

# Action for Diabetes



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<b>Contact Details for further information</b>	Joanna Clarke Clinical Domain Team Medical Directorate 6th Floor, Skipton House London Road SE1 6LH

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# Action for Diabetes

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**Prepared by Medical Directorate, NHS England**

## Contents

Foreword .....	5
Executive summary .....	7
Diabetes: where are we now? .....	8
What do we want the future to look like for people with or at risk of diabetes? .....	9
How will NHS England lead and support the new commissioning system to improve outcomes for people with or at risk of diabetes? .....	13
The way forward.....	25
Appendix A – The House of Care.....	26
Appendix B – What does NICE say about high-quality diabetes care? .....	29
References.....	30

## Foreword

Over recent years, the quality of NHS services for people with or at risk of diabetes has improved and, as a result, so have health and care outcomes.

When low rates of delivery of basic care processes and low rates of attainment of treatment goals were criticised by the National Audit Office and subsequent Public Accounts Committee Reports in the last few years, we did not know how our performance compared to other countries. In 2013, however, the Global Burden of Disease Study showed that in fact the UK has the lowest rates of early death due to diabetes of the 19 wealthy countries included in the analysis.<sup>1</sup> Another recent publication also suggests marked reductions in excess mortality in those with diabetes in UK and Canada between 1996 and 2009.<sup>2</sup>

The fact that we in England place emphasis on processes of diabetes care delivery via the Quality and Outcomes Framework and annually audit these processes via the National Diabetes Audit may be contributing positively to the longer term clinical outcomes like mortality rates.

However, while we might be doing well in some areas compared to other countries, we know there is still more opportunity in England to improve patient experience and disease outcomes, as reflected in the unwarranted variation across the country. Notably, completion rates of care processes are lower and achievement of NICE-recommended glucose targets markedly worse for those with Type 1 diabetes compared to those with Type 2 diabetes.

There is more to do on the prevention and early diagnosis of Type 2 diabetes, on the appropriate and individual management of both Type 1 and Type 2 diabetes in the community, on hospital care, on services being integrated around patient needs and wants, and, underlying all of that, care being safe.

We have a new opportunity as NHS England to improve outcomes for people with and at risk of diabetes. We are one united organisation, working at a national, regional and local level as a direct commissioner of primary care and specialised services and a support to the commissioners of secondary and community care services. One united organisation with a focussed purpose – to ensure high quality care for all, for now and future generations.

We have a great opportunity to work with partners across the health and social care system and beyond to improve outcomes. For example, the crucial work we're doing with Public Health England and local government on the prevention and early diagnosis of Type 2 diabetes through initiatives like the NHS Health Check programme.

Diabetes is a growing problem and is an example of why we need new thinking about the future of the NHS. We need to see diabetes care within a broader programme of work to improve management and prevention of all long-term conditions.

This document has been produced in response to the Public Accounts Committee report on adult diabetes services published in 2012. It is for Clinical Commissioning Groups (CCGs) as a reference to the work that is going on across NHS England, and for the wider community interested in diabetes care to see what action NHS England is taking in this important area. It

sets out the action that NHS England is taking now to improve outcomes for people with and at risk of diabetes – in both of its roles, as a direct commissioner and a support to the commissioning system.

A handwritten signature in dark ink, appearing to read 'J. Valabhji', with a long vertical stroke extending downwards from the end.

**Professor Jonathan Valabhji**  
**National Clinical Director for Obesity and Diabetes**

## Executive summary

‘Action for Diabetes’ is a reference document for CCGs and the wider stakeholder community to see what action NHS England is taking in improving outcomes for adults with and at risk of diabetes. It is particularly focussed on adults in response to the National Audit Office study and subsequent Public Accounts Committee report which both focussed only on services for adults.

It is a ‘one stop shop’, bringing all the strands of work together in one place, for anyone interested in what NHS England is doing now and over the next few years in this important area.

The document describes the action we are taking and will take in our role as a direct commissioner of services to:

- Drive the prevention of Type 2 diabetes and earlier diagnosis of all diabetes
- Support better management of diabetes in primary care

It also describes what we are doing and will do in providing leadership and support to CCGs as commissioners of secondary and community services to deliver high-quality care, as defined by NICE, to people with and at risk of diabetes. In this regard, we will:

- Provide tools and resources to support commissioners in driving quality improvement
- Ensure robust and transparent outcomes information, and aligned levers and incentives to facilitate delivery of integrated care across provider institutional boundaries
- Empower patients with information to support their choices about their own health and care and support the development of IT solutions that allow sharing of information between providers and between providers and people with diabetes
- Look to the future of the NHS to deliver continued improved outcomes for people with or at risk of diabetes

## Diabetes: where are we now?

- There are 2.7 million people diagnosed with diabetes in England<sup>3</sup>, a number that is increasing by about 5% per year. About 10% of people with diagnosed diabetes currently have Type 1 diabetes.
- In England, people from south Asian and black ethnic groups have a greater chance of developing Type 2 diabetes than people from white ethnic groups.<sup>4</sup> The risk of diabetes also increases with age. In 2010 the prevalence of all types of diabetes was 0.4% for people aged 16 to 24 years, rising to 15.1% for people aged 70 to 84 years old.<sup>5</sup>
- Diabetes is a major cause of premature mortality with over 22,000 additional deaths each year.<sup>6</sup>
- Diabetes doubles the risk of cardiovascular disease (heart attacks, heart failure, angina, strokes).<sup>7</sup>
- Diabetes is the most common reason for end stage kidney disease and the most common cause of blindness in people of working age.<sup>8</sup>
- Up to 100 people a week have a limb amputated as a result of diabetes, and in many cases this is avoidable.<sup>9</sup>
- Diabetes is estimated to have cost the UK £9.8 billion in direct costs in 2010/2011, this equates to approximately ten per cent of the total health resource expenditure.<sup>10</sup>
- It is estimated that 80 per cent of these costs are incurred in treating potentially avoidable complications.<sup>11</sup>
- In 2012/13 42.5 million items were prescribed to treat diabetes, £764 million was spent on drugs to treat diabetes in primary care.
- Many people with diabetes have complications of diabetes and/or other long-term conditions as well, and there is predicted to be a 252% increase the number of people with multiple long-term conditions by 2050.
- Nearly 1 in 5 people with diabetes have clinical depression<sup>12</sup> and for those with anxiety and/or depression health care costs increase by around 50%.<sup>13</sup>



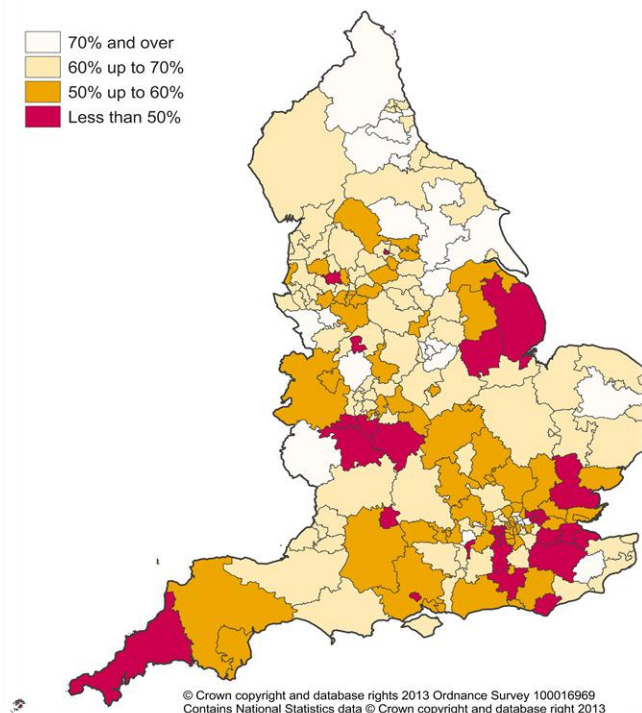
# What do we want the future to look like for people with or at risk of diabetes?

## Quality at the core

1.1 Over recent years, the quality of NHS services for people with or at risk of diabetes has improved and, as a result, so have health and care outcomes. The recent Global Burden of Disease Study 2010 showed that in fact the UK has the lowest rates of early death due to diabetes of the 19 wealthy countries included in the analysis.<sup>14</sup> Another recent publication also suggests marked reductions in additional mortality in those with diabetes in UK and Canada between 1996 and 2009.<sup>15</sup> The 2011-12 National Diabetes Audit also suggests a continuing downward trend in additional mortality among people with diabetes.

1.2 However, we know there is more opportunity to improve patient experience and disease outcomes, as reflected in the unwarranted variation across the country. For example, there is wide geographical variation in the percentage of people receiving the recommended care processes for the treatment of diabetes, as shown in the map opposite.<sup>i</sup> There is also variation according to type of diabetes, such that completion rates of care processes are lower and achievement of NICE recommended glucose targets markedly worse for those with Type 1 diabetes compared to those with Type 2 diabetes.

**National Diabetes Audit 2011/12**  
Percentage of patients with diabetes receiving eight care processes, by Clinical Commissioning Group



<sup>i</sup> A change in the definitions used to identify eye screening in GP systems means that there was a significant change in the people being noted as having received eye screening. For this reason the focus on reporting is on people receiving eight, rather than nine, care processes for 2011/12.

- 1.3 In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Below we set out what quality care and outcomes would look like for diabetes in those five areas.

### **Preventing people from dying early**

- 1.4 In the future, we would want to see people living healthier lifestyles and avoiding developing Type 2 diabetes in the first place. We would want to see that the complications of the disease are prevented or delayed by ensuring that those who develop Type 1 diabetes achieve treatment targets, while people with Type 2 diabetes are diagnosed early and treated effectively. When complications do develop we must ensure they are identified and treated as quickly as possible to minimise disability and premature mortality, as described in the sections below.

### **Enhanced quality of life for people with long-term conditions**

- 1.5 As the recent National Audit Office and subsequent Public Accounts Committee reports highlighted, not enough people living with diabetes are having the basic regular checks on their health. If poor health as a result of diabetes is not picked up and treated early, it can lead to complications such as heart diseases, strokes, blindness, kidney failure, amputation and dementia. People with diabetes are also more than twice as likely to be diagnosed with depression.<sup>16</sup> We know more can be done to improve the numbers of people receiving the essential healthcare checks for diabetes, in particular by addressing the marked geographical variation, and to help those with diabetes understand their condition better and manage their health proactively.
- 1.6 In the future, we want to see everyone with a long-term condition having a single holistic, personalised care plan, developed and agreed in partnership with their clinical team through the care-planning process. Multi-morbidity is on the increase generally, and in diabetes with associated complications we may see eye disease, kidney disease, foot disease, heart disease, stroke disease as well as depression all in the same individual. We therefore need to start with the person and their goals to develop a personalised care plan that embraces all of their conditions and needs.

### **Helping people recover following episodes of ill health or following injury**

- 1.7 People with diabetes are more likely to be admitted to hospital and have longer stays than similar people without the condition. There is evidence inpatient care

is poor in some areas and people with diabetes experience avoidable complications while in hospital. A recent English study has demonstrated higher inpatient mortality for those with diabetes compared with non-diabetic patients, with higher rates in small and medium acute trusts than in large and teaching acute trusts.<sup>17</sup>

- 1.8 New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across primary, secondary, community and mental health and social care, and in a safe timescale.
- 1.9 In the future, we would want to see fewer emergency admissions and readmissions in patients with diabetes. We would want to see those with diabetes in hospitals being empowered to continue to manage their own diabetes safely where appropriate, having access to specialist care when needed, and having a smooth transition back into the community.

### **Ensuring that people have a positive experience of care**

- 1.10 In a recent audit, nearly 80% of people with diabetes in hospital said that they weren't involved in the design of their care plan, and less than half had been allowed to self-administer insulin while in hospital.<sup>18</sup>
- 1.11 In the future, we would want to see personalised and integrated care, designed in partnership with people with diabetes, and delivered by a competent workforce in specialist and non-specialist settings. We want to see patients and carers involved in decisions about their care, receiving appropriate structured education to support self-management, having more control and managing their own health, care and treatment.

### **Treating and caring for people in a safe environment and protecting them from harm**

- 1.12 Insulin, which is used as a treatment for all people with Type 1 diabetes and many of those with Type 2, is a safe and effective treatment if used appropriately, however, incorrect or inappropriate use can lead to patient harm. There has been a particular focus on the safe use of insulin in recent years following high levels of incident reporting. There has also been focus on other areas of patient safety including the reduction of medication errors in hospital and avoidance of the development of heel/pressure ulcers that can contribute to higher rates of

lower limb amputation. High glucose levels in mothers are a major risk to unborn babies, and NICE has specified the actions that can improve safety in these cases.<sup>19</sup>

- 1.13 In the future, we would want to see all patients experience the safe treatment they deserve. We would want to see all those people with diabetes who use insulin as a treatment being supported to use it safely – both in and out of hospital, including all pregnant women with diabetes being supported to minimise risk to their babies

### **How will quality in outcomes for people with diabetes be assured?**

CCGs and NHS England are under a statutory duty to continuously improve quality across the comprehensive service. CCGs and NHS England in their respective commissioning roles are accountable for meeting this duty.

NHS England is held to account for improving outcomes by the Secretary of State, supported by the NHS Outcomes Framework, which sets out the outcomes that matter to people using NHS services. In addition to securing an improvement in outcomes through our own direct commissioning, NHS England is also responsible for ensuring that CCGs meet this core statutory duty. The [CCG Assurance Framework](#) sets out the basis for this assessment.

Integral to the assurance assessment is a discussion, based on a comprehensive delivery dashboard, of CCG delivery of the improved outcomes which they have planned to deliver. Where CCGs are found to be at risk of failing to deliver these improvements, NHS England, through area teams, will support CCGs to make the required improvements, with statutory intervention powers remaining a last resort where CCGs demonstrably lack the capacity to make these improvements.

In addition to the assurance delivery dashboard, NHS England has developed the [CCG Outcomes Indicator Set \(CCG OIS\)](#) which can be used by CCGs as a tool to understand trends in outcomes and to help them identify potential priorities for improvement. The CCG Outcomes Indicator Set is supportive of the NHS Outcomes Framework and is an important piece of additional insight to inform the assurance assessment. Paragraph 4.8 sets out the CCG OIS indicators relevant to diabetes care and outcomes.

## **How will NHS England lead and support the new commissioning system to improve outcomes for people with or at risk of diabetes?**

- 2.1 NHS England's goal is high quality care for all, now and for future generations, and we have a dual role in helping to ensure this goal is achieved.
- 2.2 We are a direct commissioner of healthcare services including primary care, specialised services, secondary care dental services, some public health services, offender health and armed forces health. We are here also to provide leadership and support to CCGs as commissioners of secondary and community healthcare services. Improving outcomes for people with or at risk of diabetes will be achieved through actions in each of these roles.
- 2.3 In our role as a direct commissioner of services, we will:
- Drive the prevention of Type 2 diabetes and earlier diagnosis of all diabetes
  - Support better management of diabetes in primary care
- 2.4 We will also provide leadership and support to CCGs as commissioners of secondary and community services to deliver high-quality care, as defined by the National Institute for Health and Care Excellence (NICE)<sup>ii</sup>, to people with and at risk of diabetes. In this regard, we will:
- Provide tools and resources to support commissioners in driving quality improvement
  - Ensure robust and transparent outcomes information, and aligned levers and incentives to facilitate delivery of integrated care across provider institutional boundaries
  - Empower patients with information to support their choices about their own health and care and support the development of IT solutions that allow sharing of information between providers and between providers and people with diabetes
  - Look to the future of the NHS to deliver continued improved outcomes for people with or at risk of diabetes

This is set out in further detail in the following pages.

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<sup>ii</sup> See Box A on p14

## What does NICE say about high-quality diabetes care?

### NICE Quality Standard

1. People with diabetes and/or their carers receive a structured educational programme that fulfills 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 HbA<sub>1c</sub> 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 at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.
11. People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
12. 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.
13. People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
14. People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

Links to the full NICE clinical guidelines for diabetes care, relevant NICE Technology Appraisals and Public Health guidance are given in Appendix B.



**In our role as a direct commissioner of services, we will:**

### **Drive more prevention of Type 2 diabetes and earlier diagnosis of all diabetes**

- 3.1 There will be a multi-agency approach to the prevention and management of obesity, an important antecedent to Type 2 diabetes. This will draw together and co-ordinate efforts between NHS England, Public Health England, local authorities, education, the Department of Health, the third sector and the food industry. We will also continue to work together with Public Health England on the roll-out of the NHS Health Checks programme.
- 3.2 Over the next few years, we will continue to develop the GP contract and incentives to help identify those at risk, earlier diagnosis and incentivising active management of risk factors identified in NHS Health Checks, wherever they took place. Early diagnosis of diabetes, leading to the prompt provision of appropriate medical care, can save lives in people with Type 1 diabetes, and avert development or progression of complications of Type 2 diabetes, some of which can be life-threatening.
- 3.3 NHS Improving Quality is working with primary care services to trial and roll out case-finding and decision-support tools in primary care to support earlier diagnosis across a range of conditions including diabetes. This work started in this financial year and will be ongoing into the next one. Work on diabetes will start in 2014.

### **Support better management of diabetes in primary care**

- 3.4 NHS England is, since April 2013, the sole commissioner of primary care services in England. We have produced single operating models for all directly commissioned services,<sup>20</sup> including primary care,<sup>21</sup> to ensure there is consistency across the whole of England, with the ambition to reduce inequalities and provide better outcomes for patients. There will be a clinically-driven focus on improving outcomes for people with long-term conditions, including diabetes. Commissioning of primary care will support responsive access to general practice, and systems to enable timely specialist advice where needed.
- 3.5 We are developing a strategic framework for commissioning primary care, including general practice, community pharmacy, primary care dentistry and optometry services. The strategic framework for commissioning of general practice services will be published in 2014 and will set out the action we are taking at national level to support commissioners in developing joint strategies for primary care as part of their five year strategic plans. In the development of all

the frameworks, we are considering how best to enable primary care contractors (general practice, community pharmacy, primary care dentistry and optometry services) to provide high quality services for patients, in particular those with long-term conditions including diabetes.

- 3.6 We will continue to encourage the best care and management for people with diabetes through the Quality and Outcomes Framework (QOF) payment mechanism to GP practices. There are 11 diabetes indicators within QOF for 2014/15, which includes an indicator patients being referred to a structured education programme within 9 months of new diagnosis of diabetes. In 2014/15, QOF will dedicate in total 86 points to diabetic care and management, which equates to 15% of the total QOF points.
- 3.7 We published the Risk Profiling and Care Management Enhanced Service specification for GPs at the beginning of 2013.<sup>22</sup> The Service encourages GP practices to identify their patient cohort who are most at risk of admission to hospital, using a multi-disciplined approach to work with health and social care professionals to deliver an enhanced care package for these patients. The multi-disciplinary teams identify how these patients are best supported and who is best placed to deliver support, and also help patients to improve self-management of their condition/s to reduce hospital admission. People with diabetes who have an increased risk of hospital admission will be supported by this programme.
- 3.8 We are committed to making available to the public the information that the health care system uses to understand how well it is performing or that patients need to make decisions. In December 2013, NHS England published an additional 40 general practice level indicators on the NHS Choices website in a new accountability area designed to provide information to people who want to get involved in conversations about their local health services.<sup>23</sup> NHS Choices and NHS England will work with HealthWatch and other stakeholders to further develop the content and presentation of this information to ensure it is as relevant and usable as possible. The new items are presented alongside those that were already published and available on NHS Choices. Of the 40 new items the following are relevant to diabetes:
- Diabetes blood pressure levels: percentage of patients with diabetes with blood pressure of 140/80 or less
  - Diabetes cholesterol levels: percentage of people with diabetes with cholesterol less than 5 mmol/l
  - Diabetes retinal screening: percentage of people with diabetes who have a record of retinal screening
  - Smoking status: percentage of patients who smoking status has been recorded in the last 27 months
  - Smoking cessation advice: percentage of patients in at-risk groups who have been offered smoking cessation advice



- Emergency hospital admissions: rate of emergency hospital admissions for selected long-term conditions as a proportion of total number of patients per GP practice
- Emergency admissions for ambulatory-care sensitive (ACS) conditions: number of emergency admissions for ACS conditions per 1,000 population
- Insulin prescribing: number of long intermediate insulin analogues as a proportion of all analogues.

3.9 NHS England also provides the primary care web tool to assist GP practices and CCGs in comparing practices for the purpose of performance improvement.<sup>24</sup> This information is practice-specific and every practice, CCG and Area Team in England has sight of their own and everyone else's data. For diabetes, the tool includes indicators on prevalence (expected vs actual), emergency admissions, HbA1c, blood pressure and cholesterol levels, and retinal screening.



**In providing leadership and support to CCGs as commissioners of secondary and community services, we will:**

**Provide tools and resources to support commissioners in driving quality improvement**

- 4.1 We are producing a sample service specification for the management of Type 1 and Type 2 diabetes that is based on the NICE Quality Standard for Diabetes. It is being co-produced with the National Clinical Director for Obesity and Diabetes, CCG colleagues and others including colleagues from Cardiovascular Strategic Clinical Networks. The service specification would not be mandatory but would be offered as a tool that commissioners can choose to use to deliver high quality care. It will offer a model for the commissioning of integrated care for those with diabetes, and will also serve as a vehicle to highlight the specific care needs for those with Type 1 diabetes where they differ from those with Type 2 diabetes.
- 4.2 Cardiovascular Strategic Clinical Networks will support the prevention of Type 2 diabetes, as well as the high quality management of all diabetes, kidney disease, heart disease and stroke, by supporting CCGs under an overarching focus on cardiovascular disease. So far, in 6 of the 12 regional Cardiovascular Strategic Clinical Networks, dedicated diabetes clinical leads have been appointed.
- 4.3 NHS Improving Quality is supporting a project to reduce the high mortality associated with diabetic foot disease. Diabetic foot disease acts as a bold marker for high CVD risk.<sup>25</sup> People with diabetic foot disease are at particularly high risk of premature death due to CVD, with 5 year mortality for those with Type 1 or Type 2 diabetes and diabetic foot disease around 50%.<sup>26 27 28</sup> The project will pilot an approach in several multidisciplinary foot clinics across the country over the next 18 months to introduce an additional clinical pathway which includes different heart tests to assess CVD risk.
- 4.4 NHS Improving Quality is supporting the production of a generic service specification to improve the quality and experience of care of young people transitioning between paediatric and adult services. This could impact on all young people undergoing transition, including those with diabetes.
- 4.5 The “Think Glucose” toolkit,<sup>29</sup> produced by the NHS Institute, is available to support improved management of patients with diabetes in hospital.

- 4.6 NHS Improving Quality is continuing to support the e-learning modules on the safe use of insulin, which over 200,000 learners have registered for (as of January 2014). Building on the success of the *Safe use of insulin* module a further 4 e-learning modules have been developed. The *Safe use of intravenous insulin infusion* module was launched in 2011, and in 2012 two further safety e-learning modules were released: the *Safe use of non-insulin therapies* module and the *Safe management of hypoglycaemia* module. The fifth e-learning module in the insulin suite was launched in 2013: the *Safe use of insulin syringes, pen devices, pumps and sharps*. The modules can be accessed [here](#).

**Ensure robust and transparent outcomes information, and aligned levers and incentives to facilitate delivery of integrated care across provider institutional boundaries**

- 4.7 We will support a 'House of Care' approach to ensuring quality of life for people with long-term conditions, including diabetes. The 'House of Care' approach, which was developed initially for patients with diabetes specifically, centres around a care planning process, where people with long-term conditions, their carers and health professionals work in partnership to agree goals and outcomes, taking a whole life approach that goes beyond the symptoms or a single condition. The approach ensures that people are treated as individuals, who may have one or many long-term conditions, physical and/or mental, and who have different life experiences and circumstances. The 'House of Care' has a solid foundation built on the commissioning cycle, pillars of patient empowerment and clinical collaboration, and a roof composed of guidance, tools and resources. The 'House' falls down if all the constituent parts are not strong and working together; each part needs equal and sustained focus. The House of Care approach needs action at three levels – the national, the local and the personal. We set out our thoughts on these three levels in Appendix A, and describe below some of the actions we are taking to support the national approach.
- 4.8 The outcomes of the care received by people with diabetes will be reflected throughout the NHS Outcomes Framework, most particularly through the indicators reducing premature mortality and on outcomes for people with long-term conditions, and the specific indicator on unplanned admissions to hospital for children with diabetes. Through the CCG Outcomes Indicator Set (OIS)<sup>30</sup>, a more detailed picture of the outcomes for people with diabetes will also be available, to provide clear, comparative information for CCGs, Health and Wellbeing Boards and local authorities about the quality of diabetes services and their associated health outcomes. Indicators specific to diabetes care in the CCG OIS include:
- Myocardial infarction, stroke and stage 5 kidney disease in people with diabetes
  - People with diabetes who have received the care processes

- People with diabetes diagnosed less than one year referred to structured education
  - Unplanned hospitalisation for diabetes in under 19s.
  - Complications associated with diabetes including emergency admissions for diabetic ketoacidosis and lower limb amputation.
- 4.9 The newly established National Cardiovascular Intelligence Network (NCVIN) will build on the innovative work of the National Diabetes Information Service (NDIS) to continue to develop a range of diabetes data, tools and information to help providers of diabetes care and health commissioners to improve services. The NCVIN will bring together a comprehensive suite of cardiovascular information products, datasets and tools through a single web portal. This will be complimented by a programme of NCVIN masterclasses to ensure that data and information is available to commissioners in driving quality improvement.
- 4.10 The National Diabetes Audit (NDA) is considered to be the largest annual clinical audit in the world. It provides an infrastructure for the collation, analysis, benchmarking and feedback of local clinical data to support effective clinical audit across the NHS in this area. NHS England sees the NDA as vital to the success of an organisation's ability to continually improve services for people with diabetes as it:
- compares the processes and outcomes of care with similar NHS organisations
  - identifies and shares good practice
  - identifies gaps or shortfalls in commissioning services
  - supports the identification of progress in meeting NICE guidelines
  - provide a local health economy view of care and outcomes where primary and secondary care organisations actively participate
- 4.11 The NDA is piloting a new patients' experience of diabetes care survey (PEDS). PEDS is an online approach to collecting information from people with diabetes about their care in both primary and secondary care. Each GP practice or diabetes clinic will be asked to promote the PEDS Survey within their service and to invite their patients with diabetes to complete the survey. All participating services will receive a report on their patients' feedback, if a sufficient number of responses are received. A CCG level report and national report will also be published.
- 4.12 The Health Quality Improvement Partnership (HQIP) has also commissioned an audit to measure the impact of transition on diabetes management (a joint National Diabetes Audit and the National Paediatric Diabetes Audit initiative).
- 4.13 Data was published on inpatient mortality for those with diabetes in England last month. Diabetes was associated with a 6.3% greater risk of inpatient mortality, when corrected for the presence of comorbidities. Mortality for those with diabetes was higher in small and medium acute trusts than in large and teaching acute trusts. Similar data can now be assessed annually. We are looking to

investigate potential contributors to this excess mortality risk as part of a quality improvement programme.

- 4.14 Further consideration will be given to updating the NHS Atlas of Variation of Healthcare for Diabetes previously published in 2012 to demonstrate the level of variation across diabetes care in England.
- 4.15 From April 2013, best practice tariffs for diabetic ketoacidosis and hypoglycaemia were introduced. NHS England will continue to support financial incentives across the commissioning system to support better management and care of long term conditions such as diabetes. Work is currently being done around financial flows in the NHS and how they can better enable effective integrated care to be commissioned and delivered.
- 4.16 At a national level, NHS England is also working with other organisations to help address existing barriers and promote services that integrated around patients' needs across all settings including primary, secondary, community and mental health and social care. This includes reviewing incentives and contracts, developing Year of Care tariffs (see paragraph 4.17), greater use of care planning and personalisation, and sharing learning from the Integration Pioneers.<sup>31</sup>
- 4.17 The long-term conditions Year of Care funding model programme aims to develop a financial framework for commissioners and providers to work with locally when funding care for people with long term conditions. This 4 year programme of work started in 2011/12 and focuses on working with eight Early Implementer (EI) sites to develop test and refine new models of commissioning and contracting for integrated care and developing a capitated funding model framework. The development of a robust local currency model based on local prices is the first step towards creating a national financial framework using local prices and finally a national currency with national prices.

**Empower patients with information to support their choices about their own health and care and support the development of IT solutions that allow sharing of information between providers and between providers and people with diabetes**

- 4.18 We will launch a new customer service platform, which will include various functionality including information on conditions, information on services, Patients Online transaction (e.g. booking appointments, managing prescriptions, viewing personal health records), patient engagement and feedback. We want to improve how people interact with health services, including online access to key elements of the care process. Our first step to achieving this vision is to give patients the ability to book appointments online, order repeat prescriptions and access their GP record from April 2014. We have secured commitment to this in the 2014/15 GP contract and work is currently underway to define in detail what the 'GP

record' will constitute, e.g. how much historical data is meaningful, and whether there is a time delay to allow a GP to 'manage' how the impact of certain test results are communicated. By March 2015, the facility will be available everywhere and we will work with patient groups to build awareness and measure the effectiveness and value of these services to inform their ongoing development and widespread adoption.

- 4.19 We are continuing to pursue the vision that patients and clinicians have access to a full medical record. We are working to make greater strides in the achievement of safe, digital record keeping in secondary care, as a precursor to integration of those records with the GP record. To this end, in mid-2013 we launched the £260m 'Safer Hospitals, Safer Wards' technology fund, £218m of which was awarded to NHS Trusts for 234 projects in December 2013. The projects that have been funded range from explicit creation of digital care records, to implementation of e-Prescribing systems, to delivery of multi-organisational proposals to create integrated digital care records across care settings. Guidance issued by NHS England to Provider Trusts in July 2013 made clear that, whilst they should choose systems that provided the best functionality to meet their own clinical requirements, to ensure that our ultimate goal of interoperability of care records across multiple settings will be achieved, use of NHS Number as primary person identifier and open Application Programme Interfaces (APIs) – a technical standard that allows data to be transferred between separate applications - has been set as a condition of receiving the funds. A further £250m has been made available for a second tranche of the fund, with an increased emphasis on delivering integrated care records between health and social care, which will be launched in early February. All allocated funds must be match-funded by NHS Trusts making the total expected investment in digitisation, e-prescribing and integrated care records over £1 billion. We will track progress towards safe, digital record keeping in secondary care through the 'clinical digital maturity index' which launched in November 2013.
- 4.20 We want to improve individuals' health literacy nationally and reduce inequalities in health literacy. We will launch an online health literacy programme with The Tinder Foundation to train 100,000 people from disadvantaged communities by April 2014.
- 4.21 Last year we published a guidance document on 'Transforming Participation in Health and Care', to help CCGs and other commissioners of health and care services to involve patients and carers in decisions relating to care and treatment, and the public in commissioning processes and decisions.<sup>32</sup>
- 4.22 We will develop a comprehensive 'Patients and carers in control' work programme including practical training, support and tools to support local communities to deliver shared decision-making, personalised care planning and better self-management of their health. This will include a wide range of activity that will include the following:

- Developing and implementing a best practice standard that defines what good, personalised, digital care plans and planning processes look like, in order to support GPs and health professionals during 2014.
- Building a Field Force of practical support and help to support NHS commissioners to make patient participation a reality.<sup>iii</sup>
- Focussing on getting CCGs ready to offer personal health budgets to anyone receiving continuing healthcare by April 2014, and to all those with a long-term condition who will benefit, by April 2015.
- Working in partnership with key stakeholders to develop a coalition to support the change needed to make a more holistic person-centred approach for people living with long-term conditions, like diabetes, a reality based on the House of Care.
- Looking at embedding the principles of shared decision making, and promoting the use of Patient Decision Aids (PDAs).
- Working with partners, such as the Royal College of GPs, to look at what support patients and the public need to be able to best make use of health information, and how clinicians can make sure that patients understand messages about their health and care. Increasing health literacy will be key to increasing individuals' ability to manage their health.
- Looking at how to encourage the commissioning of peer support services, what types of peer support work best for different health needs, and how peer support can be sustained.
- Looking at the evidence and building the business case for commissioners and providers about the benefits of patient participation.
- Considering and designing metrics and incentives to support patient participation, and considering what barriers have made it difficult to incentivise patient participation in the past.

4.23 Through all this, we will be working to put mental health on a par with physical health, and close the gap between people with mental health problems and the population as a whole. NHS England's Parity of Esteem programme is responding to the twin challenges of caring for the mental health needs of patients with 'physical' illnesses (like diabetes), and better treating the physical health needs of people with mental health problems. Through work with NICE, the Royal College of Psychiatrists, and the National Clinical Director for Mental Health, over the coming year we are aiming to embed care and support for mental health and wellbeing in more care pathways and more service standards for physical diseases. The House of Care approach demonstrates the need for

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<sup>iii</sup> The Field Force is a specific programme of dedicated funding which has been made available to Commissioning Support Units (CSUs) designed to enable them to provide bespoke support to CCGs and area teams in order to deliver personalised approaches to health care. Divided into two separate work streams, Patients in Control (PiC) and Patient and Public Participation (PPP), NHS England has established a number of CSUs across the country who will work together with a wide range of other stakeholders to pioneer new approaches, share good practice and enrich commissioning support services through community connections, especially strong engagement with the voluntary and community sector.

mental health and physical health professionals to work together with patients and carers to select the services they need to enhance their quality of life.

- 4.24 Recognising the invaluable support given by carers across the country, we will build on an online participation exercise with carers, and the first national NHS event for carers, to develop an action plan by Spring 2014 which will set out how NHS England will support carers.

**Look to the future of the NHS to deliver continued improved outcomes for people with or at risk of diabetes**

- 4.25 Through the Call to Action,<sup>33</sup> we will consider the commissioning and provision models, incentives, levers, tools and resources needed to deliver a world-class and sustainable service to everyone in England. The Call to Action encourages patients, the public and stakeholders to get involved in shaping the future of the NHS. At present, the NHS is facing significant challenges which will continue unless we change the way that services are delivered. The Call to Action provides an opportunity to promote the need for better prevention and early detection of disease to try and reduce the burden on existing services.



## **The way forward**

- 5.1 NHS England is committed to improve outcomes for people with and at risk of diabetes as part of our wider goal to achieve high quality care for all, now and for future generations.
- 5.2 This document sets out how we are planning to make those improvements, by leading the new commissioning system in our own direct commissioning capacity and by supporting CCGs in theirs.

## **Working in partnership**

- 5.3 We will only achieve our goal, however, by working with other partners like Public Health England, Health Education England, the Department of Health and other government departments, local authorities, the public health and social care sectors, professional bodies, charities and industry.
- 5.4 To support us in this challenge, and to provide expert clinical leadership, Professor Jonathan Valabhji will be key to providing focus, support, advice and challenge to the whole system in his role as National Clinical Director for Diabetes and Obesity.

## Appendix A – The House of Care

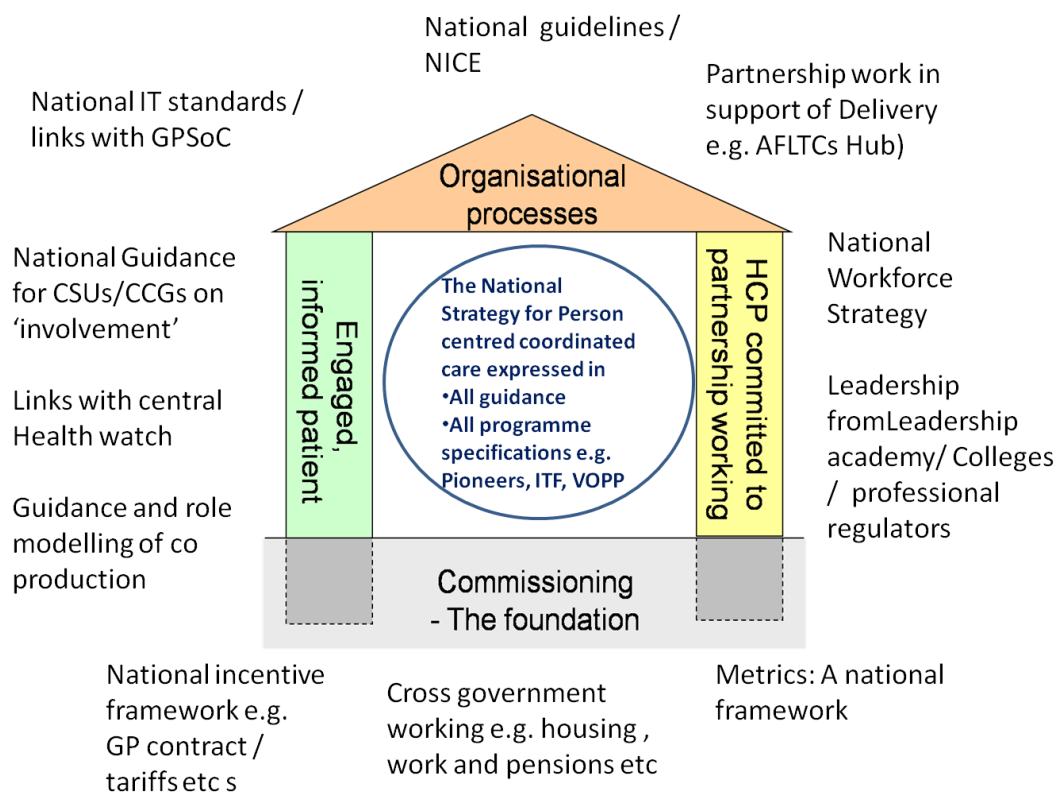
The House of Care supports:

- *Informational continuity*: people, carers and professionals will have the right information needed to provide the right care at the right time (e.g. medical care in hospital and social care at home)
- *Management continuity*: care and support along recommended pathways will be available as and when needed by people, without undue difficulty in transferring between agencies and settings
- *Relational continuity*: people will know where and to whom to turn for assistance in managing their conditions

Below we set out what the House of Care looks like at three levels: the national, the local and the personal.

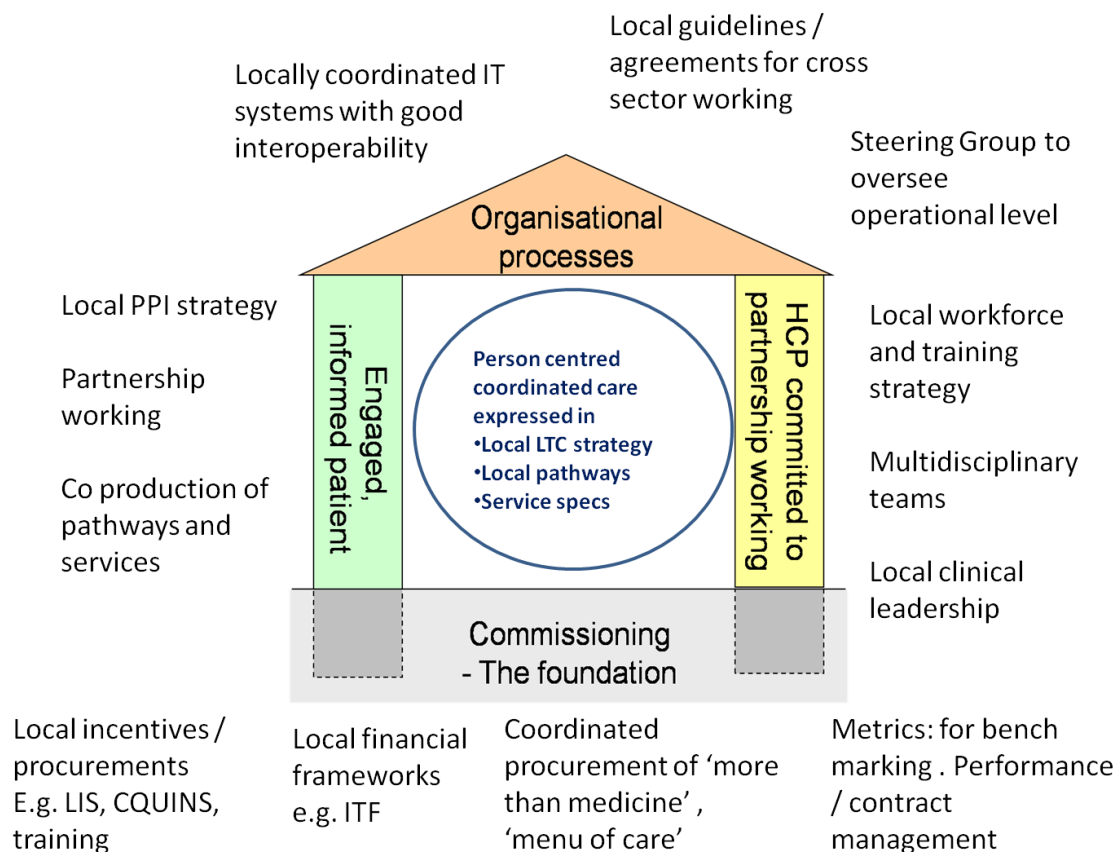
### National:

What can national organisations and policy makers can do to enable construction of the House of Care at the next two levels.



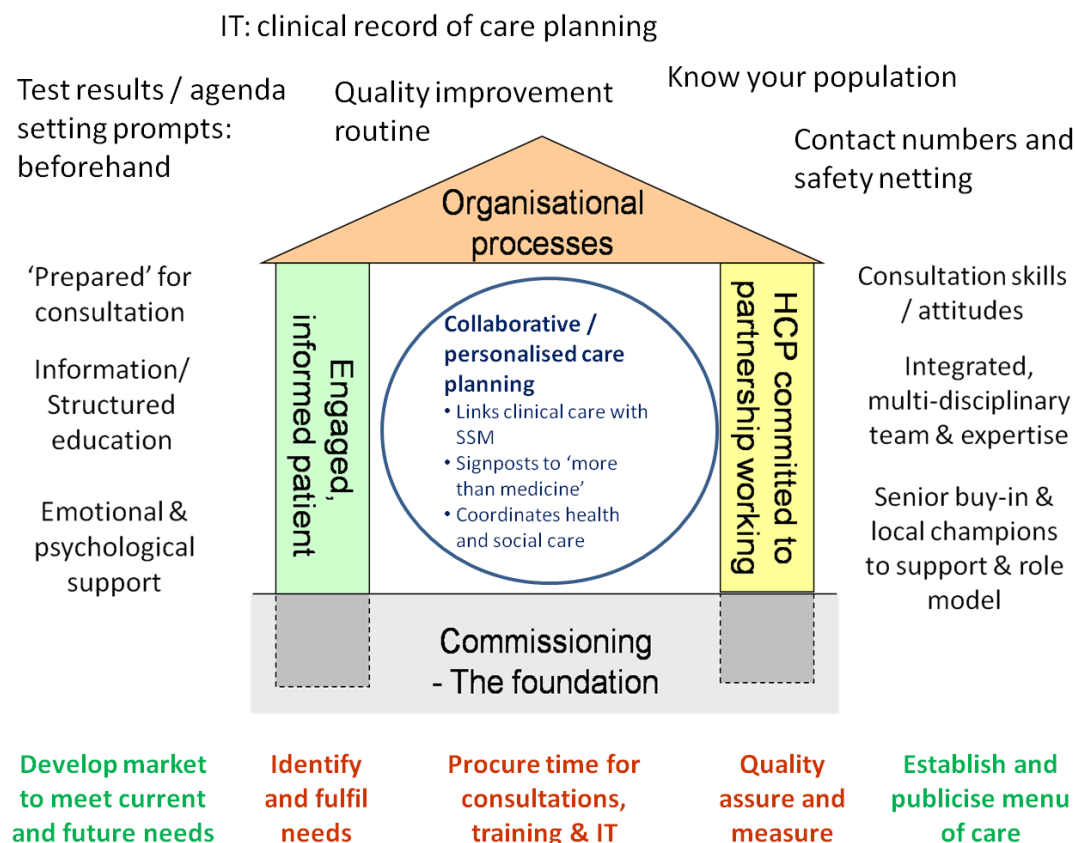
## Local:

How local health economies ensure that the House of Care involves a whole system approach, including 'more than medicine' offers.



## Personal:

How the House of Care gives professionals on the front line a framework for what they need to do for patients and ask local commissioners to secure for them.



## Appendix B – What does NICE say about high-quality diabetes care?

### Quality Standards

- [NICE Quality Standard for Diabetes \(2011\)](#)

### Clinical guidelines

- [CG10 Type 2 diabetes – footcare \(2004\)](#)
- [CG15 Type 1 diabetes in children, young people and adults: NICE guideline \(2005\)](#)
- [CG62 Antenatal Care \(2008\)](#)
- [CG63 Diabetes in pregnancy \(2008\)](#)
- [CG87 Type 2 diabetes: full guidance \(partial update of CG66\) \(2009\)](#)
- [CG91 Depression with a chronic physical health problem: quick reference guide \(2009\)](#)
- [CG119 Diabetic foot problems - inpatient management: quick reference guide \(2012\)](#)

### Technology appraisals

- [TA53 Diabetes \(types 1 and 2\) - long acting insulin analogues \(2002\)](#)
- [TA60 Guidance on the use of patient-education models for diabetes \(2003\)](#)
- [TA151 Diabetes- Insulin pump therapy \(2008\)](#)
- [TA203 – liraglutide \(2010\)](#)
- [TA248 – exenatide \(prolonged release\) \(2012\)](#)
- [TA274 Macular oedema \(diabetic\) - ranibizumab: guidance \(2013\)](#)
- [TA288 – Dapagliflozin combination therapy \(2013\)](#)

### Public Health guidelines

- [PH35 – Preventing Type 2 Diabetes – population and community interventions \(2011\)](#)
- [PH38 – Preventing Type 2 Diabetes – risk identification and interventions for individuals at high risk NICE \(2012\)](#)

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