APPENDIX C: NATIONAL FRAMEWORKS AND STANDARDS

1. REDUCING UNWARRANTED VARIATION

Variation in healthcare is often unavoidable because of its complexity and the difficulties in controlling all the variables that contribute to it. Some can be explained by the characteristics of the local population, individual patients or by differences in the capability of healthcare professionals (NHS Confed, 2004).

Often differences occur when there are local innovations benefiting smaller numbers and dissipate when the innovations become more widespread. The important thing for us to understand is whether the variation is unwarranted. The term 'unwarranted clinical variation' has been described as 'care that is not consistent with a patient's preference or related to [their] underlying illness (NHS Confed, 2004).' This can relate to substandard care around access to services and outcomes.

To limit unwarranted variation in diabetes care, we have outlined below a set of minimum standards people should expect from our services. These local and national standards and our priorities and expected outcomes are set out clearly in this framework.

The following standards and frameworks highlighted are:

- NICE Guidance & Quality Standards
- NICE Diabetes in Pregnancy Quality Standard
- NICE Quality Standard for Diabetes in Children and Young People
- Footcare Standards & Pathways
- National Diabetes Prevention Programme (NDPP)
- NHS Rightcare Diabetes Pathway
- Quality Outcome Framework (QOF)

2. NICE GUIDANCE AND QUALITY STANDARDS

NICE guidelines on prevention of Type 2 diabetes (2018) recommend that risk assessment is carried out in adults aged over 40 years (younger adults from certain minority ethnic groups) with conditions that increase their risk of Type 2 diabetes. Those eligible can also be assessed through the NHS Health Check programme. A person is considered high-risk of diabetes if they have fasting blood glucose of 5.5-6.9 mmol/l or HbA1c of 42-47 mmol/mol.

NICE recommends lifestyle-modification programmes for people at high risk. Metformin is recommended only if blood glucose control has deteriorated despite lifestyle change, or if a person is unable to participate in such programmes, particularly if their BMI is above 35kg/m2. Similarly, orlistat may be considered if BMI is above 28. No other drug therapies are recommended.

2.1.1 NICE QUALITY STANDARDS

1. People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.

2. People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

3. People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.

4. People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%) and receive an ongoing review of treatment to minimise hypoglycaemia.

5. People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

6. Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

7. Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.

8. People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

9. People with diabetes are assessed for psychological problems, which are then managed appropriately.

10. People with diabetes 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.

3. NICE DIABETES IN PREGNANCY QUALITY STANDARD (QS109)

1. Women with diabetes planning a pregnancy are prescribed 5 mg/day folic acid from at least 3 months before conception.

2. Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of their pregnancy being confirmed.

3. Pregnant women with pre-existing diabetes have their HbA1c levels measured at their booking appointment.

4. Pregnant women with pre-existing diabetes are referred at their booking appointment for retinal assessment.

5. Women diagnosed with gestational diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of diagnosis.

6. Pregnant women with diabetes are supported to self-monitor their blood glucose levels.

7. Women who have had gestational diabetes have an annual HbA1c test

4. NICE QUALITY STANDARD FOR DIABETES IN CHILDREN AND YOUNG PEOPLE

1. Children and young people presenting in primary care with suspected diabetes are referred to and seen by a multidisciplinary paediatric diabetes team on the same day.

2. Children and young people with Type 1 or Type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

3. Children and young people with Type 1 diabetes are offered intensive insulin therapy and level 3 carbohydrate-counting education at diagnosis.

4. Children and young people with Type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real time continuous glucose monitoring with alarms.

5. Children and young people with Type 1 diabetes are offered blood ketone testing strips and a blood ketone meter.

6. Children and young people with Type 1 or Type 2 diabetes are offered access to mental health professionals with an understanding of diabetes

5. FOOT CARE STANDARDS & PATHWAYS

Effective care requires multidisciplinary team working between professionals in different specialties and, in some cases, in different hospitals or across primary and secondary care. The pathway should have 3 integral components, a foot screening program, a foot protection service (FPS) and a multidisciplinary foot care service (MDFS). The components of each service are described in detail in the new NICE guidance ‘Diabetic foot problems; prevention and management’ (NG19, 2015).

6. NHS DIABETES PREVENTION PROGRAMME

The NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. It is known that many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk.

7. NHS RIGHTCARE DIABETES PATHWAY

The NHS Right Care diabetes pathway shows the core components of an optimal diabetes service, evidence of the opportunity to reduce variation and improve outcomes and the key evidence-based interventions which the system should focus on for greatest improvement, supported by practice examples from across the NHS.

The diabetes pathway defines the core components of an optimal diabetes service for people with or at risk of developing Type 1 and Type 2 diabetes that delivers the better value in terms of outcomes and cost.

The diabetes pathway has been developed in collaboration with the National Clinical Director for Diabetes and Obesity, Jonathan Valabhji, Associate National Clinical Director for Diabetes, Partha Kar, the NHS Diabetes Prevention Programme, Public Health England, Diabetes UK and a range of other stakeholders.

The pathway shows the core components of an optimal diabetes service, evidence of the opportunity to reduce variation and improve outcomes and the key evidence-based interventions which the system should focus on for greatest improvement, supported by practice examples from across the NHS.

8. QUALITY OUTCOME FRAMEWORK (QOF)

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.

An update of the QOF indicator list for 2019/20 features eight new diabetes indicators. NICE stated that the new approach, which comes following a review of the QOF in England, will improve outcomes and decrease the risk of harm from over-treatment.

Updated indicators on Type 2 diabetes include two indicators on blood glucose targets for people with and without frailty, while another sets one blood pressure target for all people without frailty. Meanwhile, three new indicators feature which have been added since the consultation draft, supporting existing NICE recommendations on cardiovascular risk assessments and statin treatment for people with Type 2 diabetes.

8.1.1 THE NEW INDICATORS

- **NM157** – The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58mmol/mol or less in the preceding 12 months.

- **NM158** – The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 12 months.

- **NM159** – The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less.

- **NM142** – The percentage of patients with Type 1 diabetes who are aged over 40 years currently treated with a statin.

- **NM160** – The percentage of patients aged 25-84 years, with a diagnosis of Type 2 diabetes, without moderate or severe frailty, not currently treated with a statin, who have had a consultation for a cardiovascular risk assessment using a risk assessment tool agreed with the NHS Commissioning Board in the last three years.

- **NM161** – The percentage of patients with a diagnosis of Type 2 diabetes and a recorded CVD risk assessment score of ≥10% (without moderate or severe frailty), who are currently treated with a statin (unless there is a contraindication or statin therapy is declined).

- **NM162** – The percentage of patients with diabetes aged 40 years and over, with no history of CVD and without moderate or severe frailty, who are currently treated with a statin (excluding patients with Type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)

- **NM163** – The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin