



PARLIAMENTARY & STAKEHOLDER DIABETES THINK TANK

Tailored Diabetes Commissioning

Development of Local CQUIN & QOF Indicators for Diabetes



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Diabetes

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Foreword



Dear colleague,

Since the Parliamentary and Stakeholder Diabetes Think Tank last met, we have been working to develop a best practice guide to local diabetes commissioning for the new generation of commissioners. Whilst it is vital that the Think Tank continues to converse and engage with clinicians and parliamentarians in Westminster, we are delighted to be able to present this practical resource to the wider clinical community.

We were struck by the large volume of good practice that is happening on the ground in the development of local Commissioning for Quality and Innovation (CQUIN) and Quality Outcomes Framework (QOF) indicators that, as yet, have no forum to be shared or adopted. Therefore, the Tailored Diabetes Commissioning; Development of Local CQUIN & QOF Indicators for Diabetes brings together a number of these best practice examples, with key recommendations for those new commissioners and managers taking these initiatives forward in their own local setting. We hope that this document will serve as a useful tool that will assist clinical commissioning groups in their efforts to design a diabetes service that is tailored to meet the needs of their local population.

I would like to take this opportunity to thank the individual contributors to this report, including Julie Bolus, Dr Garry Tan, Eleanor Roddick and Grace Vanterpool MBE. As ever, we are grateful to Sanofi for their continuing support for the work of the Think Tank. Finally I would like to thank the members of the Parliamentary and Stakeholder Diabetes Think Tank for their continued commitment to the work of the group in striving for the improvement of diabetes care in the NHS.

Yours sincerely,

Adrian Sanders MP
Chair

Introduction

To support new commissioners within the clinical commissioning groups, the Parliamentary and Stakeholder Diabetes Think Tank has created this briefing which brings together examples of ***best practice***, and sets out ***recommendations on how local QOF and CQUIN schemes can deliver for local patients***.

This briefing is intended for those who are new to the commissioning process, and/or those professionals and managers operating in communities where diabetes is a leading local priority. Additional resources from NHS organisations are also featured in this brief, to signpost further materials to support new commissioners.

Diabetes services – The case for change

Diabetes is one of the greatest health threats of the 21st century. There are currently an estimated 2.2 million adults diagnosed with diabetes in England¹ and this number is increasing as the population ages and the prevalence of obesity rises. The financial and emotional cost to people with diabetes and their families is considerable; Diabetes UK estimate that the NHS spends £25 million a day treating people with diabetes². Between the ages of 20 and 79 people with diabetes are approximately twice as likely to die as those without the condition.

Decision making on the commissioning of local diabetes services is set to be undertaken at an increasingly local level. Clinical commissioning groups (previously known as GP Consortia) will consist of GP practices and will facilitate wider professional involvement in the commissioning process. The Government stipulates that the clinical commissioning groups must include at least one hospital doctor and one nurse.

A new generation of commissioners will be emerging, as we see the gradual transition from Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) to these clinical commissioning groups. These commissioners will have to use the local incentivising tools, the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) indicators in order to tailor service delivery to meet the requirements of the local population.

In a new commissioning environment it is crucial that commissioners and healthcare professionals work together to ensure that the quality of care remains a priority during this transitional phase for the NHS.

The Future of Commissioning

The new coalition Government made it clear in their opening weeks of power that health policy will be based on a series of new principles.

Patient outcomes will be placed at the centre of NHS services, with outcome measures becoming the primary tool for service evaluation. The Government's belief in the devolution of power will see healthcare professionals taking more responsibility for the management and commissioning of care, with significantly reduced involvement from Whitehall. This shift to local and professional responsibility is designed to ensure services can be provided with greater flexibility, responding to needs of the local community and to individual patients.

¹ *Six Years On – Delivering the Diabetes National Service Framework, Department of Health, February 16 2010*

² *Diabetes in the UK 2010: Key Statistics on Diabetes, Diabetes UK, March 2010*



To assist with the increasingly localised decision making on commissioning, the National Institute for Health and Clinical Excellence (NICE) have been given the responsibility for developing Quality Standards for over 100 disease areas and conditions over the next five years. With a set of specific statements, these standards outline the most cost-effective, high quality patient care that should be delivered in a given therapy area.

The draft Quality Standard for Diabetes was published in autumn 2010 and, following consultation, the final Quality Standard was published in March 2011. The Standard contains statements to ensure patients receive regular reviews to ensure their care is effectively managed and to reduce the risk of patients developing related conditions. There are also statements recommending structured education programmes, and guidance for professionals managing specific types of patients. It is now the responsibility of local decision makers to implement it.

There are a range of tools to support new commissioners. Alongside the proposed Diabetes Quality Standard, NHS Diabetes has produced a range of commissioning guidelines. These cover many aspects of diabetes care, such as eye services, end of life care and emergency services, as well as managing diabetes and its related conditions – cardiovascular disease, kidney care and neuropathy care.

Further details on these specific commissioning guides are included at the end of this document.

Local Implementation Tools

As the Government has made clear, local commissioners within clinical commissioning groups will have the responsibility to determine what local diabetes services will be provided.

As part of this approach, commissioners will be increasingly encouraged to implement local indicators for the national tools, the Commissioning for Quality and Innovation payment system (CQUIN) and the Quality and Outcomes Framework (QOF).

With diabetes being a significant health priority, all local health managers will need to be able to demonstrate what steps are being taken to ensure local patients receive the highest standard of care.

As clinical commissioning groups start to form and take on PCTs' responsibility for commissioning, this document seeks to provide some background information on local CQUIN and QOF indicators, and goes on to look at how leading PCTs have responded to the challenge. We will showcase how local CQUIN and QOF indicators have been effectively utilised around the country to ensure diabetes services respond to the needs of local patients and signpost further information.

Local Indicators

1. Quality and Outcomes Framework (QOF)

The QOF is part of the General Medical Services contract for GPs. It is a voluntary incentive programme to encourage best practice against a set of nationally agreed indicators.

In diabetes, national QOF indicators include targets to reduce HbA1c levels and blood pressure, and to ensure patients are tested and screened for a series of related conditions such as retinopathy & renal impairment. The Department of Health has made clear that PCTs (and subsequently clinical commissioning groups) should enhance national indicators by devising their own local indicators, to ensure that QOF fully responds to local health priorities. These local health indicators can be drafted to reflect a local priority, patient population or areas of poor public health.

ii. Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation goals. In 2009–10 this accounted for 0.5% of a provider's contract value, in 2010–11 it rose to 1.5% and will remain at 1.5% in 2011/2012.

As well as two national CQUIN standards, local commissioners are responsible for devising their own schemes for providers, made up of quality indicators that set out the improvement expected from a service, and how this will be measured.

Local CQUIN indicators are made up of a numerator, such as the number of patients assessed for a particular condition, and a denominator, the determined patient population for that indicator. Indicators also have:

- an opening descriptor of what it is set to achieve
- a rationale for its inclusion
- an indicator value

Government Support for Local Indicators

In this new environment of a patient centred, locally devolved and flexible NHS, the new Government has highlighted where they see CQUIN and QOF playing a significant role in the future of service delivery at a local level.

The previous Government laid out their intentions for local flexibility in the Next Stage Review. This has also been taken on by the current Government; the Health White Paper, "*Liberating the NHS*", and subsequent consultations, published in July 2010, make several references to how new Health Ministers expect local tools to be utilised by commissioners.

In the White Paper, the Government pledges to:

"...extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals."

Similarly, the "*Commissioning for Patients*" consultation, which focuses on GP commissioning, stresses there will be a fresh focus for QOF to ensure it "*better reflects individual practices' contribution to health outcomes.*" The emphasis on localism is further underlined in the "*Local Democratic Legitimacy in Health*" consultation – "*Localism is one of the defining principles of this Government: pushing power away from Whitehall out to those who know best what will work in their communities.*"

It is clear that the Government want commissioners to be taking the lead on providing tailored services for the local population, with CQUIN and QOF being central tools to assist this process.

Some PCTs have made significant progress in developing local indicators for diabetes; some case-studies are included in this brief. However, the process of developing local indicators is still relatively new and there are other areas that are yet to look at how these tools can drive up standards in care and outcomes for patients. The case studies in this document are designed to share best practice, and support health professionals and managers still to implement local indicators.



Development and Implementation of local QOF Indicators

Local QOF schemes operate in the same manner as national indicators. GPs can obtain points by undertaking certain elements of care. Points have a monetary value, with many using the same value as the national value; one QOF point equalling £124.60.

Local indicators can be drafted that build on national indicators, to further raise goals for attainment. Also, goals can be drafted that reflect a specific local priority, such as targeting a particular patient population that may be prevalent in the community, or focusing on preventative steps in areas of poor public health.

Local healthcare professionals must be central to the process of drafting local indicators.

A model of evaluation should be established, to ensure that goals are delivering better patient outcomes, and continuing to respond to local challenges.

Case Study – Hammersmith and Fulham PCT

Hammersmith and Fulham PCT have led the way in developing local QOF indicators. The scheme, QOF Plus, was drafted in partnership with Imperial College, and covers 48 clinical and non clinical domains.

These include introducing public health screening programmes for areas such as cardiovascular disease, smoking and alcohol, and those designed to improve care in specific disease areas.

With diabetes considered to be a significant local priority, QOF Plus looks at several different aspects of care.

- **Self-management:** Targeting patients who are experiencing difficulty in controlling their diabetes, and teaching them the various techniques for self management.
- **Accessible practice:** With high numbers of patients speaking little or no English, indicators were drafted to ensure language support was provided to ensure care did not suffer. This is particularly important for ethnic minorities, who are significantly more at risk of developing diabetes.
- **Patient information:** Practices are incentivised to improve their communication systems, to strengthen the patient-professional relationship.

More information can be found at the QOF Plus website⁴.

Recommendations for drafting local QOF indicators

The experience of Hammersmith and Fulham PCT provides some useful learnings for those looking to develop or review their local QOF indicators.

i. Partnership between commissioners and professionals

Whilst commissioners may have responsibility for devising local indicators, it is essential that they fully involve health professionals in the drafting process.

Anecdotal evidence from around the country has indicated that where commissioners do not engage with professionals, it is more difficult to ensure indicators respond to local patient needs.

The drafting process must include all professionals; diabetes care is provided by multi-disciplinary teams, including diabetologists, nurses, dieticians, podiatrists, and eye health professionals, which must be reflected in the consultation process.

To encourage their involvement, local managers should ensure that health professionals have sufficient support for their patient commitments to allow them to engage in the process. Without this, professionals' capacity to contribute will be restricted.

ii. Involve local patients

Alongside the involvement of professionals, engaging directly with patients before drafting QOF indicators will ensure indicators are incentivising the services that patients need.

In Hammersmith and Fulham, over 40 patients participated in focus groups to discuss what they would most value in local services. The process was facilitated by local Diabetes UK support groups, and attended by the lead commissioner from the Trust.

To inform the development of local QOF indicators, patients were asked:

- Who should deliver local services?
- Where should services be delivered to ensure easiest access?
- What do patients expect from their diabetes support and services from diagnosis through to long term self management?

This allowed patients to feed in directly to the drafting process. In addition, local commissioning leads have continued to meet with local patient groups to ensure they remain accountable to service users.

iii. Make the case for diabetes

To ensure their involvement, health professionals should feel empowered to proactively approach commissioning leads to make the case for diabetes to be included in local QOF schemes.

Those PCTs that have successfully introduced local QOF indicators for local diabetes patients have benefited from a proactive and engaged diabetes team, who have made the case for the prioritisation of diabetes in local QOF schemes where necessary and identified which services patients would most benefit from and, therefore, which services should be prioritised locally.

iv. Incentivise education

Appropriate education is central to good diabetes management – local QOF indicators can be agreed to further incentivise patient education, to ensure it is provided for each patient in a timely and tailored fashion. Consideration should also be given to indicators that ensure follow up with patients that do not attend agreed education sessions – missed appointments significantly affects the efficiency of a Trust/Consortia's education programme.

For more information contact Grace Vanterpool MBE – Grace.Vanterpool@hf-pct.nhs.uk or 0208 846 6237



Development and Implementation of local CQUIN Indicators

Similar to local QOF indicators, local CQUIN schemes should reflect the requirements of the local patient population.

Commissioners have the discretion to look at any aspect of care that is determined to be a local priority. Whilst the Department of Health provides areas for consideration, they are clear that these should be regarded as a guide, not requirements.

One area which has led the way in incentivising quality and innovation in local commissioning by using local CQUIN indicators has been a group of PCTs in Yorkshire and Humber.

Case Study – Yorkshire and Humber

Local CQUIN indicators in Yorkshire and Humber were developed region-wide, with local PCTs working in partnership. A number of indicators targeted a range of disease and condition areas, such as hip replacements and myocardial infarction. In diabetes, an indicator was drafted to improve the care of children with diabetes.

Rather than indicators being developed on a regional basis, they will now be developed on a local basis, due in part to the transition from PCTs and SHAs to GP Consortia/clinical commissioning groups. There are key learnings from this case study about how effective indicators can be drawn up.

The first step undertaken by Yorkshire and Humber was to assess local health needs and identify health priorities. This was undertaken as part of the research for **“Healthy Ambition⁵”**, which sets out a clinically led vision for the region with a range of clinical pathways. As part of the research process, health professionals and patients were consulted; the latter in a series of focus groups, to take on board their perspective on where future improvements to services needed to be focused.

Once identified, the local health priorities were translated into indicators. Services were selected to have indicators drafted on the basis of local variations in provision, and an assessment about where CQUIN indicators could most improve health outcomes. This is a similar set of criteria to those used by the National Quality Board’s Prioritisation Committee when selecting disease areas and conditions on which to draft Quality Standards.

Diabetes services, and in particular those for children, were identified during this process as being a priority; the involvement of both local diabetes and children’s health leads was central to bringing this area to the attention of the *“Healthy Ambitions”* team.

An additional crucial step was to consider what data was already being collected by health professionals. The *“Healthy Ambitions”* team analysed routinely collected data to ensure the proposed CQUIN indicators could be easily monitored and audited. Furthermore, it was considered that a range of indicators requiring new patient data to be captured would complicate the process, and limit their ultimate effectiveness.

Recommendations for drafting local CQUIN indicators

When drafting local CQUIN indicators, there are a series of factors that will determine their effectiveness.

i. Focus on outcomes

The Government's agenda places patient outcomes as the over-riding objective of health service reform. When identifying potential areas for CQUIN indicators, clinical commissioning groups must consider if there is genuine potential for improved patient outcomes.

ii. Involve health professionals

The involvement of health professionals is also essential to the development of effective indicators. Not only do members of diabetes teams have first hand experience of the services that are required, but they also have knowledge of data collection and auditing processes, which must be the foundation of any new indicator.

Commissioners must consider the views of primary, secondary and social care staff who are responsible for patient data collection. By not involving these groups, and developing indicators in isolation, commissioners risk drafting a set of indicators that pose significant challenges to monitor and evaluate.

iii. Reward quality and innovation

Commissioners must ensure indicators incentivise progress towards stretch targets – if targets are set too low, there is a risk that indicators will offer rewards for simply completing core contracted services, rather than incentivising innovation and quality in commissioning.

iv. Consult neighbouring Consortia

Commissioners should seek to engage with neighbouring Consortia when setting targets for their indicators. As stated, it can be a useful process for new commissioners to compare the health outcome indicators of neighbouring consortia, to ensure targets are set at an ambitious and realistic level.

v. CQUIN Indicator drafting process

For drafting local indicators, the following steps should be considered:

- Identify local priorities – this should include the involvement of patient representatives and healthcare professionals.
- Assess local data collection – engage with those professionals who routinely collect patient data to match up recorded data with identified health priorities.
- Draft indicators – having selected elements of care to target, indicators can be drafted, setting stretch targets based on current outcomes.
- Test indicators with patients – where possible, commissioners should look to test the final indicators with the patient focus groups who participated at the outset of the process. This ensures that the patient perspective does not get lost in the drafting procedure.

For more information contact Julie Bolus – Julie.Bolus@doncasterpct.nhs.uk



Development and Implementation of a Diabetes Local Incentive Scheme

Case Study – Isle of Wight

NHS Isle of Wight designed a Diabetes Local Incentive Scheme that was applied across community, primary and secondary care. The two year agreement (2011–2013) is intended to pilot a new pathway contracting methodology. This has required the supportive working between primary care, community and hospital clinical staff to improve patient outcomes and service delivery. The payment mechanism for the incentive (20% budget) required the achievement of a single set of KPIs by both primary and secondary care.

Objectives

The aims of the pathway incentive scheme are to:

- ensure that all diabetics have a personal care plan which they understand and with which they can engage;
- improve the responsiveness and integration of services provided to patients along the diabetes pathway;
- remove the barriers to cooperation across the health economy so patients are supported to access the care they need when they need it;
- encourage care to be provided as close to home as possible to reduce secondary care appointments over time;
- encourage primary care professionals to increase their skills and competence in dealing with the growing cohort of patients;
- keep health economy costs to existing levels (2010–11), whilst the number of patients with diabetes is growing year on year.

Strategy

A contractual agreement with GPs through a Locally Enhanced Service contract with the PCT was put in place, alongside 18 Local Incentive Schemes agreed within hospital Acute Services Service Level Agreements. Crucially, both of these agreements contained the same pathway and service specification. In doing so, NHS Isle of Wight were able to create an intentional co-dependency to achieve the improvement across clinical outcomes; patient care quality; patient experience; workforce.

Patients were critical to this process, with two expert patients sitting on the Diabetes Clinical Group. The GPs involved in the process also engaged directly with their patients in surgery, on an informal basis, gathering anecdotal evidence on the changes. Key objectives, outcome measurement and evaluation processes, and principle action points were all designed and agreed by patients, as well as clinicians.

Example of a KPI – Patient Care Quality

Parameter	Outcome Measure	Purpose of Outcome Measure	What has to be done to achieve the target	Measure/Incentive
Patient Care Quality	At least 65% of GP practice registered diabetic patients will have a personalised care plan. (Year Two 80%; Year Three 95%)	<p>To improve the integrated and co-ordinated management of all diabetic patients along the diabetes pathway.</p> <p>To facilitate patient active engagement in the management of their condition.</p> <p>To enable dialogue between primary and secondary care health professionals.</p>	<p>Identify patients diagnosed with diabetes (all types) and ensure that all patients have a care plan which can be accessed by primary care, community care, and secondary care. (All Providers)</p> <p>Provide opportunity for patients to discuss their care plan during any related clinical interventions. (All Providers)</p> <p>Care Plan definition: As approved by the Diabetes Centre. (Note: It is expected primary care will utilise the Vision-based care plan & that secondary care will initially utilise the out-patient letter, moving to Prowellness reports over time).</p>	<p>Audit of care plans of practice registered diabetes patients will show that at least 65% (Year One) have a personalised care plan which can be accessed by primary care and secondary care clinical staff.</p> <p>The audit will take place in January/ February 2012 and will be undertaken by PCT Primary Care Commissioning or otherwise agreed with GP diabetes lead and diabetes consultants. (PCT Primary Care Audit)</p> <p>Submission Date: 28th February 2012</p>

Outcomes

All 17 GP practices on the Isle of Wight have signed up to the new pathway contract and secondary care management were extremely supportive to make it happen. Consultants, GPs and community staff have been leading the delivery of the service via a local Clinical Diabetes Group.

Recommendations

- It is vital that the process is carefully facilitated by the commissioning managers. Once the clinicians are sat around the table, it is critical that the group shares one objective: patient outcomes.
- Once the clinicians are together, it is important to start drafting the KPIs, contracts and service specifications immediately. It will carry no weight unless it is written down, and you run the risk of your commissioning group turning into a talking shop.
- Establish a robust and structured action plan that all involved must adhere to, keeping the focus on improving patient outcomes at all times.

For more information contact Eleanor Roddick – Eleanor.Roddick@iow.nhs.uk or 01983 534539



Development and Implementation of an Integrated Diabetes Model

Case Study: Derby – New Organizations for New Challenges in Long Term Conditions

Without major structural changes to the commissioning and delivery of care for long term conditions, significant financial savings cannot be achieved. Fragmenting a patient's care pathway by counting and incentivising individual steps will never be able to provide the efficient continuum of care needed by patients with long term conditions. Here we describe how we have redesigned the delivery organisations for diabetes to be able to deliver a whole care pathway for patients.

Patients with long-term conditions often attend multiple locations to see different professionals for their care because of organizational barriers between primary, community and secondary care.

Communication between organizations is not optimized, services are duplicated or are missing, and this fragmentation results in vulnerable people feeling confused and stranded between care providers. Current care pathways are generally inefficient which leads to poor health outcomes.

Design

We have removed organizational boundaries and transformed the structure and delivery of diabetes care to improve clinical delivery and outcomes. The changes have reduced overall costs. We have achieved this by forming two new not-for-profit organisations, each jointly and equally owned by local GPs and a local NHS Foundation Trust (Derby Hospitals NHS Foundation Trust) to overcome the financial and governance barriers to integrated diabetes care.

Key measures for improvement

We compared professional and patient outcomes before and after the implementation of these partnerships.

Strategy

Two consultant clinicians and local GPs drew up a clinical pathway and defined a diabetes model across primary and secondary care to deliver this pathway. It included clinical governance, integrated IT, clinical delivery in GP practices and community settings, and financial incentives for healthcare professional education.

We examined how such “integration” was done elsewhere. However, it was clear that other models would not remove traditional “perverse incentives” because the barriers between primary and secondary care providers would remain. We therefore developed a novel model to support the clinical pathway which was predicated on the formation of a new organization which would deliver diabetes care across organizational boundaries.

We presented this model to senior management in the PBC and acute hospital trust to gain support to establish a single organization to deliver the care pathway. We then bid for, and won, the contract from the PCT to deliver integrated diabetes services for the local population in Derby City.

Outcomes

Quality outcome framework (QOF) data from practices participating in the joint venture show a 38% improvement in the percentage of patients reducing their blood sugar glucose levels to target. There was also an 18% increase in the percentage of patients reducing their blood pressure to target and a 53% improvement in the percentage of patients achieving their cholesterol target.

Practices served by Integrated Diabetes Services have seen 15% reduction in new appointments, despite increasing numbers of diabetics, and a 30% reduction in follow up appointments. In contrast, other practices have seen a 15% increase in new appointments and a 1% increase in follow ups. 16.4% of new referrals have been not seen directly, but rather initial advice has been provided to the referrers. To date, over 85% of practices have been accredited in diabetes competencies.

There has been a high level of patient satisfaction with the new organisations created to deliver diabetes care.

Recommendations

- Existing organizational structures of clear divisions into primary and secondary care may not be suitable to deliver the proposed government healthcare reforms for integration of care for long term conditions. However, **fundamental restructuring of delivery organizations is possible.**
- **Shared patient records** are a powerful method of speedy communication between primary and secondary care clinicians although significant information governance barriers needed to be overcome. Such communication is fundamental to saving costs, improving care and the patient experience.
- **Clinical leadership in primary and secondary care is crucial to the development of new systems of working.** However, we learnt that clinicians in primary and secondary care may not fully recognize the different working pressures experienced by the other clinicians. Time is needed to build good relationships based on trust, which can then lead to partnership working.
- **Education of healthcare professionals** enables good professional relationships to develop. This education can be financially incentivized for practices.
- **Senior managers are key to system change.** Often the data to support the development of services is given a low priority without senior management support. For instance, difficulties in obtaining figures to calculate programme budgeting accurately were helped by senior management buy in.

RD Rea, S Gregory, M Browne, M Iqbal, S Holloway, M Munir, H Rose, T Gray, D Prescott, S Jarvis, G DiStefano, GD Tan

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Appendix 1

The View from the Diabetes Community

As part of this briefing the Parliamentary and Stakeholder Diabetes Think Tank, chaired by Adrian Sanders MP, put forward their views on the commissioning of diabetes services and the ways in which clinical commissioning groups can deliver diabetes services that meet the needs of the local health economy. The multi-disciplinary group consists of diabetologists, Diabetes Specialist Nurses, podiatrists, dieticians and representatives from Diabetes UK, JDRF and NHS Diabetes.

Patient & Professional Education

Diabetes education for commissioners, health care professionals and patients is widely acknowledged as a *'must'*. It was agreed that if the group were to draft a CQUIN or QOF indicator – it would focus on incentivising structured education programmes for these groups.

Su Down, Nurse Consultant in Diabetes, noted the work she had carried out with her colleagues in Somerset Community Health, around patient education. Somerset Community Health adopted the NHS Diabetes Structured Education programme (built on the NICE Guideline, CG66), which proved very successful in educating patients and health care professionals alike.

Concern was raised over the ability of GPs to successfully manage diabetes in the primary care setting. This concern was extended to nurses working across the NHS, without sufficient training in the condition. The spectrum of education is broad, and whilst it was agreed that not all GPs and nurses can be diabetes specialists, many felt that core competencies in diabetes care are often lacking and need to be improved.

Education alone will not be enough. It is important to consider how clinicians, commissioners and patients are encouraged to attend training.

Patient Involvement

There was unanimous agreement that patients must be central to the commissioning process. In order to facilitate this process Anna Morton (NHS Diabetes) noted that these involvement strategies must be structured. It was also noted that the nature of patient involvement is set to change. Patients need to have the confidence to challenge their doctor, and essentially critique their care, to ensure that they are offered the choice they are entitled to.

Localism

Whilst it was agreed that commissioners must take into account the needs of their local health economy, a standardised commissioning process must also be in place. Patients need to know what to expect from their treatment and what their care pathway should look like. It was suggested that a balance should be sought between integration at the national level and local flexibility.

Commissioning Bodies

The Think Tank wish to see commissioners fully engaged with the nuances of the diabetes care pathway. There was concern amongst the group that commissioning for diabetes often takes place in a vacuum, without informed input from those with sufficient understanding of the condition. Anna Morton from NHS Diabetes recommended that a diabetes representative, from each stage of the care pathway, should be present at every step of the commissioning process. She noted that it is vital that practical, rather than abstract, knowledge is at the forefront of the commissioning process. Clinical senates, and the breadth of expertise involved in clinical commissioning groups, will offer diabetes specialists further opportunities to feed directly into the commissioning process.

It was also noted that those outside of the diabetes community often consider diabetes as “easy to manage”. The group would argue that whilst 80% of people with diabetes successfully manage their condition in the community and in primary care, many also require specialist care. This means that no one patient care pathway is the same; the arrangement is often dynamic and fluid, with the diabetes patient moving in and out of secondary care.

The group concluded that when diabetes services are commissioned, those doing the commissioning must have access to a realistic assessment of the local need, based on detailed evidence, with specialist, multi-disciplinary input. It was agreed that integrated commissioning is imperative, with diabetes services commissioned as a whole, integrated care package. Furthermore, it is vital that diabetes services are commissioned for the future, not just for today.

Commissioning Structure

The group agreed that more emphasis should be put on building incentives into contractual relationships. Although clinicians report different experiences, both good and bad, without ensuring that the standards of care are enshrined in contractual arrangements, improvements will be difficult to achieve.

Whilst there is a high level of agreement in the diabetes clinical community on how to treat diabetes effectively these commonly agreed principles are still not being applied in the commissioning process.

A final point of note was that an element often missing from the national debate are the providers themselves. Providers should be fully engaged with the commissioning process, as it is at this level where great innovation can happen. Financial incentives can be very powerful, and providers should be encouraged to establish new, more efficient means of delivering the service.

The Parliamentary and Stakeholder Diabetes Think Tank was established with Adrian Sanders MP, Chair of the Diabetes All Party Parliamentary Group, in 2007. The Think Tank, supported by an unrestricted educational grant from Sanofi, is made up of diabetologists, GPs, Diabetes Specialist Nurses, dieticians, podiatrists, NHS managers and other key stakeholders. The Think Tank meets up to four times each year in Westminster to discuss a specific element of diabetes care. Previous events have covered implementation of QOF targets for HbA1c, the role of Diabetes Specialist Nurses, and patient information and education.

Following the meetings, a report is drafted of the main discussion points and recommendations. The report is sent out to participants, the Minister for Diabetes, Paul Burstow MP, and the National Clinical Director for Diabetes, Dr Rowan Hillson.

For more information on the Parliamentary Stakeholder and Diabetes Think Tank contact Katie Russell on 020 7824 1859 or Katie@insightpa.com



Appendix 2

Additional Resources

There are a series of additional diabetes commissioning resources available. This section includes details of these resources and signposts where more information can be found.

i. NHS Diabetes Commissioning Resource

NHS Diabetes has established a series of commissioning resources aimed at supporting professionals, commissioners, providers and ultimately patients.

The resource takes commissioners through a step by step guide on how to commission better diabetes care, from undertaking a local health needs assessment to confirming local services and finally, evaluating those services.

A set of commissioning guides has been drafted for each aspect of diabetes care to support the development of local diabetes services in relation to:

- Eye services
- Cardiovascular care
- End of life care
- Kidney care services
- Older people's care
- Emergency and inpatient care
- Foot care
- Mental health
- Diagnosis and continuing care services
- Neuropathy care
- Children and young people
- Pregnancy care
- Prevention and risk assessment services
- Patients with learning disabilities

These guides are designed to initiate a local discussion on the development of core contracted diabetes services.

Full details can be found on the NHS Diabetes website⁶.

ii. QOF Plus

Developed by Hammersmith and Fulham PCT, QOF Plus has a supporting online resource to guide commissioners, which can be found at www.qofplus.org.uk.

iii. NICE Quality Standard on Diabetes in Adults

The Quality Standard, developed by NICE, was published in March 2011

Appendix 3

Quality Standard for Diabetes in Adults

“The quality standard for diabetes in adults requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole diabetes care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with diabetes. The diabetes in adults quality standard supports the ‘National Service Framework for Diabetes’ and locally agreed pathways of care.”

NICE, March 2011

- 1 People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.
- 2 People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.
- 3 People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.
- 4 People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.
- 5 People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.
- 6 Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.
- 7 Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.
- 8 People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.
- 9 People with diabetes are assessed for psychological problems, which are then managed appropriately.
- 10 People with diabetes with or at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
- 11 People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.
- 12 People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
- 13 People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.



PARLIAMENTARY & STAKEHOLDER DIABETES THINK TANK

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