HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

NHS RightCare Pathway: Diabetes

NHS RightCare

The National Opportunity	5 million with non-diabetic hyperglycaemia Most receive no intervention	940, 000 undiagnosed Type 2 diabetes	>50% of diagnosed receive no structured education within 12 months of diagnosis	60% of Type 1 and 40% of Type 2 are not completing care processes	Few areas have high quality Type 1 services embedded	30% of hospitals don't have multi-disciplinary foot teams	National variation in spend and safety issues on non-elective admissions
Service component	**Risk Detection**	**Diagnosis and Initial Assessment**	**Structured Education Programmes**	**Annual Personalised Care Planning**	**Type 1 Specialist Service**	**Service Referral and key relationships**	**Identification/ Management of admissions by Inpatient diabetes team**
Interventions	Cross Cutting: 1. Shared responsibility and accountability 2. Participation in NATIONAL DIABETES AUDIT 3. Consistent support for patient activation, individual behaviour change, self-management, shared decision making 4. Integrated multi-disciplinary teams						
	Local referral pathways and provision of lifestyle change programmes	Protocol for diagnostic uncertainty	Education programmes (including personalised advice on nutrition and physical activity)	9 recommended care processes and treatment targets	Type 1 Intensive specialist service	1. Triage to specialist services 2. RCA for major amputations	Inpatient diabetes team, shared records, advice line
Target outcomes	Decreased incidence of Type 2 diabetes	Improved detection	Better diabetes management and reduced complications	Reduced variation in completion of care processes	Reduced risk of Microvascular complications	Year on year reduction on major amputations	Reduction in errors in hospitals, reducing LOS
The evidence	Intensive behaviour change can on average, reduce incidence of Type 2 diabetes by an average of 26%	Diabetes prevalence model for local authorities and CCGs	Improved health outcomes and reduction in the onset of diabetic complications in both Type 1 and Type 2 diabetes	Control of BP, HbA1c and cholesterol reduces risk of macro and micro vascular complications	Type 1 services deliver year on year improvements in blood glucose control	MDFT and supporting pathway reduces risk of complications	Young Type 1 and older Type 2 diabetes patients have higher rates of non-elective admissions

Risk Detection (T2DM)

NICE quality statement	**Quality Statement 1.** Adults at high risk of type 2 diabetes are offered a referral to an intensive lifestyle-change programme
Key Criteria	If test result is within the non-diabetic hyperglycaemic range then a referral can be made into the NHS Diabetes Prevention Programme (NHS DPP) where available) or other local lifestyle change programme* Non-diabetic hyperglycaemia (NDH) is defined as having an: - HbA1c 42 – 47 mmol/mol (6.0 – 6.4%) or - Fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/mol Only one test is required. *Only individuals aged 18 years or over will be eligible for the intervention
Making change on the ground	• NHS Diabetes Prevention Programme • Examples of NHS DPP referral pathways • Case studies
Useful links	• Prevalence estimates of non-diabetic hyperglycaemia by local authority and CCG • Diabetes prevalence model for local authorities and CCGs

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Risk Detection (T1DM and T2DM)

What it means for commissioners	• All Commissioners (CCGs) should be aware of the prevalence of diabetes and local participation rates in the National Diabetes Audit (NDA) • Identify where there is low CCG participation in the NDA , reasons and agree actions. Most recently published (2015/16) data shows low levels of NDA participation in some CCG areas. • CCGs, with their STPs should consider diabetes prevalence across their STP area and where some aspects of service should be strategically developed across the STP. The 'STP Diabetes How To Guide' sets out further details. • Commissioners work with their local practices to develop a local process to establish the number of people with T1DM and T2DM • Commissioners should consider ensuring that upon diagnosis, patients are assigned to a care team for their ongoing care needs across a STP area (whether practice or community based). • Commissioners could consider identifying a core team (i.e. Commission Specialist Lead, a Strategic Clinical Lead and System Leader) with dedicated time to redesign services and achieving better clinical and patient reported outcomes • **For Type 1 diabetes**, Commissioners should ensure: - Everyone with T1DM should have access to specialist services throughout their life time, when they feel appropriate and at least annually. - Local arrangements for a structured programme for initiating insulin immediately on diagnosis and managing insulin or insulin pump therapy including training and support for the healthcare professionals and the patients (QS 6, 2011) This will include having access to the CGM NICE Guidelines.
Useful links	• Diagnostic criteria for diabetes: Diabetes UK • Type 1 diabetes in adults: diagnosis and management • Prevalence estimates of diabetes in local authorities and CCGs
NICE Quality Standard	NICE QS 125 -Diabetes in children and young people

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Diagnosis and initial assessment

Key criteria	• Type 1 –diagnosis usually takes place in Hospital settings (secondary care), although not limited to this **CCGs must ensure appropriate referral pathways are in place for where suspected Type 1 is identified in primary care.** ❑ **Diagnostic criteria for Type 1 diabetes** • Diagnose Type 1 diabetes on clinical grounds in adults presenting with hyperglycaemia (random plasma glucose more than 11 mmol/L), bearing in mind that adults with type 1 diabetes typically (but not always) have one or more of the following: - Ketosis - Rapid weight loss - Age of onset < 50 years. / BMI <25 kg/m2. - Personal and/or family history of autoimmune disease • Type 1 diabetes in children and young people (0-18 years) is usually diagnosed by Secondary Care paediatrics services • Type 2 – Diagnosis usually takes place in Primary Care settings (GP practice) although not limited to this NG 18 -Diabetes (Type 1 and Type 2) in children and young people: diagnosis and management ❑ **Diagnostic criteria for Type 2 diabetes** - HbA1c ≥ 48 mmol/mol - A fasting glucose concentration ≥ 7.0 mmol/l - A 2-hour post 75gram glucose load (oral glucose tolerance test) glucose concentration ≥ 11.1 mmol/l In the presence of osmotic symptoms (such as polyurea, polydipsia and/or blurred vision), only 1 blood test within range is required. In the absence of osmotic symptoms a second blood test (the same test) within the range is required. **If test result is within the non-diabetic hyperglycaemic range then a referral into the NHS DPP (where on is available) or local lifestyle change programme.** Non-diabetic hyperglycaemia (NDH) is defined as having an: HbA1c 42 – 47 mmol/mol (6.0 – 6.4%) or Fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/mol

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Diagnosis and initial assessment (continued)

Key criteria	**NHS Diabetes Prevention Programme** ❑ **Diagnostic uncertainty and other high risk areas** • Consider Specialist opinion if: - Age > 50 years but BMI <25 OR family history of immune disease - Age >25 but rapid progression to insulin - Age < 25 and BMI > 25 with Type 2 diabetes - Suspected monogenic / atypical / pancreatic diabetes Mody Probability Calculator Diabetes apps Following diagnosis, the patient is called in for initial assessment (informal meeting) where: • Patient given definitive diagnosis and condition explained • Patient undergoes further assessment including: - Referral for retinal screening - Psychological assessment by a member of the MDT - The offer of an education programme - Physical activity and dietary advice - Foot inspection and ulceration risk calculation - Insulin-treated Service Users – discussion about the self-management of their insulin - Recording of the NICE and NSF 9 care processes • Patient referred for structured education. Also assurance that further education and support will be provided. • Patient invited back to care planning meeting to explain the blood tests and treatment.

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Diagnosis and Initial assessment (continued)

NICE and NSF recommended care processes	The nine recommended care processes are important markers of improved long-term care of patients with diabetes. The care processes are: **1. Blood glucose level measurement (HbA1c)** Optimum level between 6.5% and 7.5% **2. Blood pressure measurement** <140/80 mmHg with no kidney, eye or cerebrovascular damage; <130/80 mmHg with evidence of kidney, eye or CV damage **3. Cholesterol** Total cholesterol should be **5.0** millimoles per litre (mmol/L) or lower **4. Kidney function testing (Urinary albumin)** <2.5 mg/mmol for men; <3.5 mg/mmol for women **5. Kidney function testing (Serum creatinine)** >150 micromol/L - discontinue metformin **6. Weight check** Aim for a healthy weight between a BMI of 18.5 and 24.9 kg/m_2 **7. Smoking status** Check smoking status at annual review **8. Eye examinations** Screening at least annually **9. Foot examinations** Screening at least annually *Care processes 1-3 are part of the CCG Improvement Assessment Framework (CCG IAF) treatment targets for diabetes. Ensuring the effective management and monitoring of care processes can potentially reduce the risk of future complications.

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Diagnosis and Initial assessment (continued)

What it means for commissioners	**Commissioners should ensure:** • All people newly diagnosed with diabetes are offered an initial assessment and personalised care planning appointment with a member of their care team (MDT), preferably within *4-6 weeks , taking into account where urgent referral is required i.e. for patients with very high HbA1c/other severe symptoms at diagnosis. *Note: suggested timescales only (not set out in NICE Quality Standard) • Achievement of 3 NICE recommended treatment targets – i.e. Blood glucose, Blood pressure and Cholesterol • The representative MDT member undertaking initial assessment and care planning is appropriately trained and experienced • Commissioners can find data to enable them to monitor performance of the care processes at practice level in NDA or QOF data . Cardiovascular disease profiles are also helpful where you can compare care process and treatment target achievement with England, your STP and similar CCGs (with respect to age, deprivation and ethnicity) - NDA - QOF - Cardiovascular disease profiles • Commissioners should ensure that for all those with diabetes, the service is designed to provide care coordination around their other health needs, recognising that their diabetes should be managed by the appropriate healthcare professionals.
Useful links	Managing your diabetes Primis Diabetes Care Quality Improvement Tool – helps practices audit clinical data, optimise management & care of patients & reduce the risk of patients developing complications.

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Structured education programmes

NICE quality statements	**QS2 - Adults with type 2 diabetes are offered a structured education programme at diagnosis** **QS3 - Adults with type 1 diabetes are offered a structured education programme 6–12 months after diagnosis** List of quality statements
Key criteria	The importance of structured education needs to be emphasised at diagnosis. **Structured education for those with Type 1 diabetes (e.g. DAFNE)** • Provide evidence based structured education for Service Users with Type 1 diabetes in line with NICE TA60 • All Service Users are offered a structured education programme 6-12 months after diagnosis • For people with T1 diabetes to ensure Carbohydrate (CHO) Counting training is an integral part of structured education **Structured education for those with Type 2 diabetes (e.g. DESMOND and XPERT)** • Provide evidence based structured education for Service Users with Type 2 diabetes, for Service Users whose GP practice does not provide this in-house, in line with NICE TA60 • Courses include all Service Users within 12 months of diagnosis of Type 2 diabetes. All Service Users with pre-existing Type 2 diabetes who have not previously partaken in structured education *** People with diabetes should receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.** **** Patients who decline structured education should continue to be offered it.**

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Structured education programmes (continued)

What it means for commissioners	• Increase the uptake of structured education for service users with diabetes that reflects NICE guidelines and so support successful self-management of their condition. Increasing take up may require local systems to ensure: - that good quality courses are being delivered - that referrers are confident in the quality and nature of local courses and are able to provide convincing consultations to patients to encourage attendance - that courses are available in the right places at the right time - marketing materials are appropriate for the local population - that referrals are followed up to ensure people understand and are happy with the course they have signed up to • Ensure appropriate reporting mechanisms are in place, including standardised coding suitable for ready recording onto GP information systems. Also consider other levers (for example, linking payment to completion of attendance) • Assess capacity and increase where necessary • Provide practice based education in addition to signposting to or provision of formal structured education programmes • For people whose GP practice does not provide this in-house, it is still the GP responsibility to refer patient a local accredited structured education programme • Take NICE TA60 – Guidance on the use of patient-education models for diabetes (Types 1 and 2) into account when commissioning structured education • Commissioners to ensure that all people with Type 1 diabetes are offered Structured Education e.g. DAFNE and ongoing education when they require this. • Commissioners to ensure that all people with Type 2 diabetes are offered Structured Education e.g. XPERT and ongoing education when they require this.
Making change on the ground	Whilst performance at CCG level remains low nationwide, some areas have shown promising improvements, e.g. Bexley CCG, which educated nearly 10% of people with diabetes in just one year.

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Care Planning and Annual Review (for both T1 andT2)

NICE quality statements	**Quality Statement 3 (2011) – People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan** List of quality statements
Key criteria	**Care planning** is a process that puts people with diabetes firmly in the driving seat of their care. It offers people active involvement in deciding, agreeing and owning how their diabetes is managed. In the care planning review, the following should happen: • The patient is invited back to see the healthcare professional to jointly agree goals and actions for the care plan • The care planning review should repeat the annual review requirements i.e. the 9 recommended care processes and the results should form the basis of the care plan • Care planning should be undertaken by an appropriately trained healthcare professional - training that incorporates the necessary skills and knowledge on what a good care plan looks like *** The collaborative process is what makes the care plan impactful**
What it means for commissioners	Commissioners should ensure the following: • First care plan assessment should take place as soon as possible after diagnosis * *Commissioners should offer support to primary care colleagues by having the processes and training in place to deliver collaborative care planning. • The frequency of care planning should be based on individual need. This will vary with the duration of the condition i.e. in the first year of diagnosis people with diabetes may require more frequent contact with their MDT than they will later on in their condition • There should be an annual care plan review every 12 months for everyone with diabetes • This should be an on-going process for the life time of the condition • Patients should have a direct line of contact to a member of that team

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Care Planning and Annual Review (for both T1 andT2)

Making change on the ground	**Care Planning: Evidence in practice** • Diabetes UK have collected together relevant resources on their website. Commissioners can use these resources and tools to implement and improve care planning for people with diabetes. • The Year of Care (YOC) Programme has demonstrated how to deliver personalised care in routine practice for people with Long Term Conditions (LTCs), using diabetes as an exemplar • Cochrane Review on collaborative care planning found a small positive effect on HbA1c
Useful links	• Personalised care and support planning handbook for commissioners and Practical delivery guidance • Think Local Act Personal Personalised Care & Support Planning Tool

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Type 1 – Specialist Service

Key requirements	Minimum requirements for a Type 1 service: • Consultant delivered, specialist multidisciplinary support for the person with Type 1 diabetes. All staff working with people with Type 1 diabetes should be trained in DAFNE or NICE compliant alternative • Each person with Type 1 diabetes should have a named Type 1 diabetes consultant and diabetes specialist nurse. They should be offered a review with the team at least annually. • The service should have: - Sufficient capacity to enable same day review and frequent follow up of the person newly diagnosed with Type 1 diabetes - An accredited diabetes structured education programme with adequate capacity - Staff members trained in and able to deliver insulin pump therapy and CGM as per NICE guidelines - Dedicated transition service for young people with Type 1 diabetes (age 16-25 years) who are transferring from paediatrics care into adult services - Access to a diabetes trained clinical psychologist - Have an annual care plan (which includes the 9 care processes) that is shared with the person with diabetes
NICE guidance	• NICE Guidance NG17- Covers the care and treatment of adults (aged 18 and over) with type 1 diabetes • NICE Guidance CG18 - Covers the care and treatment of children and young people with type 1 diabetes • QS 125 – Diabetes in children and young people • NICE Guidance CG 43 - Covers young people transitioning between children's and adult services in health and social care • NICE QS 140 – Transition from children to adult services

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Type 1 – Specialist Service (continued)

Useful links	• National Diabetes Audit • National Paediatric Diabetes Audit (NPDA) • The Health Innovation Network Type 1 Consultation Tool • ABCD Type 1 standards of care • London: Type 1 diabetes commissioning pack

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Service referral and key relationships

Key knowledge	Care delivery is based on a multidisciplinary approach whether the care setting is the GP practice, a community multi-disciplinary team or a hospital. Take a look at the table of service elements and where they are typically provided. GP practice An individual's practice MDT will include their GP, practice nurse, and in many cases a community nurse and/or community podiatrist. Some may also include a sessional increased-access-to-psychological-therapies (IAPT) therapist. Community MDTs • Some areas have developed a community based MDT to act as the link between generalist clinicians and hospital-based specialists. Under this model hospital-based specialists, spend a proportion of their time in the community advising and facilitating the work of the community based MDT. The presence of specialists in the MDT facilitates fast-tracking of complications once diagnosed up to appropriate specialist settings and allows the team to provide more routine aspects of specialist care closer to the patient's home. • A community MDT might include a Physician (Consultant Diabetologist, but may additionally include GP with Special Interest, Diabetes Specialist Nurse, Diabetes Specialist Dietician, Diabetes Specialist • Examples of services that can be delivered by the community based MDT include: - Patient education programmes (QS1, 2011) - Pregnancy advice for women of childbearing age (QS7, 2011) - Foot protection team (QS10, 2011)) - Clinical psychology support - Additional support for those with Type 2 diabetes and poor glycaemic control • All people with Type 1 diabetes should have access to specialist services if they so choose, given the relative rarity of Type 1 diabetes and the associated specific care needs. People with other forms of diabetes, such as monogenic diabetes (e.g. maturity-onset diabetes of the young (MODY), mitochondrial diabetes), diabetes due to chronic pancreatitis or total pancreatectomy, should also have access to specialist services given their specific care needs.

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Service referral and key relationships (continued)

Key knowledge	Specialist MDTs • Specialist care services should be multidisciplinary, with membership of the MDT varying according to the specialty service. • Specialist services may include: - Transition service working with paediatric services - Diabetes foot service - Diabetes antenatal service - Type 1 diabetes service, including insulin pump service - Diabetes inpatient service - Diabetes mental health service - Specialist learning disability service - Diabetes kidney disease service - Diagnostic service where there is doubt as to type of diabetes - There may be additional services provided by the specialist provider, depending on local requirement • There will also be additional services that contribute to comprehensive diabetes care, that are dealt with through broader population based contracted services, such as ophthalmology/medical retinal services and retinal screening services. Where this is the case, it is however important that such services are still integrated within the diabetes care pathways – for example, that the recognition of significant diabetic retinopathy is associated with greater input and efforts to improve glycaemic and blood pressure control by diabetes care pathway generalists and/or specialists as appropriate. • Better working between primary and secondary care is essential to support GPs in managing their patients.
Useful links	Participation in the National Diabetes Footcare Audit enables all diabetes footcare services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. Diabetes Footcare profiles

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Service referral and key relationships (continued)

What it means for commissioners	Commissioners should: • Develop integrated commissioning models, which would allow for joint commissioning of the full pathway • Regardless of the commissioning environment, it is expected that all elements of care should be available everywhere for people with diabetes and that commissioners will work with patients, carers and providers to identify measurable outcomes for which service providers of diabetes care will be held jointly accountable. • A goal should be shared responsibility and accountability by all providers for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation, blindness, myocardial infarction and stroke for all those with diabetes in the population served. To achieve this, it will be helpful if patient records are integrated and wherever possible shared with and owned by the person with diabetes - and the two elements have good communication mechanisms to allow for continuity of care.
Making change on the ground	Appendix 1 - Better integration between primary and secondary care: Examples of good practice

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TABLE 1: Core service components: Specialist and Community MDT

Key: BLUE = Hospital
PURPLE = Community

	Service components	Service function: Key components to be commissioned to support an optimal diabetes service	Most common care setting
1.	Diagnostic service where there is doubt as to type of diabetes *(For T1 and T2)*	Provision of a diagnostic service where there is doubt as to the type of diabetes – if there is difficulty differentiating Type 1 from Type 2 diabetes, or if a rarer form of diabetes, such as MODY or mitochondrial diabetes, is suspected.	Community
2.	Diabetes inpatient specialist service *(For T1 and T2)*	Provide a review and consultation service for inpatient service users . The ThinkGlucose tool can be used for assessing who needs specialist input. For C&YP this would be via the paediatrics service. Contribute to enhanced independence for those inpatient Service Users with diabetes, in acute trusts and mental health inpatient settings. Support and help manage the diabetes of all inpatient Service users with diabetes in line with NICE Quality Standard (QS) 12	Hospital / Specialist delivered
3.	Paediatric diabetes service *(Predominantly focus on people with T1DM)*	Provide dedicated transition services for young people moving between paediatric and adult service settings (please see NICE CG15 and NICE CG87).	Hospital / Specialist delivered
4.	Transition service *(Predominantly focus on people with T1)*	Provide specialist transition services between paediatric and adult services for those of appropriate ages (suggest up to 25 years) (Please see NICE CG15 and NICE CG87).	Hospital / Specialist delivered
5.	Type 2 diabetes in younger adults (<40 years)	Heightened risk of morbidity and mortality; require intensive support to achieve optimal glucose control and cardiovascular risk reduction.	Hospital/ Specialist delivered
6.	Multidisciplinary foot team *(For T1 and T2)*	Provision of diabetes foot service for Service Users with diabetes in line with NICE NG19 (NG19 updates and replaces NICE guidelines CG10 and CG119, and the recommendations on foot care in NICE guideline CG15).	Hospital (Specialist delivered)
7.	Foot protection team (For T1 and T2)	Access to a Foot Protection Team as outlined in NICE Clinical Guidance (NG19)	Community
8.	T1DM service, including insulin pump service	Provide the full ongoing care and support required for service users	Hospital / Specialist delivered

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Core service components: Specialist and Community MDT (Continued)

	Service components	Service function: Key components to be commissioned to support an optimal diabetes service	Most common care setting
9.	Diabetes mental health service including clinical *(For T1 and T2)*	Provide psychological assessment and appropriate treatment for service users with diabetes and identified mental health issues, such as anxiety or depression. For newly diagnosed patients this means having protocols in place with IAPT services for referral. For those with severe mental illness, commissioners should set a requirement of local diabetes services to support MH services by training them in the key monitoring and care needs of patients with diabetes	Hospital and/ or Community
10.	Specialist learning disabilities service *(For T1 and T2)*	Provision of reasonable adjustments to support optimal diabetes care	Community
11.	Diabetes kidney disease service *(For T1 and T2)*	Provision of diabetes kidney service, prior to renal replacement therapy Provide specialist acute care for service users with diabetes who have kidney disease in line with NICE CG 10 and NICE CG 15. Provide kidney care for service users with progressive decline of renal function that is due to diabetes (and ensure that such decline is due to diabetes), and prior to renal replacement therapy	Hospital (Secondary care) and / or Community
12.	Maternity services *(For T1 and T2)*	Provide pregnancy advice for women of childbearing age (in line with NICE QS7, 2011 and NICE CG63), if not provided in the GP practice	GP or Community
13.	Diabetes antenatal service *(For T1 and T2)*	Provision of diabetes antenatal service including specialist antenatal diabetes care	Hospital (Specialist delivered)
14.	Additional support for those with Type 2 diabetes and poor glycaemic control	To ensure that service users with T2DM and poor glycaemic control will receive management consistent with NICE CG87 and NICE TA53, NICE TA203, NICE TA248, NICE TA288, NICE TA315.	Community

Secondary (Hospital based) services and the Community based MDTs will have responsibility for the episodes of care provided in those settings. **Please note** the role of secondary and community MDTs are only suggestions, and are subject to local determination.

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Identification and management of complications

Key criteria	Microvascular complications are the major risk in type 1 diabetes, while macrovascular complications are the major cause of morbidity and mortality in type 2 diabetes. Control of hyperglycaemia and hypertension may prevent microvascular complications in both types of diabetes; a multifactorial approach, including behaviour modification and pharmacological therapy for all risk factors, may reduce the development of micro and macrovascular complications in type 2 diabetes.
NICE guidance	• **Diagnosis and management of type 1 diabetes in children, young people and adults** • **Type 2 diabetes: The management of type 2 diabetes**
What this means for commissioners	Diabetic complications are common, costly and have a major impact on length and quality of life. There is good evidence that they can be delayed or even prevented in type 1 and type 2 diabetes by achievement of normoglycaemia, achievement of 3 treatment targets, control of other risk factors, regular review and early treatment. Commissioners should ensure: • Regular reviews and assessment of individuals with diabetes. The frequency will vary with the duration of the condition and individual needs • The 9 recommended care processes should be undertaken as part of regular reviews and assessments as they are important markers of improved long-term care and management of patients with diabetes • % achieving 3 treatment targets
Useful links	• Cardiovascular disease profiles allow you to compare complication rates in your CCG with England, your STP and similar CCGs (with respect to age, deprivation and ethnicity) • Diabetes Footcare profiles

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Better integration between primary and secondary care

Better working between primary and secondary care is essential to support GPs in managing their patients.

The benefits of a well integrated diabetes service have been highlighted in Appendix 1 and include:

- Improved patient experience,
- Reduced hospital admissions for vulnerable patients
- Reduced risk of non-elective hospitalisations
- Ensuring that all healthcare organisations involved in providing diabetes care, through partnership, clearly own the responsibility for delivering excellent care to their local population
- Providing clearly defined terms of accountability and responsibility for each health care professional and provider
- Reducing duplication of time, tests and information
- Improved intermediate and long term health outcomes for people with diabetes

Link to: **Appendix 1** for a resource outlining models of integrated care, which offer GPs alternatives to straight forward referral to secondary care and useful links for further information.

What does this mean for commissioners?

Commissioners should:

- Develop integrated commissioning models, which would allow for joint commissioning of the full pathway
- Regardless of the commissioning environment, it is expected that all elements of care should be available everywhere for people with diabetes and that commissioners will work with patients, carers and providers to identify measurable outcomes for which service providers of diabetes care will be held jointly accountable.
- A goal should be shared responsibility and accountability by all providers for the incidence of onset of complications and incidence of hard clinical endpoints such as amputation, blindness, myocardial infarction and stroke for all those with diabetes in the population served.

To achieve this it will be helpful if patient records are integrated and wherever possible shared with and owned by the person with diabetes - and the two elements have good communication mechanisms to allow for continuity of care. Integration can be further supported by formal arrangements for specialists to support GPs through:

- Email advice e.g. a specified 1 working day turn-around for email advice
- Telephone contact support e.g. a dedicated daily time window for taking calls for advice
- Virtual clinics with a consultant reviewing case notes where the GP/practice needs support in management.
- For older people, many of whom will have complications of diabetes and hence will have multiple comorbidities and may also suffer frailty, there will need to be co-ordination of health and social care

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In summary:

- The onset of Type 2 diabetes can be prevented and/or delayed by finding and intervening early with individuals at high risk

- All people with diabetes should be assigned a multidisciplinary team. Teams should be assigned to people with both Type 1 and Type 2

- Structured Care planning should occur immediately after diagnosis to determine the needs and priorities of the patient. This needs to address the individual patient's needs and co-morbidities

- All people with diabetes should have access to ongoing care, education and support planning to agree goals and priorities to access:
  - a comprehensive education programme (Type 1 and Type 2)
  - a carbohydrate counting educational programme (Type 1 and Type2)
  - an insulin pump service (Type 1)
  - continuous glucose monitoring for those who would benefit-as per NICE guidance (Type 1)
  - psychological support (Type 1 and Type 2)
  - access to appropriate technology to help individuals manage their diabetes(Type 1 and Type 2)
  - referrals directly into specialist care services or community based services where clinically indicated

- As a minimum an annual care planning review should happen for everyone with diabetes, more frequent reviews and monitoring will be required on the basis of individual needs, priorities and test results

- For further guidance to commissioners , please refer to the diabetes service specification (July, 2014)

For further guidance on Type 1 diabetes service refer to the following:

- ABCD position statement: Type 1 standards of care
- London: Type 1 diabetes commissioning pack

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