

*National Service Framework
for Diabetes:*

Delivery Strategy

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Foreword

There are 1.3 million people with diagnosed diabetes in England and every year the number of people living with diabetes increases. All deserve the best care we can offer because, if diabetes is undetected or untreated or if its complications are not managed well, it can have a devastating impact on quality of life – it is the biggest cause of kidney failure, the leading cause of blindness in adults of working age and one of the biggest causes of lower limb amputation, as well as significantly increasing the risk of coronary heart disease and stroke.

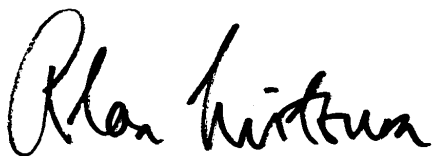
Diabetes services contain many examples of excellence. However at present services can vary enormously. We chose Diabetes as a National Service Framework because we are determined to improve the quality of care for people with diabetes regardless of where they live or who they are.

Our goal is to make the best practice already offered in some places the norm. There is strong evidence that by helping people manage their care in partnership with clinicians, and supported by good information, life expectancy can be increased, illness and disability reduced, and inequalities tackled.

Our vision, therefore, set out in the *Diabetes Standards* published last December, is of a service of excellence built on a genuine partnership with the person with diabetes – a true partnership as described in the *NHS Plan*.

This *Delivery Strategy* lays the foundations for implementing that vision. It sets out national objectives against which local NHS performance can be judged. But it also expects local health services to themselves set challenging, measurable targets that will result in tangible service improvements. This approach is in keeping with our aim of devolving responsibility to front line services. It is also the approach we shall take for future NSFs.

Over time, as this NSF is delivered locally, people with diabetes should expect better services and greater involvement in line with the framework outlined in this *Delivery Strategy*. Together with investment in NHS diabetes services, these reforms will help the NHS, over the next 10 years, deliver the improved standards we have already set out.



Alan Milburn
Secretary of State for Health



Executive summary

The *National Service Framework for Diabetes: Standards* published in December 2001 set out a vision of diabetes services which:

- leads to fewer people developing diabetes and better care for those who have it
- is centred around the needs of people with diabetes, developed in partnership with health care staff, equitable, integrated and focused on delivering the best outcomes for the person with diabetes
- offers care that is structured and pro-active providing people with the support they need to manage their own condition
- is encapsulated in standards, key interventions and implications for service planning.

The key elements proposed in this *Delivery Strategy* are:

- setting up a local diabetes network, or similarly robust mechanism, which involves identifying local leaders and appointing and resourcing network managers, clinical champions and a person(s) with diabetes to champion the views of local people
- reviewing the local baseline assessment, establishing and promulgating local implementation arrangements with a trajectory to reach the standards
- participating in comparative local and national audit
- undertaking a local workforce skills profile of staff involved in the care of people with diabetes and developing education and training programmes with the local Workforce Development Confederation.

It also reflects targets in *Improvement, Expansion and Reform: the next 3 years*:

- ensuring a systematic eye-screening programme to national standards
- putting in place registers, education and advice, to support systematic treatment regimens.

The *Delivery Strategy* offers a framework for the NHS to build capacity to:

- put in place building blocks for the NHS to reach the National Service Framework (NSF) standards over the next ten years
- deliver the national targets.

1 Introduction

- 1.1 The National Service Framework for Diabetes sets out a ten-year programme of change to deliver world class care and support for people with diabetes¹. The only way this better care and support can be delivered is through the development of the clinical practice of staff throughout the country. This *Delivery Strategy* suggests how this can be achieved.
- 1.2 It advocates how local progress can be made by 2006 to put the NHS on track to reach the NSF standards by 2013. Building on the *Standards*² published last December, it offers the framework for a systematic programme of reform. It provides a clear direction of travel together with scope for local determination of priorities and pace of change, enabling local people to build upon existing good practice as well as closing any gaps in service provision. It proposes an organisational framework to support health care professionals and ensure people with diabetes benefit from best practice wherever they live.
- 1.3 The burden of diabetes falls disproportionately on members of minority ethnic groups, older people and the poor. If badly controlled it can lead to blindness, coronary heart disease (CHD) and stroke, renal disease and lower limb amputations. As the most significant modifiable risk factor for Type 2 diabetes, action to tackle overweight and obesity will need to be central to local prevention strategies. Establishing good control of diabetes, including obesity management, will also contribute to better outcomes, reducing inequalities and the number of people with CHD.
- 1.4 The steps proposed in this document will build capacity to deliver better practice as well as putting in place basic building blocks to reach the NSF standards over the next ten years. The assumption is that Primary Care Trusts (PCTs) should consider:
- setting up a diabetes network, or similarly robust mechanism, identifying local leaders, appointing and resourcing network managers, clinical champions and a person(s) with diabetes to champion the views of local people
 - reviewing the local baseline assessment, establishing and promulgating local implementation arrangements with a trajectory to reach the standards
 - participating in comparative local and national audit
 - undertaking a workforce skills profile of staff involved in the care of people with diabetes and developing education and training programmes with their Workforce Development Confederation.
- 1.5 Delivering better care to all people with diabetes will take time. At local level it will be necessary to prioritise. Nationally, the initial priority is to focus on those who are at greatest risk of developing the complications of diabetes, indicated by poor diabetes control, and those newly diagnosed with diabetes, where the opportunity to implement the NSF standards from day 1 is greatest. A local approach to putting this into effect could initially offer:

1 References to “people with diabetes” in this *Delivery Strategy* include children and young people.

2 Department of Health. *National Service Framework for Diabetes: Standards*. London. Department of Health, 2001.

- information and appropriate psychological support and the opportunity to participate in structured (usually group) education to people diagnosed with diabetes after April 2003
- an agreed care plan, a personal diabetes record and named contact within the local service to all people diagnosed with diabetes after April 2003, along with people with poor blood glucose control (HbA_{1c} greater than 7.5%).

1.6 It will be for PCTs to decide the best approach to delivering the diabetes standards, drawing on the approach outlined in this *Delivery Strategy* whilst reflecting local circumstances and the communities they serve.

1.7 *Improvement, Expansion and Reform: the next 3 years*³, the planning and performance framework for 2003-2006, sets the priorities for the NHS over the next three years. It establishes two critical diabetes specific targets for eye screening and registers in the early stages of delivery:

- by 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007
- in primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006, ensure practice-based registers and systematic treatment regimens, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a body mass index (BMI) greater than 30.

1.8 Chapter 2 describes the organisational steps PCTs may wish to take in the first year to improve care by building capacity through diabetes networks, leadership and by supporting staff. Chapter 3 describes steps to deliver the targets over the next three years. Chapter 4 offers a framework to support PCTs in agreeing their local priorities and beginning to deliver the year-on-year improvements necessary to reach the standards. Where existing local arrangements work, and are compatible with delivering the standards, they should continue unless there are good reasons for change. Revenue funding will be included in baseline allocations to enable PCTs to make progress in delivering local priorities across the standards. Capital for retinal screening will be available to enable all PCTs to meet the national target by 2007.

1.9 This *Delivery Strategy* has been developed with the advice of an Implementation Group, jointly chaired by the former Chair of Council of the Royal College of General Practitioners, Mike Pringle, and the former Director of Policy of the Department of Health, Sheila Adam. Its membership was drawn widely from health care professionals across primary and specialist services, NHS management, national professional bodies, the voluntary sector and people with diabetes (see Annex). Its advice, and this document, has been informed by a frontline understanding of current service provision and constraints, and practical examples of what is possible when health care professionals, NHS managers and people with diabetes work together to solve problems and improve care. Examples of good practice are on the Diabetes NSF website at www.doh.gov.uk/nsf/diabetes.

³ Available at www.goh.gov.uk/planning2003-2006/index.htm.

1.10 The service framework offered in this *Delivery Strategy* is underpinned by the clinical framework for delivering consistent and high quality care put in place by the National Institute for Clinical Excellence (NICE) and should be used together with its current and forthcoming guidelines and appraisals.

1.11 Any comments or queries on this document should be addressed to:

Tara Mulvaney
Diabetes Team
Department of Health
Wellington House
133–155 Waterloo Road
London SE1 8UG
Telephone: 0207 972 4771
E-mail: tara.mulvaney@doh.gsi.gov.uk.

2 Building Capacity: Organisational Steps in the First Year

- 2.1 We assume PCTs will wish, where they have not already done so, to use the funds made available in baseline allocations to build the capacity of their health communities to reach the NSF Standards over the next ten years, delivering the planning and performance framework targets on the way.
- 2.2 Diabetes is a complex condition and people with diabetes need to access most parts of the health system. Experience has shown that better health outcomes and a reduction in health inequalities can be achieved if services are integrated.
- 2.3 Health care professionals, managers and people with diabetes in the Diabetes NSF Implementation Group identified the need for a local infrastructure to:
- build care around the person with diabetes, seeing services from their perspective and enabling staff to work across organisational boundaries to deliver the highest quality care to all
 - ensure services for diabetes do not stand in isolation. This is particularly important within primary care, where an integrated approach across NSFs in disease prevention and health promotion, across specialist services boundaries and in social care, will not only improve care but also make life easier for staff.
- 2.4 Building upon the experience of coronary heart disease (CHD), cancer and other clinical priorities, this chapter describes the organisational steps PCTs may wish to take to establish capacity where they do not have an alternative effective or robust mechanism. They can:
- set up a diabetes network, which involves identifying local leaders, appointing and resourcing network managers, clinical champions and a person(s) with diabetes to champion the views of local people
 - review the local baseline assessment, establish and promulgate local implementation arrangements with a trajectory to reach the standards
 - participate in comparative local and national audit
 - undertake a workforce skills profile of staff involved in the care of people with diabetes and develop education and training programmes with their Workforce Development Confederation.
- 2.5 Changes in these areas will be centrally supported by the NHS Modernisation Agency and the Long-term Conditions Care Group Workforce Team.

Diabetes networks

- 2.6 In developing integrated services PCTs should consider putting robust mechanisms in place to reach the standards and deliver the targets which will:
- engage all stakeholders, including clinical and other staff, managers and people with diabetes
 - work across traditional service boundaries

- have clear lines of accountability
- demonstrate excellence in leadership and management.

2.7 Clinically-led, managed diabetes networks, involving people with diabetes, provide one means of embedding these principles in practice. A network of this type will provide a structure for service planning and delivery, promote seamless care and support staff by targeting resources where they are most needed, achieving the goals of:

- integrated care
- improved clinical outcomes
- cost-effective services
- improved patient experience
- equity of service provision.

2.8 Experience has shown that networks which are inclusive and bring together all necessary stakeholders are most effective. Whilst detailed arrangements should be determined locally, an example of who might be included in a diabetes network is given at Figure 1 and a model of its possible role is given in Box 1.

Box 1

planning: on the basis of the service assessment and gap analysis undertaken this year (2002/03), agreeing local priorities and planning for implementation to deliver the targets by 2006 and the standards by 2013; and agreeing a resourced trajectory to reach the standards with progress supported by a rolling 3-year programme.

delivery: ensuring the financial, organisational and workforce resources are available and agreeing how best to use and share resources, ensuring that each organisation makes its agreed contribution to NSF implementation

leadership: providing strong leadership for delivery, championing the needs of people with diabetes across the health and social care system

information: ensuring that the implementation of *Information for Health*⁴ and *Information for Social Care*⁵ support diabetes as outlined in the *Diabetes Information Strategy*⁶, and collating, analysing and feeding back clinical audit and benchmarking information about the services provided

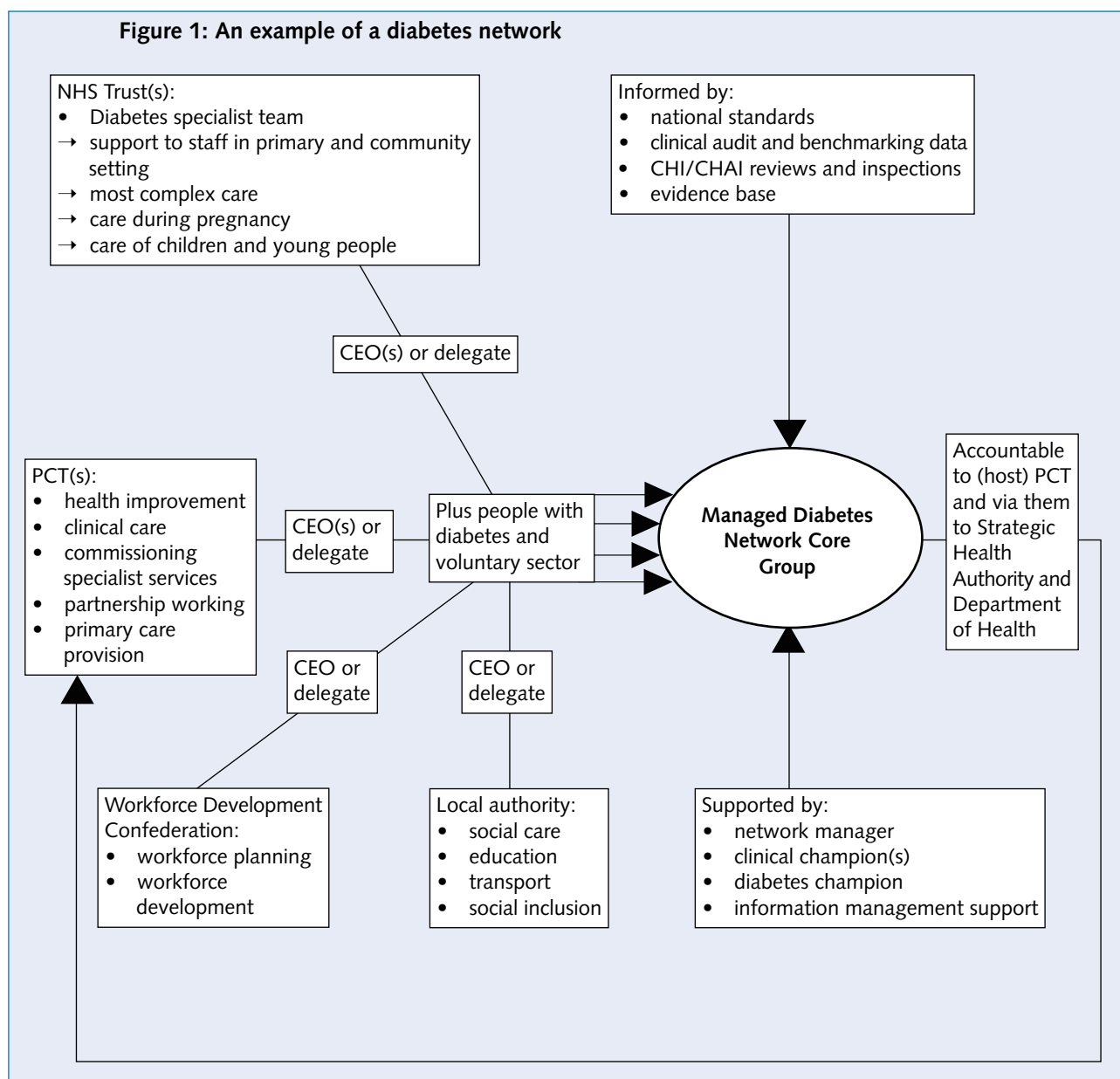
monitoring: tracking the delivery of the NSF and achievement of targets, and reporting annually to the PCT(s) and local people.

2.9 Experience also suggests that an effective network should cover a 'natural' population. For diabetes, this will usually be determined by the population served by a specialist diabetes service based within an NHS Trust. Where the network covers the population of two or more PCTs, it is good practice to design accountability arrangements to ensure that decisions are implemented.

4 Department of Health. *Information for Health. An information strategy for the modern NHS 1998–2005*. London: Department of Health, 1998.

5 Department of Health. *Information for Social Care. A framework for improving quality in social care through better use of information and information technology*. London: Department of Health, 2001.

6 Department of Health. *Diabetes Information Strategy*. London: Department of Health, 2002.



- 2.10 Many areas will already have a Local Diabetes Services Advisory Group (LDSAG) bringing together a range of players, including frontline staff and people with diabetes. Arrangements like diabetes networks with direct accountability to PCTs, and the inclusion of diabetes in broader accountability mechanisms, create the opportunity to enhance and reshape these advisory groups to ensure their energy and commitment are used to drive and enable change.
- 2.11 For some local communities, this may be a new way of working. As part of its wider service development programme, the NHS Modernisation Agency will provide support to local diabetes services. This will ensure that local health communities, working through diabetes networks, develop the skills that will support the modernisation of services and effective implementation of this NSF. The Agency will also establish a learning environment that will provide opportunities for members of the diabetes networks across the country to come together to share their implementation experience and thus learn from the successes of others.
- 2.12 The Department of Health will support local networks by identifying a small number of rapid learning sites. These will be asked to establish networks quickly and to disseminate their learning to other PCTs

to spread best practice. They will be supported by the NHS Modernisation Agency, will be run for two years and will focus on:

- ensuring effective clinical involvement and full participation of people with diabetes
- leading cultural change
- describing effective arrangements
- refining job descriptions for network managers and clinical and patient champions
- setting and monitoring local targets.

Local leadership

- 2.13 There may already be effective local leadership of diabetes services. However, where clinical networks are set up it would be helpful for a dedicated network manager, a clinical champion(s) and leader(s) among people with diabetes to be identified to lead change.
- 2.14 Clinical leadership will be crucial in building and sustaining professional ownership for the NSF. A clinical champion will be an important voice in the diabetes network to ensure that priorities and obstacles identified by frontline staff inform its priorities.
- 2.15 The Diabetes NSF is based on people with diabetes taking more control of their care. Not only at an individual level – in the relationship between the person with diabetes and the health care team – but also by ensuring that people with diabetes (and parents of children and young people with diabetes) have a strong voice in determining local services and priorities. One way of achieving this is to identify a person, or persons, with diabetes who will be resourced and provided with appropriate training and support to champion the views of local people with diabetes and their parents and families. Such a role can be linked to local action to promote wider patient and public involvement.
- 2.16 A National Clinical Director for Diabetes (see Chapter 6) will support local champions and the NHS Modernisation Agency in their work.

Supporting frontline staff: workforce skills profile

Education and training

- 2.17 The work of innovative and committed staff across primary and specialist care has been the backbone of the improvements in the care and support of people with diabetes. Examples already exist of teams working across organisational boundaries – involving staff in primary care, community care and specialist services. One way that PCTs can add their support to staff working in the front line is by undertaking a workforce skills profile of staff involved in the care of people with diabetes and developing education and training programmes with Workforce Development Confederations.
- 2.18 Continuing professional development is at the heart of continuous quality improvement. Staff across primary, community and specialist care will need to ensure they have the range of competences to support greater self-management by people with diabetes and so that people with diabetes can be confident that the member of staff they see:
- centres care around their needs
 - is properly trained and up-to-date

- provides high quality care underpinned by clinical and service protocols and audit
- has the interpersonal skills to communicate effectively with them, using computers where appropriate
- is working as part of a team, all with complementary skills.

2.19 Clinical and service protocols (increasingly available electronically) also provide clarity and support to staff in making most effective use of their time. The *National Service Framework for Diabetes: Standards* identified a number of areas where protocols could support better care – for example the assessment of people presenting with diabetes, continuing care, the follow-up of non-attenders, the transfer of young people to adult services and the initial management of diabetic emergencies by frontline emergency staff. A full list can be found on the Diabetes NSF website (www.doh.gov.uk/nsf/diabetes).

Occupational settings and roles

- 2.20 Diabetes care is increasingly being delivered not only in hospitals, but in primary and community care settings. However, specialist services will continue to take the lead for children and young people and for women during pregnancy, and provide a consultative service for those with the most complex needs. In all areas, service redesign and transformation driven by staff and supported by integrated information systems can raise the quality of care.
- 2.21 Diabetes staff have often trailblazed, developing new skills and knowledge and taking on new roles – for example, the nurse with advanced and specialist skills in diabetes and the nurse in primary care, who for some people also act as their named contact. Diabetes services are well positioned to take advantage of the extension of prescribing to nurses, pharmacists and allied health professionals. Pharmacists are a regular point of contact for people with diabetes and can play a central role in improved medicines management. The Department of Health has already published medicines management guidance as part of the NSF for older people (www.doh.gov.uk/nsf/medicinesop/index.htm) and is now developing guidance for medicines management in long-term conditions, supporting the NSFs for diabetes, renal services and long-term conditions. This will be available in 2003.
- 2.22 The Department of Health's Changing Workforce Programme has published a resource (see paragraph 6.19) to help the NHS think about the changing roles of staff involved in care and support for people with diabetes. This includes, for example, extending the role of the diabetes specialist nurse across service boundaries, developing the role of the practice nurse and making use of the emerging GPs with a special interest (www.doh.gov.uk/pricare/gp-specialinterests/gpwsiframework.pdf).
- 2.23 The pace of change will vary from place to place depending on local circumstances. Enabling primary care to extend its role in providing effective services for people with diabetes or at risk of diabetes will require an increase in primary care workforce, financial resources, information infrastructure and organisational capacity.
- 2.24 Under the proposed new General Medical Services contract framework agreement, it is envisaged that a proportion of practice income would be attributed to a quality element. Practices would have the opportunity to receive additional funding through the achievement of a range of quality standards. The new quality framework would reward practices for delivering quality care with extra incentives to encourage high standards. The contract would be practice-based and recognise the full range of professionals in primary care engaged in delivering high-quality, integrated care, appropriate to the patient's needs.

- 2.25 In addition, the specialist diabetes team can consider supporting the development of services in primary and community settings, for example through:
- providing outreach services in primary and community care settings
 - providing advice, education and training to health care professionals who are not diabetes specialists
 - supporting the development and revision of local protocols
 - informing the development of knowledge management and quality assurance in primary and community settings.

Workforce: numbers of staff

- 2.26 More staff will be needed to meet the growing expectations within diabetes services and as the number of people with diabetes continues to rise. The Department of Health's Long-Term Conditions Care Group Workforce Team (CGWT) is working closely with the Changing Workforce Programme, Skills for Health and the University for the NHS (NHSU). It is supporting the development of a workforce with the right skills and competences to work in the new ways, starting with diabetes (see Chapter 6 and www.doh.gov.uk/cgwt). Two Changing Workforce Programme pilots, testing and implementing new ways of working to improve services, tackle staff shortages and increase job satisfaction, are focusing on diabetes (details at www.modernnhs.nhs.uk).

3 Delivering the Targets: The Next Three Years

3.1 *Improvement, Expansion and Reform: the next 3 years*, the planning and performance framework for 2003–2006, sets the priorities for the NHS over the next three years. It sets two critical national diabetes specific targets: eye screening and registers (using them for systematic treatment regimens and advice).

- By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.
- In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006, ensure practice-based registers and systematic treatment regimens, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a body mass index (BMI) greater than 30.

3.2 Together with the recommendations set out in chapter 2, the steps recommended in this chapter will help PCTs deliver the targets and put in place basic building blocks to reach the NSF standards over the next ten years.

3.3 To deliver the first target PCTs will need to:

- put in place a systematic eye screening and treatment programme, including recall.

3.4 To deliver the second target PCTs will need to:

- update diabetes practice-based registers using them as the basis for systematic treatment regimens with advice and treatment in line with the Diabetes NSF standards.

Systematic retinopathy screening programme

3.5 An effective register provides the basis for detection of complications, enabling early intervention and treatment. Early detection of sight-threatening diabetic retinopathy and treatment with laser therapy is effective in preventing visual impairment. NICE guidance⁷ on retinopathy screening and early management recommends participation in a formal screening programme. Whilst many people with diabetes receive regular retinal screening, there are wide variations in policies, practice and the quality of screening provided. Ensuring a high quality systematic retinal screening programme is a national target for PCTs.

7 National Institute for Clinical Excellence. *Inherited Clinical Guideline E. Management of type 2 diabetes: Retinopathy – screening and early management*. London: National Institute for Clinical Excellence, 2002.

- 3.6 A UK National Screening Committee (NSC) programme, developed with professional organisations and Diabetes UK, will set quality assurance standards, monitoring criteria and specifications for information and professional development resources by June 2003. This will support local delivery. A project advisory group, bringing together health care professionals, NHS management and people with diabetes, will advise the NSC on the implementation, development, review and modification of the work to support local implementation in England. It will work closely with national advisory groups for Wales, Scotland and Northern Ireland to maximise the opportunities for consistency of approach.
- 3.7 By 2006, a minimum of 80% of people with diabetes are to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.
- 3.8 Early national support will include the development of:
- camera specifications for digital retinal photography and a strategy for procurement to obtain best value for money to inform local decision making
 - a clear specification for the information systems to support retinal screening (linking with the *Diabetes Information Strategy*)
 - training standards and interventions. These will include a range of professional development resources to be used locally
 - standards for a quality assurance system and methodologies for diabetes networks to undertake quality assurance
 - public and patient information about the need for retinal screening, what this involves and possible outcomes.
- 3.9 People with diabetes identified with sight-threatening or proliferative retinopathy should be referred to specialist care as either 'urgent' or 'soon' cases in accordance with the NICE guidance. People with diabetes who develop visual impairment should have access to support, such as low vision aids, to improve their quality of life.
- 3.10 Capital funds to support the purchase of digital cameras and related equipment for retinal screening will be available to generate a step change in services. Revenue funding for the detection and treatment of retinopathy will be included in the general allocations to PCTs.

Diabetes registers

- 3.11 Most people with diabetes spend only a few hours in contact with health care professionals each year. The rest of the time they manage their diabetes themselves. Supporting people to manage their own diabetes is therefore at the heart of empowering people with diabetes, improving their experiences of services and improving their health outcomes. This support needs to take full account of the different needs of people with Type 1 and Type 2 diabetes and of the particular requirements of children and young people; and prioritising those at greatest risk of developing the complications of diabetes and those newly diagnosed with diabetes.
- 3.12 Delivering this support relies upon the establishment of effective registers. Without an effective register, it will not be possible to identify those with poor diabetes control (an indicator of those who have the highest risk of complications) nor those with newly diagnosed diabetes. A special focus on people with newly diagnosed diabetes is needed to ensure they manage this major transition in their life effectively and reduce their long-term risk of complications.

- 3.13 By 2006 all people with diagnosed diabetes should be identified in an up-to-date practice-based register. This should be a collaborative effort involving primary care and specialist services. A comprehensive and up-to-date register will provide the cornerstone of care and the basis for call and recall, clinical care, prevention, continuous quality improvement, monitoring and clinical audit. All registers must meet the requirement for confidentiality and security.
- 3.14 Registers will also enable PCTs to gauge the extent of undiagnosed diabetes in their population, and will provide the infrastructure for peer review, internal and external monitoring, benchmarking, resource management and potentially research.
- 3.15 Diabetes significantly increases the risk of CHD – mortality for CHD is up to five times higher for people with diabetes. Extending diabetes registers to include those at increased risk of diabetes will facilitate effective interventions, including through structured education programmes, diet and physical activity, which will also help deliver the standards and goals in the NSF for CHD.
- 3.16 Practice-based diabetes registers can therefore be developed in primary care along the same lines as, and integrated with, the virtual CHD and stroke registers required by the NSFs for CHD⁸ and Older People⁹. In advance of the development of integrated electronic records, where effective registers are currently held at other sites and fulfil useful purposes they can be retained. For example, information systems to support structured care for children and young people would continue to be held by the paediatric diabetes team and shared with the primary care team.
- 3.17 The implementation of *Information for Health* provides the opportunity to develop information systems that offer all the functions of existing diabetes registers within integrated care records. With the informed consent of the person with diabetes, these can also provide access to details of their other conditions and interactions with the health service so as to support holistic care.
- 3.18 The *Diabetes Information Strategy* (see also paragraphs 6.21–6.25) provides details of the approach to integrated care records and diabetes registers, including advice on work to develop datasets and term sets for virtual practice-based registers and work planned to develop data capture templates.

A personal diabetes record and agreed care plan

- 3.19 Access to health records will help people with diabetes manage their care in partnership with health and social care professionals. Pilot projects are currently under way (www.doh.gov.uk/patientletters) to meet the *NHS Plan* commitment that patients should receive copies of clinical correspondence. A personal diabetes record that contains the clinical record of care, treatment and management (including test results) and is held by the person with diabetes and used by them and the diabetes team, builds upon this (see Box 2).
- 3.20 To support PCTs the Department of Health will draw together examples of personal diabetes records already in use and disseminate best practice by Autumn 2003. The *Diabetes Information Strategy* sets out proposals for providing people with diabetes with the capacity to view and interact with their electronic records, as integrated care record services are developed over the next six years.

8 Department of Health. *National Service Framework for Coronary Heart Disease*. London: Department of Health, 2000.

9 Department of Health. *National Service Framework for Older People*. London: Department of Health, 2001.

Box 2

A personal diabetes record:

- includes an agreed care plan, including education and the personal goals of the person with diabetes
- sets out how their diabetes is to be managed until their next review to foster greater understanding and ownership of the goals of diabetes care
- identifies health, social care and education needs, how they will be met and who will be responsible
- identifies the named contact.

- 3.21 A care plan is at the heart of a partnership approach to care and a central part of effective care management. The process of agreeing a care plan offers people active involvement in deciding, agreeing and owning how their diabetes will be managed. Whilst the overall goal is a genuine partnership, the person with diabetes must feel that they are comfortable with what is proposed and that they do not have to bear more responsibility than they wish.

Systematic treatment regimens

- 3.22 PCTs should, by 2006, ensure systematic treatment regimens are in place for people with diabetes. Ultimately, at the heart of these will be regular reviews, which will be based on a diabetes record and a care plan developed and agreed jointly between the person with diabetes and a member of the diabetes team.

A named contact

- 3.23 People with diabetes may be seen by many different health and social care professionals over the years. Unless services are co-ordinated, this can prove problematic for them and compromise the quality of care. Experience from other care groups has shown the benefit of designating one member of the care team as a named contact for each person with diabetes. This person acts as an initial point of contact, helping the person with diabetes navigate the service and access other members of the multidisciplinary team as appropriate. They may also be the team member who takes the lead in reviewing the diabetes management.
- 3.24 The role of the named contact is particularly important at those times when diabetes care is most difficult – for example, at diagnosis, when changing treatment, or during adolescence and the transition to adult services. Good practice shows that they should be identified in discussion with the person with diabetes.

Regular review

- 3.25 Regular review provides the opportunity for the person with diabetes and the lead health professional to bring together all the relevant information and make sense of what it means for the individual, forming the basis of the care plan for the following year. It also provides the opportunity to discuss:
- the successes of and barriers to self-care
 - the key elements of diabetes care including glycaemia, blood pressure and cardiovascular risk reduction

- the results and implications of the surveillance programmes for eyes, feet and kidney damage
- ensuring speedy access to appropriate services should problems occur.

A checklist for the review discussion is available at www.doh.gov.uk/nsf/diabetes.

- 3.26 PCTs can also plan further care and interim review around a range of local options such as timed review, problem solving visits, telephone review, direct access to blood pressure monitoring or HbA_{1c} results, structured education and as part of structured cardiovascular care.
- 3.27 Delivering systematic treatment regimens to everyone with diabetes will take time. Benefits are gained by targeting those with the highest risk of complications and getting good control early. One way PCTs can phase the introduction of systematic treatment regimens is to focus initially on people diagnosed with diabetes after April 2003 (along with those with poor diabetes control) to ensure they have an agreed care plan, a personal diabetes record and a named contact within the local service.

Advice and information through structured education

- 3.28 There are a number of ways in which PCTs can ensure that people with diabetes receive appropriate advice and information about the importance of diet, physical activity and cessation of smoking to avoid the risk of developing the complications of diabetes. Evidence has shown, however, that giving advice and information through group structured education programmes is one of the most effective ways of doing so. Good practice suggests that a structured education programme is tailored to the individual, taking account of age, social circumstances, disability and ethnic, cultural and religious influences (see www.doh.gov.uk/nsf/diabetes).
- 3.29 Education is a planned, life-long process. A skills-based approach can support self-care by improving knowledge, blood glucose control, weight and dietary management, physical activity and psychological well being. The National Institute for Clinical Excellence (NICE) will be producing an appraisal of structured education in diabetes in Spring 2003. Meanwhile, the Department of Health and Diabetes UK are supporting pilots of the DAFNE (Dose Adjustment for Normal Eating) programme for people with Type 1 diabetes¹⁰.
- 3.30 Psychological support will help people with diabetes identify any emotional and behavioural barriers that may prevent them managing their diabetes effectively. Health and clinical psychologists with expertise in diabetes can play an important role supporting other members of the multidisciplinary team in providing psychological support and in helping people modify their lifestyle to reduce their risk of developing diabetes or its complications. Parents and carers may also require direct access to psychological support, for example where people with diabetes have significant difficulties or at times of transition.
- 3.31 People with diabetes can also provide support to others, helping them to adjust to living with diabetes, and also providing advice and support to make lifestyle changes. Local parent groups and parent organisations can also be supportive. The Department of Health's Expert Patients Programme (www.ohn.gov.uk/ohn/people/expert.htm) offers opportunities for people living with long-term conditions, including diabetes, to learn new skills to help others manage their condition. The programme is currently being piloted in primary care, and will become part of mainstream NHS healthcare between 2004 and 2007. Local systems for peer support can be actively encouraged.

¹⁰ Contact: gillian.thompson@northumbriahealthcare.nhs.uk.

4 Delivering the Standards: The Next Ten Years

4.1 Chapters 2 and 3 describe the planning assumptions and steps that can underpin improvements in care, support delivery of the targets and empower people with diabetes (Standard 3). This chapter offers a framework for delivering the other standards (see Figure 2):

- Prevention of Type 2 diabetes and identification of diabetes (Standards 1 and 2)
- management and treatment of diabetes (Standards 4 and 5) – blood glucose, blood pressure, and cardiovascular risk (heart disease and stroke)
- support through times of greater need (Standards 6 to 9) – diagnosis; treatment escalation; ill health and hospitalisation; childhood, adolescence and young adulthood; pre-conception and throughout pregnancy
- detection and management of long-term complications (Standards 10 to 12) – feet, eyes, kidneys and cardiovascular disease.

Agreeing local priorities

4.2 Reaching the NSF standards by 2013 will be an overarching goal of PCTs but there will be significant differences from one place to another in the starting point for implementation. Local plans will need to reflect local priorities, building on these as capacity expands.

4.3 In order to ensure that all standards are reached, we expect PCTs will set themselves challenging, measurable targets that will result in tangible service improvement from 2003–4. These targets will need to:

- be determined on the basis of local needs and service capacity
- be challenging
- be underpinned by information and workforce developments
- be costed and resourced
- have measurable outcomes
- be owned and agreed by the local health and diabetes communities
- demonstrate a clear trajectory to deliver all the standards by 2013.

4.4 Periods of transition – for example, when changing treatment, when moving from paediatric to adult services, when admitted to hospital or during pregnancy and parenthood – are times when self-management, routine care and surveillance are potentially more difficult. Prioritising these periods of transition may help in ensuring effective long-term control of diabetes and overall health improvement for the population. Equally, in determining local priorities, PCTs will need to take account of one of the primary goals of the NSF, which is to reduce health inequalities, for example by focusing on those with poorest management of their diabetes and on populations at greatest risk of developing diabetes.

Figure 2: Diabetes NSF Standards to be reached by 2013	
Prevention of Type 2 diabetes	<i>Standard 1</i> The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.
Identification of people with diabetes	<i>Standard 2</i> The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.
Empowering people with diabetes	<i>Standard 3</i> All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.
Clinical care of adults with diabetes	<i>Standard 4</i> All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.
Clinical care of children and young people with diabetes	<i>Standard 5</i> All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.
	<i>Standard 6</i> All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.
Management of diabetic emergencies	<i>Standard 7</i> The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.
Care of people with diabetes during admission to hospital	<i>Standard 8</i> All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.
Diabetes and pregnancy	<i>Standard 9</i> The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.
Detection and management of long-term complications	<i>Standard 10</i> All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.
	<i>Standard 11</i> The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.
	<i>Standard 12</i> All people with diabetes requiring multi-agency support will receive integrated health and social care.

- 4.5 The increase in Type 2 diabetes mirrors the increase in the proportion of people who are either overweight or obese. Reducing the risk of Type 2 diabetes – by preventing or reducing overweight and obesity, promoting healthy eating and increasing physical activity – can therefore have a significant impact on future service needs. Because the risk factors are very similar to those for coronary heart disease (CHD), PCTs will find it more effective to integrate their risk reduction strategies with local prevention programmes established under the NSF for CHD. The experience of CHD prevention has already shown the added value of working together with other local organisations, for example through a Local Strategic Partnership. This *Delivery Strategy* provides an opportunity to build upon and strengthen those links (see paragraph 6.45).
- 4.6 A range of illustrative targets for each key intervention in the *Standards* – from prevention through to complications – is on the Diabetes NSF website. PCTs and diabetes networks should draw upon these and adapt them to agree and monitor local plans in line with local priorities.
- 4.7 Health Service Circular HSC 2001/026, issued with the *Standards*, required local NHS organisations to assess health needs and service capacity to inform early local priorities and planning. Several assessment tools are already available for this. The Department of Health has produced guidance on baseline assessment through the Trent Public Health Observatory (www.trentpho.org.uk/products/diabetes.htm).

Evidence and information

- 4.8 There is a wealth of information available to support local delivery of priorities. This has been drawn together in the *Standards* as well as in NICE guidelines. In developing their local programmes, therefore, PCTs and diabetes networks may wish to draw upon:
- the evidence-based key interventions set out in the *Standards*, including the detailed interventions on the web
 - the service models published with the *Standards*, which have been updated in the light of comments received during the consultation. Feedback to the proposed models showed that local services could achieve the objectives of a particular service model in a variety of ways. The service models now on the Diabetes NSF website are therefore descriptive models that *could* be adopted rather than prescriptive descriptions of *how* to go about it
 - NICE guidelines and appraisals (www.nice.org.uk)
 - programmes and initiatives already in place, underpinning other NSFs, such as prevention programmes for CHD.

All this information will be brought together in the National Electronic Library for Health (NeLH) Diabetes NSF Zone (see paragraph 6.36).

- 4.9 The web version of the *Standards* summarised the evidence base as at December 2001. Further evidence of effectiveness will emerge over the period of NSF implementation, as will further NICE guidance. Better information on clinical services and on patient experience, together with Commission for Health Improvement (CHI) reviews and, in future, inspections by the Commission for Healthcare Audit and Inspection (CHAI)¹¹, will inform priority setting and service improvement. Diabetes networks will need a systematic process to maintain an overview of local practice and a focus for acting upon emerging evidence. Local clinical protocols, with audit of implementation, will be important to implement NICE guidelines and the interventions highlighted for action in the *Standards*.

11 Subject to legislation.

5 Ensuring Progress

- 5.1 Recognising that local health systems will be at very different stages of developing diabetes services, this chapter describes how progress will be monitored.

Accountability for delivery

- 5.2 Under the Priorities and Planning Framework, national targets will be reflected in planning and performance management arrangements between PCTs and their Strategic Health Authority. Strategic Health Authorities are accountable to the Department of Health for ensuring that there is consistent progress, with investment agreed through the planning process, towards achieving these targets and that effective processes are in place. Further guidance has been published in the *2003–2006 Planning Cycle Guidance for Strategic Health Authority Directors of Planning*¹².
- 5.3 Progress will also be monitored as part of the wider monitoring of the NHS under the *NHS Plan*. Implementation of the Diabetes NSF will be subject to review by the Commission for Healthcare Audit and Inspection (CHAI), after its establishment in 2004. Structures are also being developed to ensure that patients and the public are involved in monitoring services. Nationally, there will be a Commission for Patient and Public Involvement in Health, to be established from January 2003 and from April 2003 Patients Forums will begin to be established for every PCT and NHS Trust. Patient Advice and Liaison Services, to assist patients and carers in dealing with problems and concerns, are in many cases already up and running. In addition, all local authorities with social services responsibilities will have the power to scrutinise local health services through their Overview and Scrutiny Committees.

Continuous quality improvement

- 5.4 Clinical governance (underpinned by the statutory duty of quality) is the local delivery mechanism for ensuring safe and high quality care. Clinical governance will ensure that NHS organisations have in place systems to assure the quality of their services and processes to ensure continuous improvement year-on-year. Care centred on the needs of people with diabetes, effective risk management, learning from complaints and clinical audit will be some of the key elements.
- 5.5 Numerous parts of the NHS and social care systems contribute to the care of people with diabetes. Diabetes networks will provide a forum to share ideas, achieve change, and ensure best use of resources and for clinical governance activities. Diabetes is well established as a topic for clinical audit in primary care, and there are innovative examples of comparative audit shared between practices within PCTs and health authorities. Many diabetes services already measure the process and outcomes of care systematically, enabling them to assess progress over time, tackle inequalities and carry out clinical audit.

12 Available at www.doh.gov.uk/planning2003-2006/index.htm.

- 5.6 In addition, in order to improve quality and meet national requirements, health systems will need to participate in comparative local and national clinical audit. This will be based on the development of local capacity by diabetes networks to collate and analyse information, to compare local service quality and clinical outcomes with achievements elsewhere and to contribute data to the National Clinical Audit Support Programme (NCASP: see paragraph 6.41). The Quality Indicators in Diabetes Services (QUIDS) system (www.quids.org.uk) is likely to form the basis of the approach to clinical audit in diabetes. PCTs and NHS Trusts should, with their Strategic Health Authorities, look carefully at their capacity to produce the information extracts for QUIDS reports, which must be underpinned by good clinical data collection so that local services can use national comparative data to support clinical audit.
- 5.7 The *Diabetes Information Strategy*, including the establishment of registers to identify people with diabetes and support the delivery of effective care, health system-wide information systems for clinical governance and quality assessment, and the development of a core dataset for diabetes care, applicable for both primary and secondary care, will support PCTs in monitoring continuous quality improvement.

Performance indicators

- 5.8 Comparative benchmarking information assists local health systems to compare their own performance with that of others and can stimulate the NHS to work differently. There is already some information relevant to diabetes care available from the monitoring of existing NSFs, for example for cardiovascular risk management in the NSF for CHD. There are also some national data on health outcomes, and health inequalities, derived from routinely available data and through national surveys such as the Health Survey for England.
- 5.9 A set of proposed performance indicators (PIs), based largely on health and clinical outcomes, was set out for consultation when the *Standards* were published. These have gained broad support, although concerns were expressed that many of the indicators are aspirational at this stage because the information is not yet collected. A summary report of the consultation and the indicator set is available on the Diabetes NSF website. As local health system-wide databases to monitor the success of diabetes services become established, the range of information being used routinely at local level will become wider and PIs can be developed further as a by-product of information supporting clinical care.
- 5.10 A smaller number of high level performance indicators (HLPIs) is used in reaching an overall performance assessment rating of PCTs and NHS Trusts. From 2003, the Commission for Health Improvement (CHI and subsequently the Commission for Healthcare Audit and Inspection, CHAI) will be responsible for performance ratings and indicators. The results of the consultation on the proposed set of indicators will be shared with CHI to inform the next phase of indicator development. Work will continue to ensure that key HLPIs reflecting the effective implementation of this NSF are included in the performance assessment framework for both PCTs and NHS Trusts in 2003/04 and beyond.

6 National Support for Local Action

6.1 There are national programmes designed to support local implementation of the Diabetes NSF. These include:

- leadership through a National Clinical Director for Diabetes
- support from the NHS Modernisation Agency for improving services
- finance
- workforce planning and development
- information strategy
- research and development
- clinical decision support and audit – including NICE
- patient and public involvement
- prevention strategies.

Leadership and organisational change

National Clinical Director

6.2 The Department of Health will appoint a National Clinical Director for Diabetes, in early 2003, to provide national leadership and support to localities in the delivery of the NSF. The National Clinical Director for Diabetes will oversee the implementation of the NSF by:

- supporting NHS clinicians and managers in reaching the standards and delivering the targets
- ensuring clinical commitment through professional leadership at national level
- ensuring that emerging new knowledge is effectively disseminated through modernisation plans
- advising Ministers and officials in the Department of Health on priorities and progress
- working with the NHS Modernisation Agency, the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement (CHI) – and the Commission for Healthcare Audit and Inspection (CHAI) when it is established in 2004 – and other bodies to support delivery.

6.3 The National Clinical Director for Diabetes will work closely with the other national clinical directors. Each Strategic Health Authority will be asked to arrange an early visit for them to their area so that they can meet the main stakeholders, get a picture of the issues on the ground, and share the local vision and programme for improving life for people with diabetes. The National Clinical Director for Diabetes will also work closely with national stakeholders.

The NHS Modernisation Agency

- 6.4 The NHS Modernisation Agency (www.modernhs.nhs.uk) supports local NHS staff and their partner organisations in improving services for patients by focusing on four key areas:
- improving access – helping to provide fast and convenient services
 - raising standards of care – improving the quality and safety of the patient's experience
 - supporting local improvement – building local capacity
 - spreading good practice – helping everyone share their knowledge and learning.
- 6.5 The NHS Modernisation Agency will provide resource to support local health systems and diabetes networks, drawing on expertise from across the Agency's programmes.
- 6.6 The Department of Health has published an inter-professional resource pack to support learning and development at practice and PCT levels in delivering NSFs. The leaflets that comprise the pack are available individually on the National Primary and Care Trust Development Team website at www.natpact.nhs.uk. Focusing on the generic requirements of all the NSFs, one of the key leaflets highlights public health interventions for factors such as overweight and obesity, physical inactivity and smoking. Another leaflet focuses on chronic disease management looking at issues such as patient empowerment, self-care, prescribing and medicines management. In much the same way, services for diabetes should not be seen in isolation and a common approach to service delivery across the various NSFs may prove the most effective strategy in some cases. This will be particularly true in areas such as prevention and social care. Identification of converging priorities across the NSFs and opportunities for cross-cutting activities will be an important aspect of planning at local level.

Finance

- 6.7 Some elements of the Diabetes NSF require additional resources across primary, community and specialist care. Other elements require changes in working practices and better organisation drawing on best current practice.
- 6.8 Extra resources for the NHS were announced in the 2002 Budget, with an annual average increase of 7.4% above inflation over the five years from 2003–4 to 2007–8. This is the largest ever sustained increase in NHS funding and provides scope for investment and service improvement at all levels.
- 6.9 From 2003–04, the move to three-year revenue and capital allocations will provide a surer foundation for PCTs to plan improvements based on local analysis of local needs and priorities.
- 6.10 PCTs will be given control of 75% of the growing NHS budget, with freedom to purchase care from the most appropriate providers and moving towards a hospital payment system based on results, using a case-mix adjusted national tariff with regional variations.
- 6.11 Revenue funding to deliver the national targets and to begin to make progress in delivering local priorities across the standards will be included in the general allocations to PCTs. Capital funds to support development of the diabetic retinal screening programme will be available where they can generate a step change in services.

Primary care contracts

- 6.12 Implementation of the Diabetes NSF in primary care is expected to take place in the context of the planned new General Medical Services (GMS) contract, which is being negotiated between the NHS Confederation and the BMA General Practitioners Committee and Personal Medical Services contracts.
- 6.13 The new GMS contract framework agreement makes clear that new work would be recognised and rewarded in a number of ways. This would include ensuring that changes in workload are taken into account, within the global sum allocation, in the quality and outcomes framework by providing additional resources for new work or taking on a new quality standard, and through additional payments for providing enhanced services or the provision of additional services where other practices have opted out.
- 6.14 It is envisaged that individual practices would also have the ability to seek to opt out of chronic disease management under the new contract, but without detriment to patient care. In such cases the full responsibility for ensuring the provision of high quality services would lie with the PCT. Practices would have greater control over their workload and opportunities to receive additional funding for achieving a range of standards, with extra incentives to encourage even higher standards.

Workforce planning and development

- 6.15 Diabetes services need to ensure there are enough staff with appropriate skills who are well-led, supported, and deliver high-quality care. The *NHS Plan* gave commitments to expand staff numbers by 2004. The increase of 20,000 in nurse numbers has already been achieved and numbers continue to rise. Whilst it will take time for the new staff to be trained and come into the NHS, the Government is on track to achieve the increases in allied health professionals. Action is being taken to speed up recruitment of GPs, where more progress needs to be made if the target is to be met, whilst the number of consultants in diabetes and endocrinology is estimated to rise by well over 50% over the next eight years. Progress is also being made in many areas that have paediatric multi-disciplinary teams and paediatricians with a special interest in diabetes. Combined with new ways of working, increasing numbers of staff will help to improve the experience of people with diabetes and the working lives of staff.
- 6.16 The Department of Health's Long-Term Conditions Care Group Workforce Team (CGWT), working closely with the Changing Workforce Programme, Skills for Health and the University for the NHS (NHSU), is supporting the development of a workforce with the right skills and competences to work in the new ways, starting with diabetes. It is a multi-disciplinary, multi-agency stakeholder group which includes patient and carer interests. It will provide leadership and support to local services in adopting best practice in staff training, education and deployment and in ensuring that this is built into local and national workforce plans. The terms of reference and membership are on the CGWT website, www.doh.gov.uk/cgwt.
- 6.17 The work programme of the CGWT will be taken forward by a Diabetes Sub-group, comprising of key stakeholders and reporting to the CGWT. The programme includes:
- working with national leaders and other stakeholders to identify and prioritise key workforce pressures and challenges, draw up detailed and timetabled action plans to take each forward, including how stakeholders are to be involved more widely, and publish those plans on the CGWT website. Such work will include the introduction of new, or newly defined, roles and disseminating good practice in recruitment and retention – **by Summer 2003**

- working with national leaders, professional groups, Diabetes UK, local diabetes networks and others, to understand and refine assumptions underpinning projections of workforce demand and supply, and to understand the impact of possible new roles in health and social care teams to deliver the NSF – **initial assumptions to be agreed by April 2003**. The process will be on-going as the impact of changes and new pressures are assessed
- a project undertaken by Skills for Health to produce a competence framework for the diabetes workforce, linked to existing frameworks and other work. The project will describe the competences required in the whole care team to deliver services to the standards set out in the NSF. Working with the NHSU and Skills for Health, the competence framework will be used to devise education and training curricula for diabetes care and appropriate qualifications – **the competence framework will be delivered in Autumn 2003**. Also, working with the NHSU, the competence framework will be used to begin to assess the gap between current training provision and what is needed. **This analysis to be completed six months after the competence framework**
- developing a high-level training and development strategy for the long-term conditions workforce, involving an analysis of supply problems and strategies for dealing with them, as well as exploring innovative and flexible approaches to staff education delivery – a detailed work programme to take this forward will be published – **by Summer 2003**
- modelling an approach to strategic workforce planning for diabetes services (using the Devon and Cornwall peninsula as a microcosm), using data to extrapolate for national diabetes workforce planning purposes and to produce a workforce planning toolkit – **by April 2003**.

6.18 The CGWT works closely with the national Changing Workforce Programme (CWP), which helps the NHS and other health and social care organisations to test and implement new ways of working to improve patient services, tackle staff shortages and increase job satisfaction. It supports organisations to redesign staff roles to provide a more patient-centred service, with care being provided by multi-disciplinary teams, working in the right locations. Two diabetes pilots underway in Luton and Peterborough will help to identify new ways of working in delivering diabetes services.

6.19 The CWP's publication, *Workforce Matters – a guide to role redesign in diabetes care*¹³, published with this Delivery Strategy, provides guidance on introducing new roles locally, with examples of how this has already been done in practice.

6.20 Further information about the terms of reference, priorities and membership of the CGWT and about the CWP pilots is available through the CGWT website: www.doh.gov.uk/cgwt.

Information strategy

6.21 *Information for Health* and the *Diabetes Information Strategy* aim to ensure that information infrastructure, systems and services are developed to support the needs of people with diabetes, the delivery of integrated care, and the commissioning, planning, management and monitoring of diabetes services as described in this NSF.

13 Department of Health. *Workforce Matters – a guide to role redesign in diabetes care*. London: Department of Health, 2002.

- 6.22 The *Diabetes Information Strategy* is published with this *Delivery Strategy* (see www.doh.gov.uk/ipu). It has been developed by the NHS Information Authority and the Department of Health in collaboration with an advisory group including people with diabetes, diabetes charities, clinicians and managers from all sectors of the NHS, and information experts. The Diabetes NSF Implementation Group (see Annex) also provided advice on its development.
- 6.23 The strategy considers the current state of information provision to support diabetes, describes a vision of what it should be, and sets out the actions and implementation plans required to implement the vision. Its key components are:
- support for prevention and management by improving access to information about diabetes
 - empowering people with diabetes by providing access to health records and more general information
 - underpinning integrated care with integrated information systems, including registers
 - delivering the capacity to plan and monitor services, mainly using information which is a by-product of the information used to deliver care.
- 6.24 The following key strands of work are already underway:
- development of a specification and standards for integrated care record services, including registers, to support diabetes care (see www.doh.gov.uk/ipu for the latest draft)
 - refinement of clinical datasets to enable information sharing across the care pathway, the production of comparative information, and measurement
 - development of a programme to produce national comparative clinical audit information for local and national use
 - extension of access to the diabetes knowledge-base.
- 6.25 The Diabetes Information Strategy explains how local implementation of *Information for Health* and *Delivering 21st Century IT Support for the NHS* will support the delivery of diabetes care as outlined in the NSF.

Research and development

- 6.26 The knowledge base for diabetes services, and its accessibility to clinicians, practitioners, managers, people with diabetes and others making decisions about diabetes services is to be developed.
- 6.27 The Department of Health/Medical Research Council (MRC) Review of Research on Diabetes, *Current and Future Research on Diabetes: A Review for the Department of Health and the Medical Research Council*¹⁴, is published with this Delivery Strategy and is available on the Diabetes NSF website. This review of future research in the United Kingdom spans the entire field from molecular biology and genetics, through prevention, diagnosis, treatment and self-management, to the organisation of health services. The Review was undertaken by an Advisory Committee with researchers from many disciplines. An open public consultation on the future research agenda was organised with the help of Diabetes UK to inform the work of the Committee.

14 Department of Health. *Current and Future Research on Diabetes: A Review for the Department of Health and the Medical Research Council*. London: Department of Health, 2002.

- 6.28 The Review has been submitted to the Department of Health and the MRC for consideration. It will also be useful to other agencies funding research and to academic and clinical groups involved in research on diabetes. Although partly concerned with the most basic biomedical science, a strongly emergent theme from the Review was the many opportunities for translating this research into clinical and public health practice. The most relevant to the implementation of the Diabetes NSF are:
- **causes of Type 2 diabetes:** determination of interactions between genetic, biochemical and environmental factors including diet, physical activity and obesity
 - **prevention of Type 2 diabetes:** development of preventive strategies for populations based on epidemiological and behavioural research to increase physical activity and improve diet
 - **screening:** focused research studies to assess the benefits and costs of screening groups at high risk of Type 2 diabetes and cardiovascular disease in order to develop and evaluate new public health measures (see paragraph 6.32)
 - **self-management:** development of a comprehensive research base for appropriate educational and psychological interventions to help adoption of new lifestyles and use of knowledge and skills for self-management of diabetes by different groups of people with diabetes, including children and adolescents and people from minority ethnic communities
 - **service organisation:** transfer of the focus of diabetes care from hospital clinics to primary care creates needs and opportunities for research into complex systems, service organisations and change.
- 6.29 The Research Advisory Committee considered that diabetes research networks might be established in conjunction with the proposed diabetes networks in order to facilitate research and the transfer of research into practice.
- 6.30 The Department of Health will explore, in collaboration with the MRC, Diabetes UK and others, how best to take forward the proposals in the Review of Research on Diabetes.

Screening for Type 2 diabetes

- 6.31 A case can be made for a more systematic approach to offering screening for Type 2 diabetes. However, the evidence is not clear on which high-risk groups should be offered screening, which screening test should be used, the balance between the benefit and harm of any screening programme and the cost effectiveness. Decisions about any screening programme are made using the criteria set out on the web site of the UK National Screening Committee (NSC) (www.nsc.nhs.uk).
- 6.32 As the Joint Department of Health/MRC Review of Research on Diabetes has identified, further research is required to inform the advice on targeted screening for diabetes that the NSC will provide in 2005. As part of this work, a pilot project will be undertaken under the auspices of the NSC to test the practical implications and outcomes of implementing a systematic programme in primary care to ensure that:
- all people with heart disease or stroke are tested for diabetes
 - those in older age groups and those with a first degree relative with diabetes, who also have a body mass index (BMI) greater than 30, are invited for a screening test for diabetes, and
 - all those identified with diabetes in the pilot receive a comprehensive risk assessment and risk reduction therapy to reduce their risk of heart disease and stroke.

The focus for this pilot will be in serving those populations among whom the prevalence of disease and risk factors is highest, thus addressing inequalities.

Clinical and practice decision support and audit

National Institute for Clinical Excellence (NICE)

- 6.33 The Department of Health has commissioned a number of appraisals and clinical guidelines from the National Institute for Clinical Excellence (NICE) to support implementation of this NSF. These are listed on the Diabetes NSF website; further details can be found on NICE's website at www.nice.org.uk.
- 6.34 Further priorities for appraisals and for clinical guidelines and clinical audit tools, to support delivery of the NSF, will be considered for future phases of the NICE work programme.
- 6.35 Other sources of information on clinical evidence can be found on the Diabetes NSF website.

National Electronic Library for Health

- 6.36 The National Electronic Library for Health (NeLH) (www.nelh.nhs.uk) offers fast and easy access to best evidence and is open to clinicians, managers, patients and the public. NHS Direct Online (www.nhsdirect.nhs.uk) was launched as the patient gateway in December 1999. NeLH has developed a 'Diabetes NSF Zone' (www.nelh.nhs.uk/nsf/diabetes), one of a series of web pages offering one-stop access knowledge and know-how resources for the implementation and delivery of each NSF.
- 6.37 NeLH includes a specialist 'branch' library for diabetes, which offers access to relevant material and an interactive forum for discussion and an evidence-based in-depth diabetes knowledge resource (www.nelh.nhs.uk/diabetes). People with diabetes can access this resource through NHS Direct Online.
- 6.38 Details on over forty locally developed NHS pathways for diabetes are currently held on the NeLH Care Pathways Database (www.nelh.nhs.uk/carepathways), launched in 2001. This service is being extended, with guidance from the NHS Modernisation Agency's Changing Workforce Programme, to include protocols and patient group directions, and is developing a national standard web format for 'digital pathways' which can be easily linked to electronic patient records.

Decision Support

- 6.39 Decision support systems are an area for national action identified in the *Diabetes Information Strategy*. Developing tools to support decision-making at the point of care, in all care settings, will greatly enhance the quality of care provided for people with diabetes. In primary care, the Department of Health is working with PRODIGY and other primary care initiatives (including the Health Informatics Programme for Coronary Heart Disease and PRIMIS) to review what is needed to support improved use of computers and information. The revised programme of work that flows from this review will address the need to support the delivery of high quality diabetes care.

Clinical audit

- 6.40 Clinicians and practitioners need help to use available knowledge to support clinical and practice decisions about individual patients and service users, and to audit their practice.
- 6.41 Work has begun, through the National Clinical Audit Support Programme (NCASP) (www.doh.gov.uk/ipu/ncasp), co-ordinated by the NHS Information Authority and working closely with the Commission for Health Improvement (CHI), professional bodies and Diabetes UK, to develop national comparative risk adjusted clinical audit data for national and local use. This will be based on a small number of indicators initially that will use information collected as part of local clinical audit. This comparative information will provide the context for clinical audit and, together with additional

local clinical audit data and routine information on clinical outcomes, will be useful to clinical teams and others in service assessment, and in identifying inequalities that need to be addressed and other quality improvements. In addition the National Paediatric Diabetes Audit currently being run jointly by Diabetes UK, the Royal College of Paediatrics and Child Health and the British Society for Paediatric Endocrinology and Diabetes will need to be taken into account.

- 6.42 In the future, national clinical audit developments will be steered by the Office for Information on Health Care Performance being established within CHI. The Office will be responsible for:
- assessing performance (including clinical and performance indicators)
 - national clinical audits
 - national surveys of patients and staff.
- 6.43 As part of this work, the Office will set out criteria against which national clinical audits will be assessed. It will endorse national clinical audits that conform to the criteria and may provide support to enable existing audits not meeting these criteria to do so.

Patient and public involvement

- 6.44 Empowering and enabling patients and the public to participate in decision-making and make their views heard about their own health, individually and collectively, is central to this NSF, for example through the diabetes network. There is a range of other initiatives underway or planned by the Department of Health which will support this goal, including:
- a Patient Advice and Liaison Service rolled out in all NHS Trusts and PCTs from April 2002
 - a local independently audited survey of patients' experience conducted annually in all trusts and PCTs from April 2002
 - an ongoing programme of national NSF-based patient surveys, including a specific survey exercise in future on diabetes
 - a local guide to NHS services published by PCTs and distributed to all households in autumn 2002
 - a new national Commission for Patient and Public Involvement in Health (CPPIH), a non-departmental public body to monitor and set standards for patient and public involvement throughout the country, in early 2003
 - a Patients' Forum for every NHS Trust and PCT, set up by the CPPIH to monitor and review the range and operation of services from the perspective of the users of those services
 - a statutory duty on the NHS to make arrangements to consult and involve patients and communities in its planning and decision making processes, and a new health scrutiny role for local authority overview and scrutiny committees. Guidance on how this should work will be issued in January 2003
 - a new Independent Complaints Advocacy Service (ICAS), commissioned and provided by PCT Patients' Forums
 - a programme for reforming systems for dealing with complaints and clinical negligence claims against the NHS, including training and development of staff and improved arrangements for acting on lessons.

Prevention strategies

6.45 Type 2 diabetes and CHD share the common lifestyle risk factors of obesity, physical inactivity and smoking. There are a range of best practice models and national initiatives to underpin health improvement services in these areas:

- **Five-a-day Programme** to increase the consumption of fruit and vegetables, particularly in deprived groups. New Opportunities Fund (NOF) funding is available for 66 PCTs for two years from Autumn 2002 to deliver Five-a-day initiatives in communities where consumption of fruit and vegetables tends to be lowest, and where rates of cancer and heart disease are highest. The Five-a-day website, www.doh.gov.uk/fiveaday, provides further information, including a framework for all PCTs developing a local Five-a-day initiative. NOF funding has also been made available to scale-up the **National School Fruit Scheme**, so that by 2004 every child in nursery and aged four to six in infant schools will be entitled to a free piece of fruit each school day
- **PE and Sport Programme** – £581 million of NOF funding for a PE and Sports programme, launched in November 2001, which aims to bring about a step change in the provision and use of PE and sports facilities for young people and for the community in general across England. Local Education Authorities (LEAs) are the lead organisations for the implementation of projects but must work with other partners, including PCTs, to ensure that the initiative delivers education and health outcomes. LEAs have submitted their initial applications to the programme. The closing date for Stage Two, which requires a detailed application for each of the projects within the grant scheme, is March 2004
- Nine **Community Pilots for Increasing Physical Activity** to be established in the Spring of 2003. Supported by £2.5 million funding, these local pilots will extend the evidence base for what works. The money will be used to fund one pilot in each of the English regions. Based in neighbourhood renewal areas, three of the pilots will also involve Sport Action Zones. The pilots will test out different community approaches to increasing the numbers of adults and children in the deprived, target groups who are moderately active and to reducing the numbers of sedentary adults and children, including those at risk of diabetes. One of the pilots will test free swimming for children
- **Healthy Schools Programme** based upon the National Healthy School Standard, with action on diet and physical activity. The programme has a strong appeal to schools in deprived communities and participation is greater in schools based in these communities. Phase 1 of the programme has emphasised the establishment of healthy schools partnerships with a target of achieving 100% accreditation of Education and Health Partnerships (EHPs) by April 2002. Phase 2 will place a greater emphasis on achieving results at individual school level, particularly in deprived areas in accordance with the cross-cutting spending review on inequalities. The aim is that 15% of schools in each local programme with the highest deprivation indicators join the Healthy Schools Programme by 2006. The “Wired for Health” website www.wiredforhealth.gov.uk provides further information on the Healthy Schools Programme
- **School Sport Co-ordinators** – each partnership includes a Partnership Development Manager (PDM) based in a Specialist Sports College or LEA. Each PDM works with four to six secondary schools that each has a School Sports Co-ordinator (SSCO) who is released from timetable for 2 to 3 days a week to work on the programme. Each SSCO works with up to five primary/special schools that each has a Primary Link Teacher who is released from timetable for one or two days a month

- The **Food in Schools Programme** – launched by the Department of Health with the Department for Education and Skills in March 2001 to provide a co-ordinated approach to food and nutrition in schools, encompassing teaching, provision and management. This programme will support the National School Fruit Scheme and the **National Healthy School Standard**
- **NHS smoking cessation services** are available across England and have received specific funding (a total of £76m since 1999). They offer counselling and support, with smoking cessation aides NRT and bupropion, to smokers wishing to quit. The role of smoking cessation in delivering health gain has been endorsed by NICE and is key to tackling health inequalities. More information is available from the Department of Health website at www.doh.gov.uk/tobacco.

ANNEX: Diabetes NSF Implementation Group Membership

Chairs:

Sheila Adam	Director of Public Health, North East London Health Authority (formerly Director of Policy, Department of Health)
Mike Pringle	GP in Nottinghamshire and Professor of General Practice, University of Nottingham

Members:

George Alberti	Former President, Royal College of Physicians
Tina Ambury	GP in Lancashire and Vice-Chair, Royal College of General Practitioners
Sarah Banham	Advanced Nurse Practitioner, Wyre Forest PCT
Peter Betts	Consultant Paediatrician, Southampton University Hospitals Trust
Gillian Braunold	GP in London and member of the General Practitioner Committee
Mary Burden	Diabetes Nurse Consultant, Heart of Birmingham Teaching Primary Care Trust
David Colin-Thome	GP in Runcorn and National Director of Primary Care, Department of Health
Sue Cradock	Consultant Nurse – Diabetes Care, Portsmouth Hospitals NHS Trust/Portsmouth City Primary Care Trust
Valerie Day	NHS Modernisation Agency, Department of Health
Azhar Farooqi	GP in Leicestershire and Clinical Governance Lead, Eastern Leicester City Primary Care Trust
Colin Hardisty	Assistant Regional Medical Director, Trent Regional Office
Richard Himsworth	Portfolio Director Diabetes Research, Department of Health
Peter Houghton	Chief Executive, Norfolk, Suffolk and Cambridge Health Authority
Jim Kennedy	Local Government Association
Paulette Lewis	Director of Midwifery, Mayday University Hospital
Malcolm Lowe-Lauri	Chief Executive, Kings College Hospital
Andrew Morris	Chairman, Scottish Diabetes Group
Leonie Mountney	Head of Delivery, Population Health and Service Delivery Management, NHS Information Authority
Mary-Ann Munford	Chief Executive, Basildon Primary Care Trust
Praveena Patel	Podiatrist, Birmingham Community Trust
Brenda Purnell	Chief Dietitian, Bolton Primary Care Trust
Sue Roberts	Consultant Diabetologist, Northumbria Healthcare NHS Trust
Paul Streets	Chief Executive, Diabetes UK
Bridget Turner	Person with Diabetes
Joan Wheeler	Person with Diabetes
Jane Wilkinson	Chair, Diabetes Implementation Group, Wales
Jenny Winter	Association of the British Pharmaceutical Industry
Bob Young	Consultant Diabetologist, Salford Royal Hospitals NHS Trust

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Department of Health
PO Box 777
London SE1 6XH
Fax: 01623 724524
e-mail: doh@prologistics.co.uk

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Produced by the Department of Health
29895 1p xk Nov 02 (XXX)
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First published: November 2002

29895/*National Service Framework for Diabetes: Delivery Strategy* can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.

29895/*National Service Framework for Diabetes: Delivery Strategy* is available on the department's website at:
www.doh.gov.uk/nsf/diabetes/research