Commissioning Diabetes Prevention and Risk Assessment Services

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

Commissioning for Diabetes Prevention and Risk Assessment Services 5

Features of Diabetes Prevention and Risk Assessment Services 6

Diabetes Prevention and Risk Assessment Services Intervention Map 8

Contracting Framework for Diabetes Prevention and Risk Assessment Services 10

Standard Service Specification Template for Diabetes Prevention and Risk Assessment Services 22
Commissioning for Diabetes Prevention and Risk Assessment Services

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

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

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

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

This commissioning guide has been developed by NHS Diabetes with key stakeholders including clinical and social services professionals and patient groups represented by Diabetes UK.

It is not designed to replace the Standard NHS Contracts as many of the legal and contractual requirements have already been identified in this set of documents. Rather, it is intended to form the basis of a discussion or development of diabetes prevention and risk assessment services between commissioners and providers from which a contract for services can then be agreed.

This commissioning guide consists of:

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

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

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

- A diabetes prevention and risk assessment contracting framework that brings together all the key standards of quality and policy relating to this aspect of care

- A template service specification for diabetes prevention and risk assessment services that forms part of schedule 2 part 1 / Module B, Section 1 of the Standard NHS Contract covering the key headings required of a specification. It is recommended that the commissioner checks which mandatory headings are required for each type of care as specified by the Standard NHS Contracts.

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

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High quality diabetes prevention and risk assessment services should:

- actively seek out those at risk of diabetes, e.g. through NHS Health Checks, assessing recorded versus predicted prevalence of diabetes from primary care diabetes registers
- offer active intervention to people of all ages at risk of developing diabetes
- place emphasis on the prevention of type 2 diabetes for all age groups through the prevention and reduction of the prevalence of obesity in groups at increased risk of developing diabetes, e.g. minority ethnic communities
- be developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care ensuring people are at the centre of decisions about their care and support - ‘no decision about me without me’.
- 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
- be delivered in accordance with the standards for clinical practice for diabetes set by the National Institute for Health and Clinical Excellence
- 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
- have effective clinical networks with clear clinical leadership across the boundaries of care which clearly identify the role and responsibilities of each member of the diabetes healthcare team
- ensure that there are a wide range of options available to people at risk of developing to support self management and individual preferences
- take into account services provided by social care and the voluntary sector
- provide patient/carer/family education on diabetes and other lifestyle interventions
- provide education on diabetes prevention and risk to other staff and organisations that may come into contact with people at risk of developing diabetes
- have a capable and effective workforce that has the appropriate training and updating and where the staff have the skills and competencies in the management of people at risk of developing diabetes
- provide multidisciplinary care that manages the transition between adult and older peoples’ services

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3 http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp


6 http://www.diabetes.nhs.uk/commissioning_resource/
• have integrated information systems that record individual needs including emotional, social, educational, economic and biomedical information which permit multidisciplinary care across service boundaries and support care planning\textsuperscript{vii}

• produce information on the outcomes of diabetes prevention and risk assessment care including contributing to national data collections and audits

• have adequate governance arrangements, e.g. local mortality and morbidity meetings on diabetes care to learn from errors and improve patient safety

• take account of patient experience, including Patient Reported Outcomes Measures, and the NHS Outcomes Framework, in the development and monitoring of service delivery\textsuperscript{viii}

• actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents

\textsuperscript{vii} \url{http://www.diabetes.nhs.uk/year_of_care/fi}

\textsuperscript{viii} \url{http://www.ic.nhs.uk/proms}
Diabetes and Risk Prevention Services

Intervention Map

NHS Diabetes
Diabetes care – Prevention and risk assessment

Diabetes risk assessment

High Risk?

Yes

Glycaemia test

- e.g. Fasting plasma glucose
- HbA1C

Go to page 9

Follow up according to agreed protocols

Discussion and advice

- healthy lifestyle

No

Follow up according to agreed protocols

Referral to other prevention services

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

Diabetes prevention services

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

Diabetes care – Prevention and risk assessment

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

Health Needs Assessment

- Raising awareness
- Signposting/self directed referral

Discussion and advice

Health Needs Assessment

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

Glycaemia test

- e.g. - Fasting plasma glucose
- HbA1C

Follow up according to agreed protocols

Referral to other prevention services

- healthy lifestyle

Discussion and advice

- e.g.
  - weight management programmes
  - healthy eating
  - exercise facilities
  - motivational workshops
  - smoking cessation
  - NHS Health Checks
  - surgery / drugs to reduce body weight

Go to page 9
NHS Diabetes
Diabetes care – Prevention and risk assessment

From Page 8

Glycaemia test result → High blood glucose levels → Refer to diabetes diagnosis and continuing care services
- within one day, if symptomatic
- within one week for routine referral

Borderline result → Oral glucose tolerance test

High response outside normal parameters → Refer to diabetes diagnosis and continuing care services

High response within normal parameters → Follow up in two years time
- weight management programmes
- health diet regimes
- exercise facilities
- motivational workshops
- smoking cessation
- NHS Health Checks
- surgery / drugs to reduce weight

Normal glucose levels → Referral to other prevention services
Introduction

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

The framework brings together the key quality areas and standards that have been identified by NHS Diabetes, Diabetes UK, the Royal Colleges and other related organisations.

The principles that establish a safe pathway for patient care

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

- Commissioning
- Clinical Case Direction or the overall Care Plan (i.e. the management of an individual patient)
- Provision of the clinical service or process
- Organisational platform on which the clinical service or process sits (the provider organisation)

A straightforward or simple pathway is one in which the overall management including both Clinical Case Direction and the delivery of the clinical processes conventionally sits within one organisation. However, with a more complex pathway, there is a danger that fracturing the overall management pathway into components carried out by different clinical teams and organisations will require duplication of effort leading to inefficiency and increased risk at handover points. This can be managed by establishing clear governance arrangements for all the layers in the pathway.

In addition, Commissioning Bodies must balance the benefits of fracturing the pathway against increased complexity and ensure that the increased risks are mitigated.

The governance arrangements required for all three layers and the commissioner responsibilities are shown below:
In essence, at each level, there are governance arrangements to ensure sound and safe systems of delivery of patient care with clear lines of accountability between each level.

**The diabetes prevention and risk assessment service**

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

Diabetes prevention and risk assessment care is provided by a number of different teams in the primary, community and acute setting. It is essential that there is co-ordination of care of the patients and that the General Practitioner retains responsibility for overall patient care across the whole pathway and retains overall responsibility for the management of any side effects and complications.

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

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

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

**Ensuring quality**

Commissioning Bodies should ensure that the diabetes prevention and risk assessment services commissioned are of the highest quality. There may, in addition, be some organisations that wish to offer their services, but do not have a history of providing such care. Commissioning Bodies should ensure:

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

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

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

Under the ‘elements’ column there are cross references to the Standard NHS Contract for Community Services – bilateral (main clauses and schedules). (The cross references also apply to the clauses and schedules in the Standard NHS Contract for Acute Services). This is to assist commissioning bodies 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>
</table>
| Governance | Leadership Cross references to the Standard NHS Contract for Community Services Module C: 11,16,19,33,48,49,51,53,60 Module D: Schedules: 6,15 | Clarity of the organisation’s purpose with explicit commitment to providing high quality services  
A culture that demonstrates an open learning ethos  
An organisation that is legal and ethical in all its activities | Provider must have organisational structure that provides leadership for all professions and disciplines  
In particular, there must be a corporate clinical director with the responsibility and accountability for the clinical service  
There must be a learning framework in the organisation | There should be a designated clinical director with responsibility and accountability for the diabetes prevention and risk assessment services |
| Governance | Integrated Governance Cross references to the Standard NHS Contract for Community Services Module C: 11,19,27,48,49,51,53,54,56,60 Module D: Schedules: 6,12,15 | An organisation that is guided by the principles of good governance:  
- clarity of purpose  
- participation and engagement  
- rule of law  
- transparency  
- responsiveness  
- equity and inclusiveness  
- effectiveness and efficiency  
- accountability  
An organisation that accepts responsibility and accountability for all its actions | Clear organisational and integrated governance systems and structures in place with clear lines of accountability and responsibilities for all functions. This includes interfaces and transitions between services | Quality Governance in the NHS. A guide for provider boards |
| Governance | Clinical Governance Cross references to the Standard NHS Contract for Community Services Module B: Sections: 1 (part 2), 3, 4 Module C: 4,4A,6,9,10,12,14,15,16,17,19,21,26,27,29,31,32,33,48,49,51,53,54 | Explicit commitment to quality and patient safety  
Patient focused with respect for the personal wishes of patients in all aspects of their care  
A commitment to innovation and continuous improvement | Clinical Governance systems and policies should be in place and integrated into organisational governance with clear lines of accountability and responsibility for all clinical governance functions  
e.g.  
- Clinical Audit  
- Clinical Risk Management  
- Untoward Incident Reporting  
- Raising Concerns  
- Staff Development  
- Complaints Management  
- Patient and Public Involvement  
- Patient dignity and respect | All sub-contractors must meet governance and leadership arrangements of the main provider organisation  
Commissioner, provider and NHS Litigation Authority must review the Clinical Negligence Scheme for Trusts arrangements/or other organisational / professional indemnity arrangements  
The service should have in place written protocols and procedures defining clear lines of accountability and responsibility  
The service is required to comply with guidelines, public health guidance and appraisals published by the National Institute for Health and Clinical Excellence that are relevant to the care provided by the service |
### Governance

**Module D:**
- Schedules: 3, 6, 10, 11, 15, 17

- 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
   - Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population.
   - Type 2 diabetes: preventing the progression from pre-diabetes to type 2 diabetes among high risk groups (public health guidance) expected publication May 2012.
   - Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence.

### Clinical Quality

**Quality assurance**

Cross references to the Standard NHS Contract for Community Services

- Module C: 4, 12, 16, 17, 18, 19, 20, 21, 31, 32, 33, 54
- Module D: Schedules: 2, 3, 6, 10, 11
- Module E: 3, 4

Understanding the concept of clinical quality

- Has concern for quality while working efficiently
- An understanding of the use of audit, patient and staff feedback to improve quality
- An organisation that provides clarity of objectives and promotes reflective practice to improve quality of patient care

Quality assurance systems must be in place and approved by commissioning body with regular reporting of outcomes.

Providers are required to publish quality accounts for the public reporting of quality including safety, experience and outcomes.

Providers should participate in national audit programmes.

Diabetes prevention and risk assessment services must comply with the following access targets:

- Individuals undergoing blood glucose tests, e.g. as part of the NHS Health Checks, who are found to have results outside normal parameters should be referred to and seen by diabetes diagnosis and continuing care services within a week.
- Symptomatic individuals undergoing blood glucose tests e.g. as part of the NHS Health Checks, who are found to have results outside normal parameters should be referred and seen within the same day.
- Individuals who are vomiting should be referred to A&E immediately.

The service is required to participate in the following activities/programmes:

- Patient Experience Surveys
- Diabetes E
<table>
<thead>
<tr>
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<tr>
<td>Clinical quality</td>
<td>Workforce / staff</td>
<td>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</td>
<td>Staff are competent and fit for purpose</td>
<td>Provider to satisfy commissioner that they can recruit (or procure) and retain a competent clinical team to deliver the service</td>
</tr>
<tr>
<td>Clinical quality</td>
<td>Cross references to the Standard NHS Contract for Community Services</td>
<td>Provider to satisfy commissioner that all staff have current appraisal, clearances and registration checks and have demonstrated competence in all procedures relevant to pathway</td>
<td>Specific qualifications required of health professionals providing the service are:</td>
<td>All healthcare professionals involved in delivering diabetes prevention and risk assessment care are required to have the following relevant competencies (see Skills for Health - Diabetes Competencies for diabetes)</td>
</tr>
<tr>
<td>Clinical quality</td>
<td>Staff are competent and fit for purpose</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 diabetes prevention and risk assessment care are required to have the relevant competencies in using appropriate equipment, e.g. blood glucose and ketone monitors</td>
</tr>
<tr>
<td>Development</td>
<td>Cross references to the Standard NHS Contract for Community Services</td>
<td>All healthcare professionals involved in delivering diabetes prevention and risk assessment care are required to have the following relevant competencies (see Skills for Health - Diabetes Competencies for diabetes)</td>
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| Clinical quality | Registration and licensing  
Cross references to the Standard NHS Contract for Community Services  
Module B: Sections: 3,5  
Module C: 4,4A,5,9,10, 11,12,14,15,16, 17,18,19,21,26,27, 29,33,34,35,36,38,40, 43,48,49,52, 53,54,56,60  
Module D: Schedules: 6,10,11,12,15 | The Provider is required to be registered with the Care Quality Commission to demonstrate that 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:  
- Coronary Heart Disease NSF 16  
- The Mental Health Strategy27  
Compliance with Care Quality Commission Reviews                                                                                                      |
| Clinical quality | Outcomes  
Cross references to the Standard NHS Contract for Community Services  
Module B: Section: 1 (part 3),3  
Module C: 4A,14,  
Module D: Schedule 11 | Comprehensive understanding and commitment to delivering and improving outcomes of care | Compliance with the NHS Outcomes Framework18                                                                 |                                                                                                       |
| Clinical quality | Patient pathway  
Cross references to the Standard NHS Contract for Community Services  
Module B: Sections: 1 | Responsiveness and participative approach to including patients’ views about their care in the design of care pathways  
Collaboration with other organisations involved in the patient pathway to provide a seamless pathway of care | All possible entry and exit points must be defined with comprehensive patient pathways that facilitate smooth passage and effective, efficient care for patients  
All interfaces in the pathway must be defined so that continuity of care is ensured with no fracturing of the pathway | The pathway of a diabetes and risk assessment service includes the following activities:  
i. Raising awareness on healthy lifestyles and risk factors for diabetes  
ii. Advice on healthy lifestyles and risk factors for diabetes  
iii. Risk assessment/screening for people at high risk of diabetes  
iv. Referral to prevention services that improve lifestyles/reduce risk factors for diabetes |
<table>
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<td>Module C: 4, 4A, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20, 21, 27, 29, 31, 33, 34, 35, 36, 38, 40, 52, 54</td>
<td>There must be specification of cleartimelines and alert mechanisms for potential breaches.</td>
<td>v. Referral for investigation and diagnosis of diabetes</td>
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<td>Module D: Schedules: 2, 3, 4, 9, 11, 17</td>
<td>There should be audit of pathway to ensure that standards are met.</td>
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<td>Raising awareness and advice:</td>
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<td>Module E: 5</td>
<td>There must be explicit specification of provider and commissioner responsibilities for the whole patient episode from first contact with the service to final discharge.</td>
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<td>- local campaigns on diabetes and related conditions, e.g. obesity, CHD etc.</td>
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<td>Accountabilities should be agreed and documented by all stakeholders.</td>
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<td>- support to national campaigns on diabetes and related conditions, e.g. change for life campaign.</td>
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<td>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>
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<td>- targeting specific populations, e.g. Asian, obese, travellers etc</td>
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<td>At entry to pathway: The Commissioner should assure themselves that the provider has systems and processes in place to:</td>
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<td>- awareness raising in many locations e.g. schools, GP practices, supermarkets, sports centres, pharmacies, LTC centres, pubs/clubs, maternity units, local employers, Care Homes, centres of worship, for people with learning disabilities and severe mental illness, prisons, charities/ third sector providers</td>
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<td>i) register patients</td>
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<td>Risk assessment/ screening:</td>
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<td>ii) collect relevant clinical and administrative data</td>
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<td>- There should be agreed protocols for the identification of children, young people, adults and older people who may be at risk of developing diabetes, e.g. NHS Health Checks for 40 - 74 year olds.</td>
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<td>iii) manage the appointment process, (reappointment and DNA process, if appropriate)</td>
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<td>- There should be agreed protocols for the screening of pregnant women for gestational diabetes.</td>
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<td>iv) provide information to patients</td>
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<td>- There should be agreed protocols in place to screen for diabetes in Nursing and Care Homes, including those that care for older people with mental health conditions, e.g. dementia.</td>
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<td>v) undertake initial assessment in the appropriate location</td>
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<td>- There should be protocols for the screening for diabetes in older people that utilise appropriate methods for this population.</td>
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<td>At point of intervention: The Commissioner should assure themselves that the provider has systems and processes in place to ensure that:</td>
<td></td>
<td>Referral to prevention services:</td>
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<td></td>
<td>i) the advice and intervention is conducted safely and in accordance with accepted quality standards and good clinical practice.</td>
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<td>- There should be protocols to signpost individuals who attend diabetes prevention and screening services for other help and advice, e.g. healthy diet regimes, weight management programmes etc.</td>
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<td></td>
<td>- People at risk of diabetes may need to be referred to the following prevention services to increase their chances of improving their health:</td>
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<td>- NHS Health Checks.</td>
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<td>- Weight management programmes</td>
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</tbody>
</table>
| Clinical quality | Patient pathway |  | ii) the patient receives appropriate care during the intervention(s), 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  
| | | 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) make urgent onward referrals where life-threatening conditions or serious unexpected pathologies are discovered during an intervention/assessment  
| | | ii) ensure that patients receive discharge information relevant to their intervention including arrangements for contacting the provider and follow up, if required  
| | | iii) provide timely feedback to the referrer regarding intervention, complications and proposed follow up, if required  
| | | iv) ensure that support is in place with other care agencies as appropriate  
| | |  
| | | Referral to services that will investigate and diagnose diabetes:  
| | |  
| | | • Exercise facilities  
| | | • Motivational workshops  
| | | • Smoking cessation  
| | | • Surgery (e.g. bariatric surgery) or drugs to reduce weight  
| | | People at risk of developing diabetes may need to be referred to services that investigate, confirm and manage diabetes as part of their care  

<table>
<thead>
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<th>ELEMENTS</th>
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<td>Estates and equipment Cross references to the Standard NHS Contract for Community Services Module C: 5, 33, 56 Module D: Schedules: 2, 3, 4, 6, 11, 17</td>
<td>Commissions 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.</td>
<td>H&amp;S strategy and policies in place and implemented with awareness throughout the organisation. Accessibility to executive responsible for H&amp;S. Health and safety policies as per provider agreement with commissioners.</td>
</tr>
<tr>
<td>Clinical quality</td>
<td>Knowledge and understanding of building regulations Access to advice on “fit-for-purpose” equipment and facilities</td>
<td>Understanding of building regulations. Understanding of clinical accountabilities of health and safety policies.</td>
<td>Commission to efficient use and satisfactory maintenance of equipment.</td>
</tr>
<tr>
<td>Clinical quality</td>
<td>Data and information management Cross references to the Standard NHS Contract for Community Services Module C: 4, 51, 17, 19, 54, 56, 60</td>
<td>Cross references to the Standard NHS Contract for Community Services Module D: Schedules: 2, 3, 4, 6, 11, 17.</td>
<td>The ability to analyse data and have access to information that can predict trends and that could identify problems. The ability to capture evidence based practice from R&amp;D National Service Frameworks, NICE guidance. The ability to use data and information appropriately to improve patient care. Transparency and objectivity.</td>
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<td>Data and information management</td>
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<tr>
<td>TOPIC</td>
<td>ELEMENTS</td>
<td>CHARACTERISTICS, SKILLS AND BEHAVIOURS</td>
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| Data and information management | Strategy and policies | | • 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 | |
Commissioners and providers should take responsibility for making references to the latest version of the various documents and guidance.

7. NICE Preventing the progression from prediabetes to type 2 diabetes among high risk groups (public health guidance) expected publication May 2012, http://guidance.nice.org.uk/PHG/Wave19/62
8. NICE, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, Jan 2009, http://guidance.nice.org.uk/CG76
9. NHS Institute for Innovation and Improvement, model CQUIN scheme: inpatient care for people with diabetes, 2009
13. Department of Health, Royal College of General Practitioners, Royal Pharmaceutical Society of Great Britain, NHS Primary Care Contracting, Guidance and competences for the provision of services using practitioners with special interests (PwSis) - Diabetes, http://www.rcgp.org.uk/pdf/CIRC_PwS%20Diabetes.pdf


Standard Service Specification Template for Diabetes Prevention and Risk Assessment Services

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

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

The following documentation, developed by the Diabetes Commissioning Advisory Group, provides further detail/guidance to support the development of this specification:

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

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

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

Description of diabetes prevention and risk assessment services:

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

The final specification should take into account:

- national, network and local guidance and standards for diabetes services.
- local needs.

This specification is supported by other related work in diabetes commissioning such as:

- the web-based Diabetes Community Health Profiles (Yorkshire and Humber Public Health Observatory)
- the web-based Health Needs Assessment Tool (National Diabetes Information Service).

These provide comprehensive information for needs assessment, planning and monitoring of diabetes services.

Introduction

- A general overview of the services identifying why the services are needed, including background to the services and why they are being developed or in place.
- A statement on how the services relate to each other within the whole system should be included describing the key stakeholders/relationships which influence the services, e.g. multi-disciplinary team etc
- Any relevant diabetes clinical networks and screening programmes applicable to the services
- Details of all interdependencies or sub-contractors for any part of the service and an outline of the purpose of the contract should be stated, including arrangements for clinical accountability and responsibility, as appropriate

Purpose, Role and Clientele

1. A clear statement on the primary purpose of the services and details of what will be provided and for whom:
   - Who the services are for (e.g. individuals of all ages at risk of diabetes)
   - What the services aim to achieve
   - The objectives of the services
   - The desired outcomes and how these are monitored and measured

Scope of the Services

2. What does the service do? This section will focus on the types of high level therapeutic and lifestyle interventions that are required for the types of need the services will respond to.
   - How the service responds to age, culture, disability, and gender sensitive issues
   - Assessment – details of what it is and referrals to all relevant services/care
   - Service planning – High level view of what the services are and how they are used; how patients enter the pathway/journey; what are the stages undertaken and follow up care. The aims of service planning are to:
     - Develop, manage and review interventions along the patient journey
     - Ensure access to other services/care, as appropriate
   - Holistic review of individuals at risk of developing diabetes using the principles of an integrated care model for people with long term conditions that is centred around the individual
   - Risk assessment procedures, e.g. NHS Health Checks
   - Detail of evidence base of the service – i.e. the contracting framework for diabetes prevention and risk assessment services, guidance produced by the Royal College of Physicians, Diabetes UK, etc.

Service Delivery

3. Individual Journey/pathway
   Flow diagram of the patient pathway showing access and exit/transfer points – see the diabetes prevention and risk assessment intervention map as a starting point

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

5. This will include a breakdown of how the patient will receive the services and from whom. It should be a clear statement of staff qualifications/experience and/or training (if appropriate) and clinical or managerial supervision arrangements. It should specify, as appropriate:
   - Geographic coverage/boundaries – i.e. the services should be available for all individuals of all ages groups who live in the clinical commissioning group area
   - Hours of operation
   - Minimum level of experience and qualifications of staff (i.e. doctors – diabetologists and GPs, Nursing staff – diabetes nurse specialists, district, practice nurses etc, other allied health professionals, e.g. podiatrists, dietitians, optometrists, pharmacists etc and other support and administrative staff)
   - Staff induction and developmental training

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

Identification, Signposting/ Referral and Acceptance criteria

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

8. How should individuals be referred or how are they signposted?
   - Who is acceptable for referral and from where
   - Details of evaluation process - Are there clear exclusion criteria or set alternatives to the service? How might an individual be transferred?
   - Response time detail and how are individuals prioritised
Discharge/Service Complete/Transfer/Transition criteria

9. The intention of this section is to make clear when an individual should be transferred from the diabetes prevention and risk assessment service to another and when this would be reached.

- How is the intervention pathway reviewed?
- How does the service decide that an individual is ready for discharge/transfer to other services?
- How are goals and outcomes assessed and reviewed?
- What procedure is followed on discharge, including arrangements for follow-up?

Quality Standards

10. The service is required to deliver care, where appropriate, according to the standards for clinical practice set by the National Institute for Health and Clinical Excellence.

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.

Activity and Performance Management

13. This must include performance indicators, thresholds, methods of measurement and consequences of breach of contract. These will be set and agreed prior to the signing of the overall agreement.

14. Activity plans – Where appropriate, identify the anticipated level of activity the service may deliver; provide details of any activity measures and their description/method of collection, targets, thresholds and consequences of variances above or below target.

Continual Service Improvement

15. As part of the monitoring and evaluation procedures, the service will identify a method of agreeing measurements for continuous improvement of the service being offered and work to ensure unmet need is both identified and brought to the attention of the commissioner.

16. Review

This section should set out a review date and a mechanism for review.

The review should include both the specifications for continuing fitness for purpose and the providers’ delivery against the specification.

This should set out the process by which this review will be conducted.

This should also identify how compliance against the specification will be monitored in year.

17. Agreed by

This should set out who agrees/accepts the specification on behalf of all parties.

This should include the diabetes providers, commissioner and network (if appropriate).

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