complications  
3. Specialist kidney care  
• people with diabetes who need specialist kidney care should be seen by joint nephrology and diabetes services  
• there should be protocols in place to screen, prevent and manage other complications of diabetes, e.g. foot care, cardiovascular care and eyes  
• the management of a person with diabetes who is admitted for management of their renal condition should follow the principles set out in the emergency and inpatient commissioning guide, i.e.  
  o have access to the multidisciplinary specialist diabetes team  
  o have admission and discharge care plans  
  o have close liaison with their care co-ordinator  
  o there should be protocols in place to allow patients, who are able to do so, to self manage their diabetes medication.  
Patients may need to be referred to the following services as part of their kidney care:  
• Vascular services (for vascular access)  
• Dialysis  
• Transplantation services – including access to combined kidney and pancreatic transplantation services, as appropriate  
• Renal Welfare Officer  
• End of Life Care (see also Commissioning Guide for Diabetes and End of Life Care) |
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIAGNOSIS SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality</td>
<td>Patient pathway</td>
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<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Clinical quality</td>
<td>Clinical emergency situations</td>
<td>Ability to negotiate and agree arrangements with appropriate personnel and organisations to provide effectively for emergency situations</td>
<td>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</td>
<td>There should be protocols in place to ensure the availability of advice and support of specialist diabetes clinical staff to manage diabetes clinical emergency situations, e.g. during a surgical procedure or other clinical intervention for the management of the renal condition</td>
</tr>
<tr>
<td>TOPIC</td>
<td>ELEMENTS</td>
<td>CHARACTERISTICS, SKILLS AND BEHAVIOURS</td>
<td>OUTPUTS</td>
<td>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</td>
</tr>
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</tbody>
</table>
| Clinical quality | Estates and equipment  
Cross references to the Standard NHS Contract for Acute Services  
Main clauses: 5, 29, 33, 56  
Schedules: 3, 10, 19 | Understanding of building regulations  
Access to advice on “fit-for-purpose” equipment and facilities | Commissioners must assure themselves that patient care is delivered in appropriately built and equipped facilities which meet relevant HTMs and Building Notes, and, where appropriate, are registered and are safe and clean.  
Equipment must be fit for purpose  
Commitment to efficient use and satisfactory maintenance of equipment | Health and safety policies as per provider agreement with commissioners |
| Clinical quality | Knowledge and understanding of health and safety  
Cross references to the Standard NHS Contract for Acute Services  
Main clauses: 5, 11, 19, 54, 56, 60 | Understanding of clinical accountabilities of health and safety policies | H&S strategy and policies in place and implemented with awareness throughout the organisation  
Accessibility to executive responsible for H&S for quicker, first contact services | |
<table>
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<tr>
<th>TOPIC</th>
<th>ELEMENTS</th>
<th>CHARACTERISTICS, SKILLS AND BEHAVIOURS</th>
<th>OUTPUTS</th>
<th>DIABETES SERVICES SPECIFIC OUTPUTS/COMMENTS</th>
</tr>
</thead>
</table>
| 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 | • Quality and Outcomes Framework 41  
• Hospital Episode Statistics 44  
• UK Renal Registry 45  
• Patient Experience 18,38  
• Patient Satisfaction 38  
• Patient Reported Outcomes Measures 20  
• National Diabetes Continuing Care Dataset 46  
• National Renal Dataset 47 |
Source documents

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


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


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


16. National Diabetes Support Team, Improving emergency and inpatient care for people with diabetes, the report of a working party of representatives of the inpatient and emergency care community in partnership with the National Institute for Innovation and Improvement, March 2008

17. The information centre, National Kidney Care Audit - http://www.knowledge.ic.nhs.uk/kidneycareaudit


35. NHS Kidney Care, Achieving Autonomy for Kidney Services Seven Steps Toolkit http://www.kidneycare.nhs.uk/Library/Achieving_Autonomy_for_Kidney_Services_FINAL.pdf


42. Department of Health, Renal services information strategy: Supporting part two of the National Service Framework for Renal Services, 2005

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

44. Hospital Episode Statistics,

45. UK Renal Registry,
   http://www.renalreg.com/About-Us/about.html

46. National Diabetes Continuing Care Dataset,

47. National Renal Dataset,
   http://www.ic.nhs.uk/services/datasets/document-
Standard Service Specification Template for Diabetes and Kidney Care

This specification forms Schedule 2, Part 1 or section 1 (module B), ‘The Services - Service Specifications’ of the Standard NHS Contracts.

Service specifications are developed in partnership between commissioners and provider agencies and are based on agreed evidence-based care and treatment models. Diabetes and Renal Networks have an important role to play in developing the specifications. Specifications should be open to scrutiny and available to all service users/carers as a statement of standards that the user/carer can expect to receive.

The following documentation, developed by the Diabetes Commissioning Advisory Group in conjunction with NHS Kidney Care provides further detail/guidance to support the development of this specification:

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

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

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

Description of diabetes and kidney care services:

Diabetes and kidney care services includes an assessment of risk of chronic kidney disease as part of the initial and continuing management of people with diabetes, management of renal function and associated conditions such as hypertension and metabolic bone disorders, management of all the stages of renal failure with specialist input with access to transplantation and dialysis services.

The final specification should take into account:

- national, network and local guidance and standards for diabetes and kidney care services.
- local needs.
- cross references to the Specification for the Commissioning of Peritoneal Dialysis Pathway and the autonomous kidney services toolkit

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.

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*c NHS Kidney Care, Achieving Autonomy for Kidney Services Seven Steps Toolkit http://www.kidneycare.nhs.uk/~/assets/Achieving_Autonomy_for_Kidney_Services_FINAL.pdf
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 diabetes team and renal team, etc.

• Any relevant diabetes and renal clinical networks and screening/risk assessment programmes applicable to the services, e.g. NHS Health Check.

• Details of all interdependencies or subcontractors 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.

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. children, young people, adults and older people with diabetes who require kidney care for the renal complications of 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 and 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 coordination function
  o Ensure that transition from childrens’ to adults’ services or adults’ to older peoples’ services is negotiated and explicitly planned around the assessed needs of each individual person

• 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 and kidney care, guidance produced by 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 patient intervention map for diabetes and kidney care services as a starting point.

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

5. This will include a breakdown of how the patient will receive the services and from whom. It should be a clear statement of staff qualifications/experience and/or training (if
appropriate) and clinical or managerial supervision arrangements. It should specify, as appropriate:

- Geographical coverage/boundaries – i.e. the services should be available for children and young people, adult and older people who live in the clinical commissioning group area
- Hours of operation including, week-end, bank holiday and on-call arrangements
- Minimum level of experience and qualifications of staff (i.e. doctors – diabetologists, nephrologists and GPs, Nursing staff – diabetes nurse specialists, renal care nurses etc, other allied health professionals, e.g. dietitians, 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, and accepted to the services. Acceptance should be based on types of need and/or patient.

8. How should patients be referred?

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

Discharge/Service Complete/Patient Transfer/Transition criteria

9. The intention of this section is to make clear when a patient should be transferred from 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\(^1\)\(^2\)\(^3\)

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\(^4\)

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.

\(^1\) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

\(^2\) http://www.nice.org.uk/guidance/qualitystandards/chronickidneydisease/ckdqualitystandard.jsp

\(^3\) http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

\(^4\) http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp
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 and kidney care providers, commissioner and network.