

# The NHS Diabetes Commissioning Guide: Making change happen

Brian Karet

## Article points

1. The *Diabetes Commissioning Toolkit* was launched to support the cost-effective commissioning of high-quality, locality-focused diabetes care with a particular emphasis on engaging the individual.
2. In the environment of many new policy documents and the increasing sophistication of commissioning skills, a new guide needed to be developed.
3. The *NHS Diabetes Commissioning Guide* should make high-quality service delivery more widely available, so that people with diabetes can get the best, most appropriate care, no matter who they are or where they live.

## Key words

- Commissioning
- Diabetes guide
- Policy

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The *Diabetes Commissioning Toolkit* (Department of Health, 2006) was launched in 2006 to support the cost-effective commissioning of high-quality, locality-focused diabetes care with a particular emphasis on engaging the individual. Since then, policies have evolved, such as *World Class Commissioning*, *Practice-Based Commissioning*, *High Quality Care for All*, and *The NHS Constitution for England*, that seem to have complicated the commissioning process. This article describes the changes to commissioning since the publication of the *Diabetes Commissioning Toolkit*, outlines the scope of the new online commissioning guide from NHS Diabetes, and discusses the benefits of commissioning an integrated diabetes service.

In November 2006, much fanfare greeted the arrival of the first disease-specific commissioning toolkit – the *Diabetes Commissioning Toolkit* (Department of Health, 2006) – which was published through a collaborative effort of the Primary Care Diabetes Society, the Association of British Clinical Diabetologists, Diabetes UK, and the National Diabetes Support Team (now NHS Diabetes) and the Yorkshire and Humber Public Health Observatory. It included, for the first time, a comprehensive health needs assessment tool that guided commissioners through the collection and interpretation of diabetes-related data to a decision-making process.

Many commissioners involved in the procurement of services for people with long-term conditions were in awe of the clarity

by which the process for commissioning diabetes services had been described, as they had never encountered such a tool. The result was that the 2006 toolkit was adapted by commissioners for use in other areas.

## Policy changes

Even as the ink was drying on the 2006 document, however, evolving policies were changing the arena in which commissioning was being delivered, and this was during a period of relative political stability.

## *World Class Commissioning*

The *World Class Commissioning* document from the Department of Health (DH, 2007) is a series of competencies designed to promote positive engagement between commissioners and providers to deliver high-

quality care. PCTs are assessed (with financial implications) on their degree of compliance with each of these competencies.

### *Practice-Based Commissioning*

*Practice-Based Commissioning* (DH, 2004) is now a well-known initiative and is intended to increase the degree of front-line clinical involvement with commissioning.

### *High Quality Care for All*

In 2008, the DH published *High Quality Care for All*, a command paper (i.e a PCT must-do). It introduced such concepts as risk assessment, which in turn led to the vascular checks programme, individuals having the right to choose their GPs, and personal care budgets. It also put a lot of emphasis on engagement with local clinicians, but this seems to have been widely ignored, particularly around the siting and scope of “Darzi” integrated primary care centres. These centres are a series of polyclinics that are planned to house GPs, dentists and community and social care facilities. Some have been blocked by local opposition, as in Camden, and many have failed to hit their patient registration targets, being regarded as “white elephants”.

### *The NHS Constitution for England*

*The NHS Constitution for England* (DH, 2009) is a brief document that sets out the core values of the NHS and a set of rights and responsibilities for patients, carers and healthcare professionals around seven key principles. Importantly, all NHS bodies and private and third sector (voluntary and charitable) providers supplying NHS services will be required by law to take account of this constitution in their decisions and actions, and the constitution embeds the decisions of NICE in law. Responsibility for monitoring the implementation of this (quality of clinical services and user experience) has been taken up by the Care Quality Commission who are able to report on all aspects of care across primary and secondary care.

## *The NHS Diabetes Commissioning Guide*

In the environment of all these policy documents and the increasing sophistication of commissioning skills, a new guide needed to be developed. The new *NHS Diabetes Commissioning Guide* (NHS Diabetes, 2009a) is a web-based tool that will assist commissioners to mould high-quality services to the needs of their population.

Some other things have also changed in the past 4 years that make intelligent commissioning an imperative. The prevalence of diabetes has exceeded even the most pessimistic predictions (Hadley-Brown, 2009) and this is especially true of areas with high ethnic minority populations (Health Survey for England, 2005).

The amount of funding available to the NHS over the next 8 years following the financial crisis of 2009 is likely to be severely restricted with even conservative estimates suggesting between 2% and 3% annual real spending reductions (Appleby et al, 2009).

There are increased expectations by health service users that are often not met and sometimes unachievable (Appleby and Rosete, 2003). Over the past 25 years, health service spending has quadrupled in absolute terms and more than doubled in real terms. Well-publicised increases in medical and nursing staff numbers, and such initiatives as 48-hour access and 18-week waits, combined with a culture of easy access to litigation, have contributed to the situation.

There is a desire for increased involvement of the individual in the management of their chronic condition and greater reliance on self-care. This ethos is the basis for the Year of Care initiative whose pilots are being evaluated (NHS Diabetes, 2009b). Although at first glance this may have increased initial workload implications for primary care teams, there is some evidence to show that if people are more engaged in their care, they consult less frequently over the longer term and have better metabolic control combined with increased satisfaction (Degeling, 2006).

### Page points

1. *High Quality Care for All* (DH, 2008) introduced such concepts as risk assessment, which in turn led to the vascular checks programme, individuals having the right to choose their GPs, and personal care budgets.
2. *The NHS Constitution for England* (DH, 2009) is a brief document that sets out the core values of the NHS and a set of rights and responsibilities for patients, carers and healthcare professionals around seven key principles.
3. The new *NHS Diabetes Commissioning Guide* is a web-based tool that will assist commissioners to mould high-quality services to the needs of their population.

### Page points

1. The 2009 *NHS Diabetes Commissioning Guide* looks to equip people who are commissioning, delivering and receiving diabetes care with the right tools to make it excellent, safe and affordable.
2. It is important to find out what users and providers want and need from the service. It is most effective to hold facilitated, well-advertised meetings for everyone involved in diabetes care, including service users, and generate a prioritised list of service developments.
3. Ensure that support for new models of care comes from the senior management of all organisations involved.
4. Investing in people means supporting and training primary and community care teams to provide defined skills, such as insulin initiation, hypoglycaemia prevention and adherence to care programmes.

### What the guide hopes to achieve

The 2009 *NHS Diabetes Commissioning Guide* looks to equip people who are commissioning, delivering and receiving diabetes care with the right tools to make it excellent, safe and affordable. This does not happen by accident and the right steps need to take place in all areas to ensure success.

### Assessing your service

An accurate picture of what diabetes care looks like in your area is key to developing a service to meet the needs of the population. This is often termed a Health Needs Assessment (HNA) and the new guide contains an electronic HNA tool for every PCT that is pre-populated with locally collected data and population modelling data, collated by the National Diabetes Information Service (NDIS), that should assist commissioners in critically evaluating their current service and identifying areas for prioritisation.

### Find out what people want from the service

It is important to find out what users and providers want and need from the service. It is most effective to hold facilitated, well-advertised meetings for everyone involved in diabetes care, including service users, and generate a prioritised list of service developments.

To facilitate this process from “where are we now?” to “where do we want to be?”, the 10 regional programme managers from NHS Diabetes ([http://www.diabetes.nhs.uk/regional\\_support/](http://www.diabetes.nhs.uk/regional_support/)), in collaboration with local commissioners, will work with clinicians, service users and community partners using a Leading Change programme described in the guide (NHS Diabetes, 2009a). This programme should help local teams answer two other questions: “how do we get there?” and “how will we know when we’ve arrived?”, using a set of key activities and described and measurable outputs.

### Produce supporting evidence

Supporting evidence should be produced based on case studies, either locally or

nationally, and should look at how the prioritised work areas can evolve.

### Involve senior management

Ensure that support for new models of care comes from the senior management of all organisations involved. This invariably happens by ensuring that there is high-level input into the diabetes decision-making body, for example the Diabetes Service Advisory Group or the Diabetes Pathways Group.

### Support self-care and self-management

Make sure that supported self-care and self-management principles are core to all redesigns and that the mechanisms to make this happen are in place from the start. This involves all staff being trained in behavioural change, motivational interviewing and goal setting. It also necessitates the provision and supported uptake of user education courses such as DAFNE (Dose Adjustment for Normal Eating), DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) and X-PERT. Primary care teams need to be incentivised to refer people in, and users need to be encouraged to attend and complete the courses.

### Invest in services, staff and training

Effective measurement of service improvement is crucial to sustaining ongoing involvement and development.

Invest in people to maintain the drive and focus to achieve the desired outcomes. Organisationally, this invariably means procuring the services of a dedicated service delivery manager. Dedicated does not just refer to commitment but to someone whose sole role it is to make the service as effective as possible and who has the backing of everyone involved in local diabetes care. Clinically, it means promoting and supporting clinical champions in primary, secondary and community care. It also means supporting and training primary and community care teams to provide defined skills, such as insulin initiation, hypoglycaemia prevention and adherence to care programmes.

### Diabetes: A long-term condition

To address some of the quality and fiscal imperatives of *World Class Commissioning*, there has to be greater emphasis on a more generic service provision for people with long-term conditions, including diabetes. This is necessary not just because people with diabetes frequently have other comorbidities and complex needs (Struijs et al, 2006), but that effective integration of services reduces both duplication of diagnostic tests and appointments (which is frustrating for patients and clinicians), improves quality and effective use of resources and reduces costs.

The key word here is integration. It is about integration of the management of service delivery to keep the needs and wishes of the person with the long-term condition at the centre of the care model. This involves the establishment of clear joint working arrangements across different organisations focused on a single joint strategy and preferably a single service specification and contract for jointly commissioned services.

It is important that joint commissioning should not be an excuse for a lack of responsibility and that clear lines of responsibility and governance are described for all aspects of care. Wherever possible, services that are not essentially disease-specific should be integrated, for example community and social care, prevention, call and recall for annual reviews. This is something that is much easier to achieve with a single IT system, agreed coding and easily visible markers of progress. Data sharing protocols should be established and consent arrangements clarified, but effective data sharing alone within and across care providers can lead to enormous benefits in terms of reduction of duplication and enhanced clinical and patient engagement (NHS Diabetes, 2009b).

### Core elements of the guide

Providing high-quality diabetes care is multi-faceted and complex and reflects the journeys that people with diabetes and their carers may take during their lives. Whether

this journey comprises a series of short demand-driven episodes or takes a long and convoluted path depends on the person's age, lifestyle, psychological, social and cultural status, expectations and bio-metabolic state (what type of diabetes they have and what sort of complications they develop).

The commissioning guide will take local diabetes groups through the process of re-commissioning some or all of these components of care, including ones often not specifically provided, for example diabetes care for people with learning difficulties, diabetes care for older people and end-of-life care.

### Conclusion

*The NHS Diabetes Commissioning Guide* should help everyone involved in delivering or receiving diabetes care to make the best, most effective diabetes care available to a much wider population. For commissioners this involves putting together service specifications that are deliverable and appropriate – both clinically and financially – that reduce variability and measurably improve quality.

For care providers, including doctors, nurses and dietitians, among others, there is a clear objective of consistent high-quality care delivery, no matter where they work, but there is also an opportunity to innovate, improve choice, reduce cost and improve quality, through an integrated care approach using agreed outcomes.

For people with diabetes, use of this guide should lead to a more informed choice, more meaningful engagement, more local accountability and a better, more consistent patient experience.

There is some fantastic diabetes care going on around the country, often through the endeavours of dedicated groups of individuals who have the vision and skills to make high-quality service delivery for people with diabetes a reality. This guide should help those skills to be much more widely available, so that people with diabetes can get the best, most appropriate care, no matter who they are or where they live. ■

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**“The 2009 NHS Diabetes Commissioning Guide looks to equip people who are commissioning, delivering and receiving diabetes care with the right tools to make it excellent, safe and affordable.”**

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