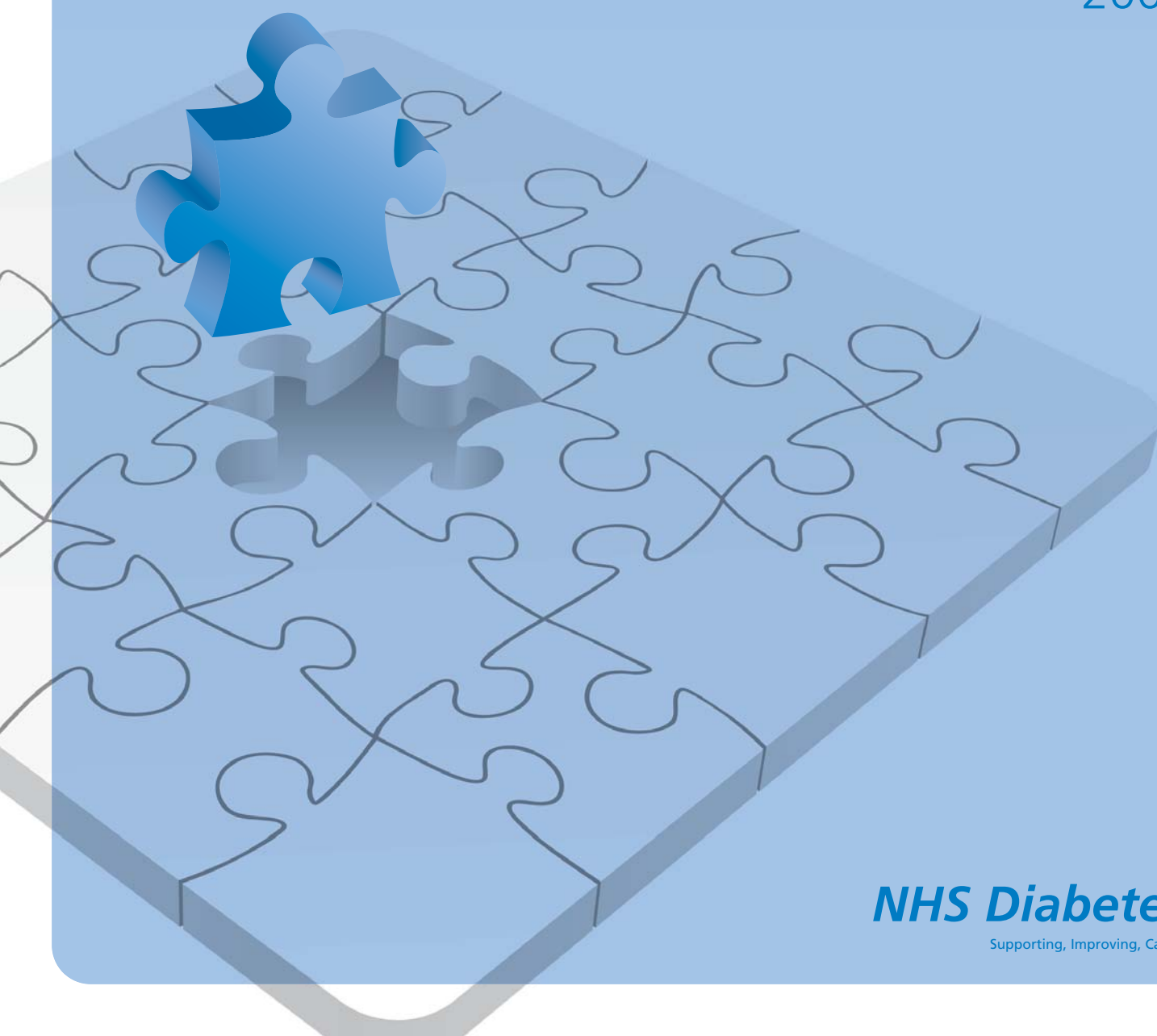


Commissioning Diabetes Without Walls

2009



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The following organisations have contributed to the development of this document:

RCP, NHS Diabetes, DH, RCGP, RCPCH, RCS, RCN, PCDS, CDC

Diabetes UK, ABCD, NDIS

Background of the Diabetes Commissioning Guide

Update on the 2006 Diabetes Commissioning Toolkit

In 2006, the Diabetes Commissioning Toolkit was launched to support commissioning of improved quality of diabetes care and patient experience. The Toolkit was well received and has guided many areas to better care and value for money. It was always the intention to refresh the Toolkit to reflect the changes in policy and clinical progress and to continue the aim of improving services to improve the outcomes, experience and design of diabetes services for people everywhere. The Diabetes Without Walls Guide is supported by the NHS Diabetes Commissioning website.¹

New policies since the 2006 publication

National policy has changed the face of commissioning services since the original commissioning toolkit was published, the key policy changes include:

- The introduction of World Class Commissioning² which encourages providers to achieve a high quality of care;
- Practice Based Commissioning³ which leads to higher clinical engagement in commissioning; and;
- The Next Stage Review⁴ that promotes a patient-centred, integrated whole-system service that delivers diabetes care when, where and how it is required to meet individual needs.
- The NHS Constitution⁵ recognises that effective care planning gives each individual a more equal voice in their care. Efficient delivery of highest measurable quality of clinical services and experience for those individuals is now monitored by the Care Quality Commission (CQC). To support the quality agenda, NICE has published advice on managed introduction of newer expensive therapies and support for new service commissioning.

¹ NHS Diabetes website is available at: www.diabetes.nhs.uk

² World Class Commissioning www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083204

³ Practice based commissioning www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/DH_076565

⁴ High Quality Care for All, the Next Stage Review www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

⁵ The NHS Constitution for England www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419

Commissioning Diabetes Without Walls

Everyone with diabetes deserves the highest standards of personalised diabetes care no matter where, when or by whom it is delivered.

Diabetes is a common, complex, lifelong, and life-threatening condition. In diabetes, health and well-being are determined by the way in which a person with diabetes cares for him or herself, as well as the care, education and support provided by healthcare and other professionals, and the overall organisation of care.

Diabetes care may involve multiple professionals in many places working in different hierarchies with different funding and variable communication. Fragmented and disorganised care can cause confusion, duplication and omission. Inefficient care is frustrating and possibly damaging for patients, and wastes health and social resources. Health care professionals delivering diabetes care must be trained in diabetes, and must know the boundaries of their knowledge. They must have opportunities to extend these boundaries and keep up to date.


The person with diabetes is central to his or her care and must be continuously involved in care planning and management decisions. Patients want good care, convenient to home or work and tailored to their needs at that time. They want a clear, well-organised system where everyone looking after them knows what is going on, and what they are doing. If they have a problem then they want prompt, expert advice.

Because people with diabetes pervade all parts of the NHS from GP surgery to the intensive care unit, and all specialties, it makes sense to integrate diabetes care across all sectors. Arrangements should be flexible as patients move around the different parts of the NHS at different times in their diabetic career.

Commissioning should provide for routine annual review as well as for specialist care as needed (e.g. unstable or complex diabetes, kidney care, eye care, pregnancy). It is crucial to ensure good communication with the patient and between all professionals and agencies managing the patient. It is also crucial to provide prompt, effective social support for patients as its lack can harm diabetes outcomes (e.g. problems managing at home worsening, diabetic foot ulcers and precipitating prolonged hospital admission). Diabetes interacts with other health problems – in most cases making management more complex or intensive, and usually more expensive.

Diabetes is inexorably increasing in frequency. We must ensure that we use our resources wisely to support high quality diabetes services, which provide good value for money in a sustainable way.

Teams without Walls (2008) is a collaborative project between the Royal Colleges of Physicians, General Practitioners and Paediatrics & Child Health, supported by the NHS Alliance.



The working report states:

“Teams without Walls (TWW) is an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians.

The aspiration behind this paper is to create an NHS that puts the patient at the centre of everything we do – involved, empowered and enabled to achieve the very best outcomes for their health. Services will be organised around patient journeys through the NHS, translating the latest evidence into practice, with patients cared for by competent teams, delivering services close to home where it is safe and sustainable to do so.”

World class commissioning (WCC) is transforming the way services are commissioned, leading to improved health outcomes and reduction in health inequalities, adding life to years and years to life. The Department of Health’s focus on strong user and clinical involvement in the commissioning process fits well with the emphasis within the diabetes community of working in a TWW way.

WCC promotes and encourages innovation in commissioning and enables the NHS to ensure quality of care, whilst increasing cost efficiency and productivity. World class commissioning will deliver better health and well-being, care and value for all.

The TWW approach starts with commissioners getting to know everyone who can help them in their PCT area – a diabetes commissioning team without walls. Your local diabetes network can help. Talk to people who have diabetes, people who know about diabetes and people who are delivering diabetes care. Break down the walls within your patch. A plan is on paper. It is people who deliver the service. You may find you have more local expertise and resources than you realise.

I greatly appreciate all the help we have had in this project from the many collaborators and stakeholders. We hope that this commissioning guide will be a useful resource for NHS commissioners, and will ensure that high-quality care is available for everyone with diabetes.

Dr Rowan Hillson MBE

National Clinical Director for Diabetes

Aims of the 2009 Diabetes Without Walls Guide

Diabetes care should be excellent, safe and affordable, and boundaries that hinder effective collaborative working between health professionals should be removed.

This commissioning guide aims to provide those commissioning, delivering and receiving diabetes services with the tools to:

- Efficiently undertake an effective Health Needs Assessment of their local population to gain an accurate picture of the local clinical need
 - Support local prioritisation of effort and improvements based on the Health Needs Assessment outcomes, to provide an accurate reflection of what people want or need from the service
 - Support service improvements in prioritised areas of diabetes care by offering guidance and a practical evidence base through the use of realistic and meaningful case studies.
- Support implementation of a truly integrated diabetes services
 - Promote the concept of supporting self-care and self-management where appropriate, to ensure that a variety of mechanisms for supported self management are available to all.
 - Support effective measurement of service improvements in diabetes care, to drive the desired outcomes and maintain a consistent focus on the aims of the service
 - Offer a full suite of resources and tools to support the Diabetes Commissioning Guide on the NHS Diabetes website

Commissioning Diabetes as a long term condition

With the focus on improving quality, innovation and productivity, we are moving towards a commissioned long term conditions service for individuals, regardless of the conditions they live with. Using innovation, integration reduces duplication of diagnostic tests, appointments, improves quality and productivity, as so reduces costs. An integrated approach will bring also benefits to service users by consolidating the processes currently offered by individual specialty areas into a more streamlined care experience.


The 2009 Commissioning guide supports the move to integrated care, particularly within integrated Vascular Management. However, the reality is that this aspiration is still some way from delivery in most places, and there is still need to recognise commissioning of integrated diabetes care as a specialty for now.

Ten top tips for the commissioning of long term conditions

The DH Long Term Conditions Team has put together the following ten top tips for the commissioning of Long Term Conditions.

These principles also apply to the commissioning of diabetes services:

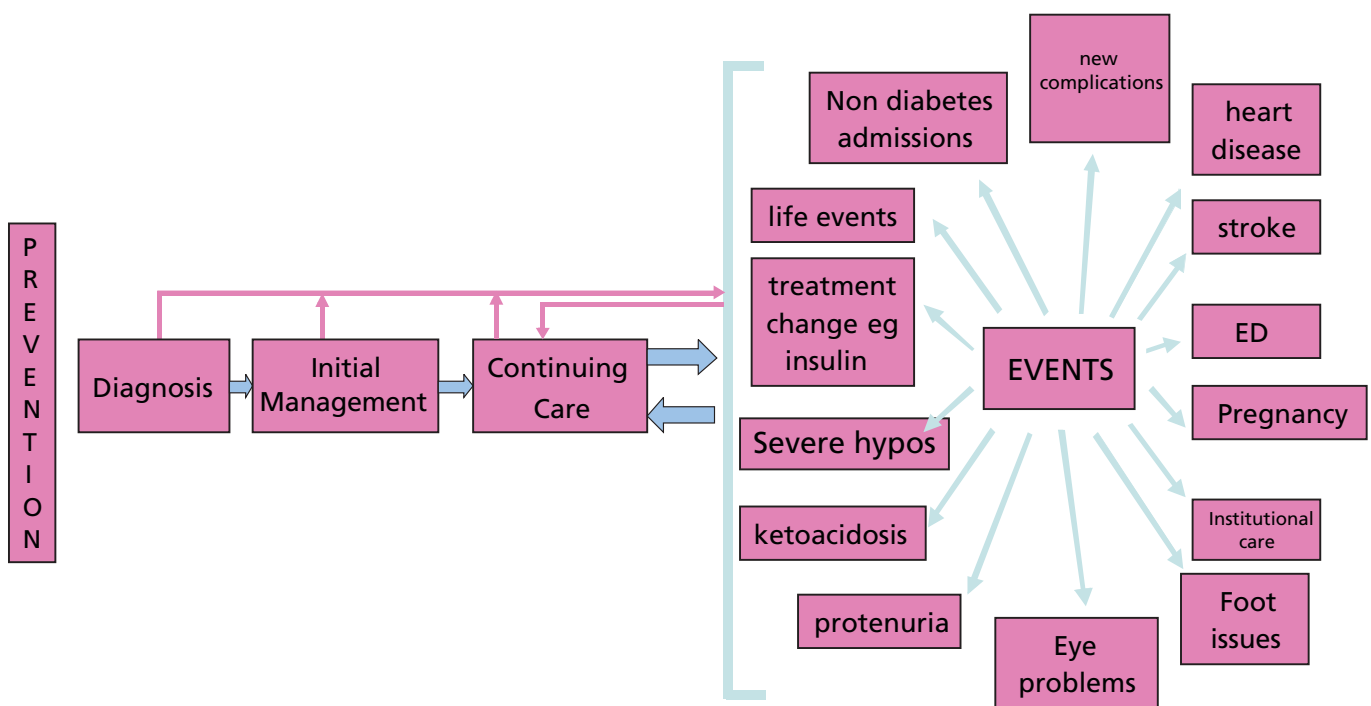
- 1 Proactively create a user-centred, can-do culture.** Create a simple user-centred vision for the whole system, i.e. diabetes care, and promote it using clinical champions, user cases, etc.
- 2 Share one vision, strategy, priorities and targets.** Invest in a close working relationship with other commissioners focused on a single vision. Establish clear joint working arrangements and work as one team to develop a single joint strategy which meets the targets of all commissioners.
- 3 Stimulate and support provider innovation to meet specifications.** Encourage the integration of services that are not disease-specific e.g. community and social care. Support frontline co-working of integrated teams, e.g. team development, clinical champions, making populations co-terminus. Facilitate exposure to ideas from elsewhere. Fund/use PCT capacity and capabilities to support pilots.
- 4 Assess user risk using existing algorithms with primary care data.** Use a recognised method, e.g. the combined predictive model (Kings Fund) and clinical judgement or, failing that, a simpler method e.g. a whiteboard system.
- 5 Innovate to educate and motivate users and carers for self care.** Promote motivational interviewing and co-creation staff training. Also develop motivational counselling service for users. Promote on-going user education courses, e.g. DESMOND – engage and incentivise GPs to refer; use sales and marketing techniques. Use expert service users.

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- 6 **Specify few measures of outcome and experience, including integration.** A single specification and contract for jointly commissioned services. Specify integrated care and only a few of the most pertinent metrics, e.g. delayed discharge, admissions avoided, user satisfaction.
 - 7 **Clear professional responsibility for specific user outcomes.** Assign responsibility for wellbeing of a defined population to a provider. Specify one 'key work' for each service user to coordinate and integrate across services and professionals.
 - 8 **Take quick wins and work-arounds in IT.** Enable remote ready-only access. Transfer paper records to one of the existing IT systems. Support development/ purchase of a new IT for a workable subset of providers.
 - 9 **Establish information sharing protocols and consensus** – Agree to sharing protocol between commissioning organisations. Ask providers to get user consent to share information with the other local professionals supporting them. Run pseudo-anonymised reports to share. Involve and engage clinicians; make information sharing optional for GPs initially. This can reduce duplicated care and testing.
 - 10 **Engage and upskill primary and community care providers.** Ensure GPs are engaged in all developments. Create or specify roles responsible for improving a defined skill-set in a defined provider set, e.g. GP practice staff ability to treat diabetes.

Key Elements of High Quality Diabetes Care

High quality diabetes services are well integrated across primary, specialist, community, social services and child health services. The services are delivered by appropriately qualified staff working within their boundaries of knowledge and are skilled to understand the individual needs of someone living with a long-term condition.

The journey of a person with diabetes varies depending on age, complexity of the condition, and their lifestyle and expectations. In general, the journey encompasses a series of interventions that have been described in the Diabetes National Service Framework in the following model:



Key characteristics of Integrated Diabetes service

Fully integrated diabetes care offers the experience of seamless services across primary, emergency, specialist, community and social care. The care is designed around each individual's need for long term condition care, regardless of conditions. This requires care delivered by diabetes-skilled and specialist staff within the multi-disciplinary team. The services will emphasise support for individuals to self-care (take control of their own care) within their communities.

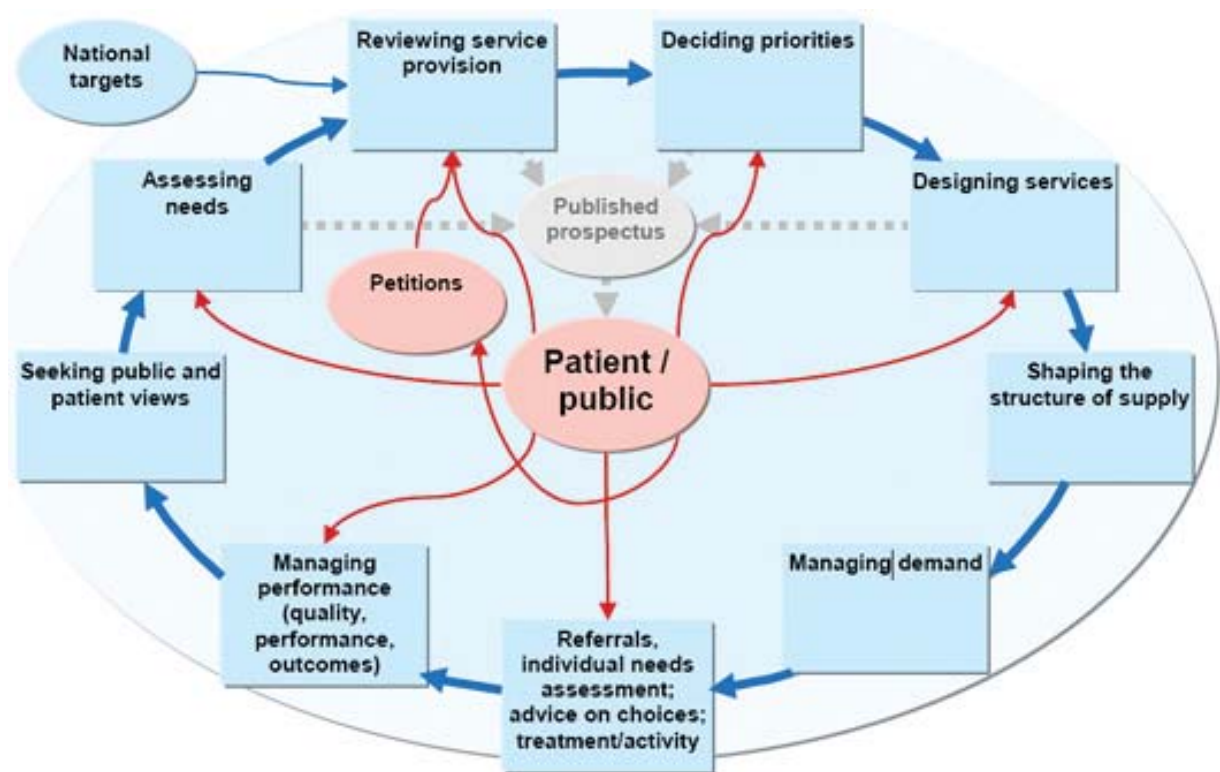
Specifically they are likely to:

- Maximise opportunities for preventing complications of diabetes through an effective empowerment and partnership approach, focusing on individual care planning, support for professional and patient education, and emotional and psychological care
- Provide appropriate specialist care when and where it is convenient to the person with diabetes (care closer to home)
- Provide early proactive intensive care of at high risk cases with early complications
- Provide a multidisciplinary approach using effective communication across boundaries and specialties
- Provide a service commissioned on use of competencies, not roles, to deliver care
- Provide improved inpatient care, by responding to the requirements of the person with diabetes and to reduce their length of stay in hospital regardless of the reason for admission
- Reduced amputations through improved awareness and treatment by ward staff
- Provide a safe use of insulin / prescribing whatever the context
- Provide early information and specialist diabetes support for pre-conception and pregnancy for women who have diabetes
- Ensure children and young people and their families using services are informed and empowered to take control of their care,
- Ensure children and young people and their families using services experience a smooth transition into adult services through professionals working across boundaries to ensure this happens
- Provide dignity and respect to older people with diabetes and offer a multi-disciplinary service to meet individual needs

Commissioning an integrated diabetes service

Commissioning diabetes must be seen as a whole system, integrated approach, covering the entire diabetes patient journey to ensure that opportunities for improving care and making most efficient use of resources is realised. The processes used for integration should be actively

commissioned, in addition to service design and performance. The integrated approach reflects the 'Teams Without Walls'⁶ concept developed by the Royal College of Physicians, and is reflected in the Department of Health full commissioning framework cycle below:



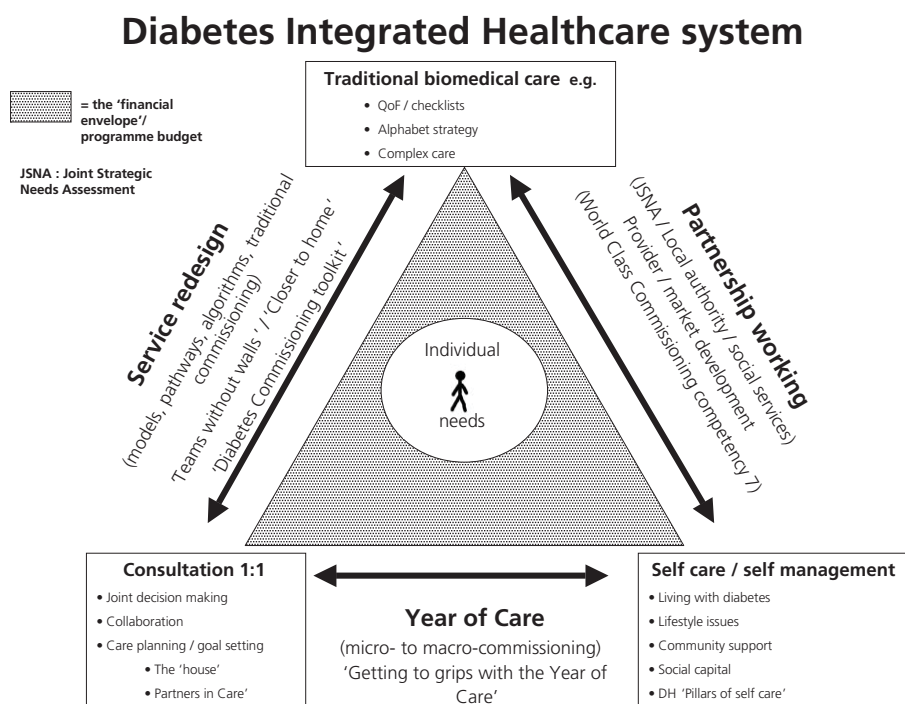
In redesigning diabetes services, which will dissolve barriers between organisations and professions, a much closer partnership approach is needed. An integrated care pathway approach to service delivery is required, and this takes joint commissioning between health and social

care, improved information sharing between organisations, more effective planning across different organisations in a local health economy, and improved arrangements for working between different assessment and planning systems.

⁶Teams without Walls. The value of medical innovation and leadership, Report of a Working Party of the Royal College of Physicians, the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health (2008)

Successful implementation of integrated working depends on effective clinical leadership, service user representation, and innovation in planning work across the traditional primary / secondary care boundaries. Clinical engagement and

innovation will drive improved outcomes. Clinicians' professional experience of delivering care, and understanding of patients' needs, will be crucial to designing high-quality personalised health and care services.



All components need to be commissioned. At the centre of the model are the needs of the individual person with diabetes (and / or other long term conditions).

At the three corners of the triangle are the key components of care to meet those needs. The balance of these for each individual will depend on the nature of their condition, and the way the condition affects the person themselves. The three elements all commissioners will need to commission are:

1. Traditional 'biomedical' care either as part of a surveillance and secondary prevention programme, or as part of clinical management.
2. Collaborative one-to-one consultations between the person with diabetes and the healthcare professional, based on a partnership approach which is effective in supporting self-management. This is embodied in 'care planning'.
3. Services which support the individual living with the condition within their community with an emphasis on support for self-care.

We offer some case study models of integrated care in our web-based commissioning tool, but there is no single correct way to integrate care. Models and methods need to be locally sensitive.

Delivering Diabetes World Class Commissioning

To support the development of World Class Commissioning the Department of Health published a set of competencies identifying the knowledge, skills, behaviours and characteristics that underpin effective commissioning⁷ and an Assurance Framework to assess how commissioners are progressing towards world-class performance⁸.

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

Commissioning care for a specific condition such as diabetes will need to take place within the context of a more strategic commissioning process, within the Long Term Conditions context. Strategic needs assessment will involve working across partner organisations to assess the potential demands that are facing the service now and in the future. Linking this assessment with the results of patient and community engagement will enable commissioners to understand how the resources available could be better spent or further investment made to improve

services and outcomes. Commissioners will then be in a position to discuss their needs with existing or alternative providers to see what contribution they might make to the overall delivery of the solution.

What will be needed for effective commissioning of diabetes care?

Commissioning diabetes care should be a strategic process involving a wide range of different people, including patients, carers and clinicians, and taking into account the local vision for health and social care in the whole community.

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

⁷ Available on the DH website at www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Competencies/index.htm

⁸ Available on the DH website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085148

Tools to support diabetes commissioning

1. Electronic Diabetes Health Needs Assessment Tool

The Diabetes Health Needs Analysis Tool, developed by the National Diabetes Information Service (NDIS), provides a fully populated Health Needs Assessment for your PCT. This draws together key data and modelling to assist commissioners in relating national good practice to their local services. The Health Needs Analysis Tool will help ascertain if diabetes should be a particularly high local priority. We would welcome feedback from commissioners about how they have used these resources and any suggested improvements. The tool is available at: www.ndis.ic.nhs.uk

2. Community Health Profiles

Community Health Profiles, provided by the Yorkshire and Humber Public Health Observatory, supply data relating to adults with diabetes.

The tool is designed to provide an overview of the key areas of diabetes care and highlight issues for further investigation. It allows you to download a diabetes profile for each PCT in England so works as a benchmarking tool of current performance of diabetes care against other similar PCTs across the country.

Support from the Community Health Profiles will provide commissioners with

comparative diabetes performance data for their PCT which accessible from www.yhpho.org.uk/.

3. Diabetes Care Commissioning Guides

Once the Health Needs Assessment process has been completed and priority care areas have been selected for improvement, a set of guides to commissioning diabetes care have been produced to help improve specific health area needs and are available on the NHS Diabetes website www.diabetes.nhs.uk/commissioning

Commissioning Care Guides will be available for:

- **Diabetes and Pregnancy**
- **Diabetes for Children and Young People**
- **Diabetes Diagnosis and Continuing care**
- **Diabetes and Mental Health**
- **Inpatient Diabetes**
- **Foot care and Diabetes**
- **Diabetes and Kidney Care**
- **Diabetes and Learning Difficulties**
- **Diabetes and Retinal Screening, Neurology and Cardiovascular**
- **Diabetes care for Older People and Complex Needs**
- **End of Life Care**
- **Prevention and Risk Assessment**



4. Diabetes Programme Budgeting

Commissioners may also wish to link to the programme budgeting tool in order to assess how much is spent locally compared to benchmarked peers and what outcomes are achieved; this is a useful way for commissioners to assess across the portfolio where spend is (or is not) delivering required outcomes.

5. Quality and Outcome Framework

Commissioners have a number of different 'levers' available to them to support the process of service redesign and improvement. Commissioners may wish to examine the information available through the Quality and Outcomes Framework on the quality of primary care and can choose to provide further incentives through local

negotiation, for example through a local enhanced service (LES). Commissioners may also decide to negotiate local tariffs for services outside the scope of the national Payment by Results tariff for diabetes.⁹

6. Commissioning for Quality and Innovation

The Next Stage Review included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework¹⁰. The CQUIN schemes are locally determined based on local priorities.

Some suggested CQUINs and performance measures have been highlighted in the NHS Diabetes Commissioning Guides.

⁹ Further information on Diabetes and Payment by Results is available on the NHS Diabetes website at www.diabetes.nhs.uk

¹⁰ Available on the DH website http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/CQUIN/DH_095232

The value of specifying services

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

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


- That they were developed in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care (as set out in *National Standards, Local Action (DH)*)¹¹
 - Were designed in response to the local needs assessment, ensuring the service can meet the specific needs of the local population
 - Had an inclusive design process that involved people with diabetes, service user representatives and champions, and
- all clinicians with both specialist and generalist expertise
 - Took note of the principles of delivery for all long term conditions, embodied in the chronic care model (see the NHS and Social Care Long Term Conditions Model¹²)
 - Took into account the overarching principles of the Diabetes NSF¹³, including the centrality of self management as the key to good outcomes and the need for a proactive organisation
 - Made sure that there are a range of options available to people with diabetes to support self management and individual preferences
 - That where possible and realistic services are close to the user's home and based in the community
 - Ensured and demonstrated that staff have the competencies needed to deliver the functions
 - Are covered by written protocols and guidance that are adhered to and monitored¹⁴
 - Having agreed local plans to deliver key outcomes such as timeliness, continuity of care etc

¹¹ Available on the DH website at <http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf>

¹² Available on the DH website at <http://www.dh.gov.uk/en/Healthcare/Longtermconditions/Longtermconditionsmodel/index.htm>

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

¹⁴ Diabetes Competency Framework is available on the Skills for Health website at <https://tools.skillsforhealth.org.uk/suite/show/id/40>

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- Contributing to national data collections or audits
 - Providing the complete range of services to those people who are not able to access services in line with the locally agreed model of care, e.g. residential homes, prisons, travellers, housebound, those with long term complications and disabilities
 - Having arrangements in place for local audit, benchmarking against national quality markers (including patient/people with diabetes experience of services and a process for addressing the outcomes of such audits)
 - Actively monitoring take up of the service, responding to non-attenders, monitoring complaints and managing

outcomes across the population of patients by seeking out areas and individuals where further input would create improvements

This guide is not intended to be prescriptive; it is presented as good advice to support Diabetes Commissioners and highlights key issues to consider, as well as summarising available supporting resources and offering illustrations of how services are commissioned to respond to local needs in different parts of the country. It is recognised that each local health community will need to prioritise in different ways.

The Commissioning Guide is designed to support improved commissioning in areas of diabetes care prioritised as a *result* of a Health Needs Assessment process.

www.diabetes.nhs.uk

Further copies of this publication can be ordered from Prontaprint, by emailing diabetes@leicester.prontaprint.com
or tel: 0116 275 3333, quoting DIABETES 107