How commissioning could affect diabetes care for older people

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Last autumn, I highlighted that pathways for the older person with diabetes were being developed by NHS Diabetes in the form of commissioning guides (Da Costa, 2009). These have now been published: *Commissioning Diabetes Prevention and Risk Assessment Services* (NHS Diabetes, 2010a) and *Commissioning Diabetes Services for Older People* (NHS Diabetes, 2010b).

Development

Both guides were developed with key stakeholders, including clinical and social services professionals, and patient groups represented by Diabetes UK, Age Concern and others. The guides are not designed to replace standard NHS contracts, but rather to form the basis of discussion between commissioners and providers – in these specific examples regarding prevention, risk assessments and diabetes services.

Both documents describe key features of good services, high-level intervention maps (both clinical and administrative) or flowcharts; and, unlike care pathways or clinical protocols, they aim to describe how a true "diabetes without walls" service should operate across all healthcare sectors. All key standards of quality and policy relating to these aspects of care are thus brought together within a contracting framework.

The guides

The focus of the prevention and risk assessment services tool (NHS Diabetes, 2010a; *Box 1*) is self-explanatory. Where it could impact on older people with diabetes is:

- Actively seeking out those at risk of diabetes.
- Offering active prevention to people of all ages.
- Reducing the prevalence of type 2 through prevention of obesity.
- Providing effective and safe care to those at risk of developing diabetes in a range of settings.
- Ensuring services are accessible and responsive to people with learning disorders.
- Supporting self-management.
- Providing people with diabetes and carer education, and other lifestyle interventions.
- Providing multidisciplinary care that manages the transition between adult and older people's services.

Clearly, detecting more people with diabetes will increase the known population with the condition, and put further strain on already stretched services. There appears not to be the funding for more clinicians, which means we will need to approach this increased demand differently and more imaginatively, for example in different care settings and with non-professionals. It will require services to review and possibly prioritise their resources, which may enable integration of primary and secondary care as clarity of referral and access will be key.

The features of *Commissioning Diabetes Services for Older People* (NHS Diabetes, 2010b; *Box 2*) build on the prevention and risk assessment services tool, recognising that high-quality diabetes care is provided by services that actively identify and manage people with diabetes who have special needs as a result of extreme frailty, advanced age (>80 years) or residency within a care home. The intervention map encompasses raising awareness (nationally, locally and in targeted groups) and includes prevention, risk assessment and stages for high- or low-risk individuals. Referrals from care homes and other services are included, and the focus on care planning, which is agreed and initiated with user involvement, and includes education for the person with diabetes. It also includes referral to specialist care.

The contracting framework for both of these guides has governance at its heart. Elements such as leadership, characteristics, skills and behaviours, outputs generally and specifically are included. Finally, a standard service specification template for diabetes services for older people is included.

Conclusion

These guides, resourced from the Department of Health, informed by National Service Frameworks, NICE and other national initiatives, provide a framework we can assess our services against, change focus or resources, and hopefully improve care for what can often be a neglected group. Failing to meet a nationally agreed plan provides a more persuasive argument for resources, with certain caveats. Therefore, I would recommend to all readers that these guides are obtained, and their services reviewed against them. ■

Da Costa S (2009) Does one size fit all? The needs of the older person with diabetes. *Journal of Diabetes Nursing* **13**: 306

NHS Diabetes (2010a) *Commissioning Diabetes Prevention and Risk Assessment Services.* NHS Diabetes, Leicester

NHS Diabetes (2010b) *Commissioning Diabetes Services for Older People.* NHS Diabetes, Leicester

Box 2. Features of high-quality diabetes services for older people.

Diabetes services for older people should include:

- Mechanisms for the appropriate screening and detection of diabetes in older people.
- An agreed care plan with clearly specified objectives.
- Appropriate support to optimise blood glucose control.
- Coordination of specialist, community, and primary care services, including palliative care.
- Immediate access to appropriate specialist support, e.g. ophthalmology, cardiovascular and renal services.
- Supported discharge (including multidisciplinary needs assessment).
- Smooth transition to care-home residency, where appropriate.
- Support and guidance for family and carers, including telephone “hot-line” availability.
- Close healthcare professional liaison with care homes in the identification and care of older people with diabetes.
- A template for more detailed information gathering such as those of a diabetes minimum dataset for audit and research purposes.
- Multidisciplinary care that manages the transition between adult and older peoples’ services.

From: NHS Diabetes (2010b)

Box 1. Features of high-quality diabetes prevention and risk assessment services.

- Actively seek out those at risk of diabetes.
- Offer active intervention to people of all ages at risk of developing diabetes.
- Place emphasis on the prevention of type 2 diabetes for all age groups through the prevention and reduction of the prevalence of obesity.
- Be developed in a coordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care and involving users.
- Be commissioned jointly by health and social care based on a joint health-needs assessment that meets the specific needs of the local population, using a holistic approach.
- Provide effective and safe care to people at risk of developing diabetes in a range of settings, including the individual’s home, according to recognised standards.
- Take into account the emotional, psychological and mental wellbeing of the person with diabetes.
- Take into account all diverse and personal needs with respect to access to care.
- Ensure that services are responsive and accessible to people with learning difficulties.
- Have effective clinical networks with clear clinical leadership across the boundaries of care which clearly identify the role and responsibilities of each member of the diabetes team.
- Ensure there are a wide range of options available to people at risk of developing diabetes to support self-management and individual preferences.
- Take into account services provided by social care and the voluntary sector.
- Provide education on diabetes and lifestyle interventions to people with diabetes and their families or carers.
- Provide education on diabetes prevention and risk to other staff and organisations that may come into contact with people at risk of developing diabetes.
- Have a capable and effective workforce that has the appropriate training and updating and where the staff have the skills and competencies in the management of people at risk of developing diabetes.
- Provide multidisciplinary care that manages the transition between adult and older peoples’ diabetes services.
- Have integrated information systems that record individual needs including emotional, social, educational, economic and biomedical information, thus permitting multidisciplinary care across service boundaries.
- Produce information on the outcomes of diabetes prevention and risk assessment, including contributing to national data collections and audits.
- Have adequate governance arrangements, local mortality and morbidity meetings on diabetes care to learn from errors and patient safety.
- Take account of patient experience, including person-reported outcome measures, development and monitoring of service delivery.
- Actively monitor the uptake of services, responding to non-attenders and monitoring complaints and untoward incidents.

From: NHS Diabetes (2010a)