Royal College of Physicians

Diabetes Care Accreditation Programme (DCAP)

Diabetes Care Accreditation Programme – progress report

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Executive summary

This is the second progress report from the Diabetes Care Accreditation Programme (DCAP), which will be shared as an update for the DCAP steering group and our partner organisations. The pilot assessments have now been completed. Further work on developing the level 1 and 2 standards is now complete. Working groups have also developed guidance templates for organisations that register with the programme. Nine sites have registered with DCAP and training sessions have begun to help those services progress.

We are continuing work with national leads to ensure DCAP is appropriate for each devolved nation in the UK. We continue to engage with other national quality improvement projects and national regulators. We have been working towards more streamlined electronic data capture, although this is at an early stage. We also need to consider whether representation from people living with diabetes is strong enough in the programme and how we might engage and involve them further.

Background

Diabetes inpatient care varies considerably across hospitals, regions and nations, and people with diabetes often express concern about the management of their condition in hospital. The Royal College of Physicians (RCP) Accreditation Unit and Diabetes UK set up the Diabetes Care Accreditation programme (DCAP) to provide assurance that national standards for diabetes care in hospital are being met equally across hospitals in the UK.

The current standards for inpatient diabetes care have primarily been developed by the Joint British Diabetes Societies for Inpatient Care (JBDS), supported by Diabetes UK, the Association of British Clinical Diabetologists (ABCD) and the Diabetes Inpatient Specialist Nurse (DISN) UK group.

DCAP also includes representation from people living with diabetes. The work has been informed by international consensus documents, the National Diabetes Inpatient Audit (NaDIA) and, in England, the Getting it Right First Time (GIRFT) programme. The accreditation standards have evolved and combine recommendations from the Diabetes UK Making Hospitals Safe report, NaDIA, GIRFT and JBDS guidelines. They cover all the aspects of high-quality diabetes inpatient care.

The programme officially launched in May 2023, with the aim of improving inpatient care for people living with diabetes. The pilot programme showed that DCAP helped teams review their services and identify gaps in care provision, further developing collaborative working and increasing their ability to evidence the care they provide.

Diabetes Care Accreditation programme (DCAP)

Developing the programme

The RCP Accreditation Unit was chosen as the partner to deliver this work due to its expertise and experience in delivering many other accreditation programmes. Diabetes UK brings together partners, knowledge, and expertise from within health systems in England, Scotland, Wales and Northern Ireland as well as a proven track record of championing better care for people living with diabetes. Development of DCAP started in 2019 following the Diabetes UK Making Hospitals Safe report and NaDIA demonstrating that diabetes care was not universally standardised and there was no mechanism to assure that services were delivered to a high standard for all people with diabetes in hospitals.

At present, inpatient diabetes care is monitored by regulatory bodies within each of the UK nations and against few specific diabetes standards. In the past, measuring the quality of diabetes inpatient care relied heavily on NaDIA data, which have been included in hospital reports produced by the Care Quality Commission (CQC). It is worth acknowledging that NaDIA audited diabetes inpatient care in England and Wales only and these audits are no longer undertaken.

Aim of the programme

Diabetes is a key part of the long-term plan for each of the UK nations. DCAP aims to improve inpatient care by setting quality standards and measuring how services perform against them. This is done through an external cycle of peer assessment which will drive continuous improvement. Services will be required to work towards achieving level 1 and level 2 standards within a specified timeframe (see below).

DCAP works closely with JBDS, Diabetes UK and ABCD to ensure that standards are up to date and appropriate. We know that improvements in inpatient care can lead to a reduction in harm, reduced length of stay and better patient experience. Over time the programme will begin to collect a large database comparing the quality of diabetes care across hospitals. Consideration will need to be given to how this data can be used to further improve care and how the data should be stored to allow easy access and analysis.

Further aims include:

1. To make measuring the quality of inpatient diabetes care a routine part of daily work in hospitals across the UK
2. To help hospitals understand how they are performing against national standards and against their own internal standards
3. To provide a uniformly high level of diabetes care and reduce inequity of care across hospitals in the UK
4. To work with national regulatory bodies to include measures of diabetes care in overall hospital reports
5. To provide a standardised structure that will support inpatient diabetes teams to continuously evaluate and improve their service.

The DCAP accreditation pathway

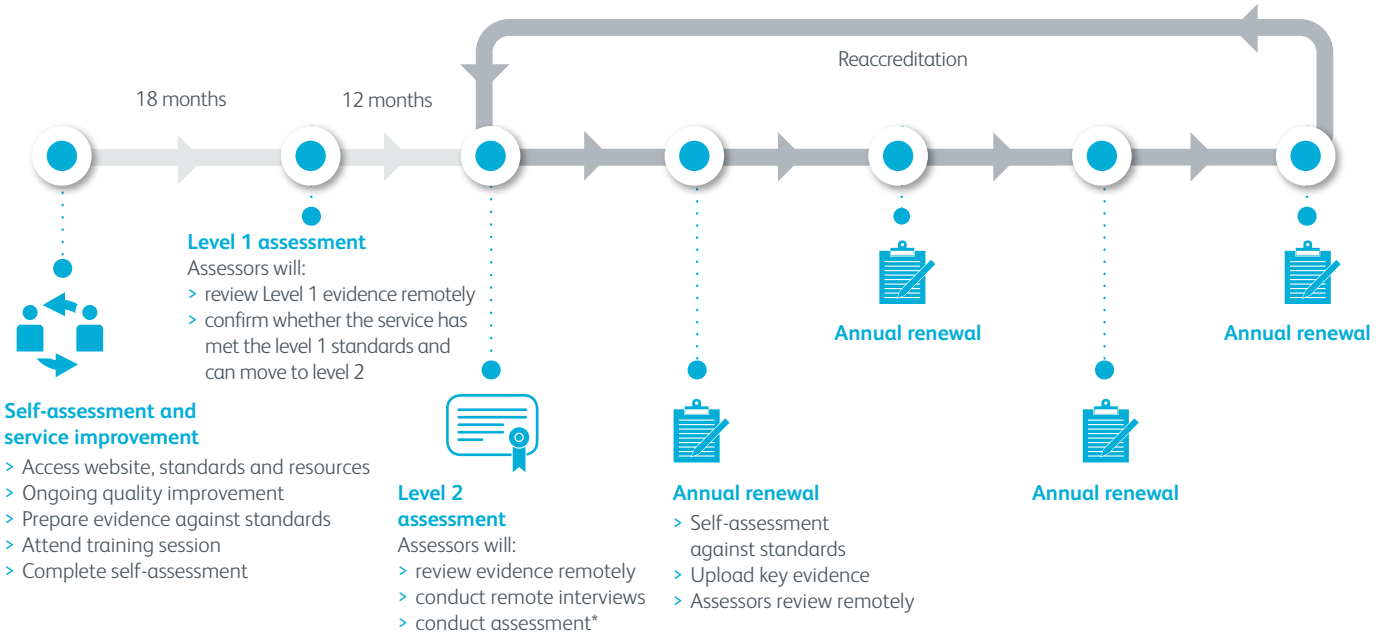
The first 12–18 months of the accreditation pathway are about quality improvement where services do most of the hard work. A service will benchmark themselves against the DCAP standards and work towards improving quality until the standards have been met.

The service will then need to upload evidence to the DCAP website to demonstrate their compliance and once this is completed, they will be able to request an assessment. As we know there is considerable variation in levels of service provision, we have therefore proposed a level 1 and 2 tier approach to support services. This will allow a further 12 months for services to develop and reach the enhanced standards of level 2.

- **Level 1** – these are the initial standards to improve service quality
- **Level 2** – these standards are an enhancement to the initial standards. Accreditation assessments are based on services meeting all the level 1 and 2 standard evidence requirements.

Once accredited, services will need to complete an annual review submission online which will ask for key pieces of evidence to show continued compliance with the standards. After 5 years the process comes full circle and services will require a full assessment again. This will follow the same format as the original assessment.

It is proposed that the assessment process will be delivered entirely remotely. The accreditation pathway is illustrated below:



* Services which don't meet or maintain accreditation standards may be granted a period of deferral to resolve some matters.

DCAP pilot

Completion of the pilot

The pilot programme was launched in April 2022 with the aim of testing the proposed accreditation pathway. We used learnings and challenges from the pilot to inform and adapt the final programme.

It was important to engage with services from the very beginning to ensure they were clear on the aims of the pilot, what support was available and to help them build a better understanding of the DCAP pathway and standards. A total of nine services across the East of England (6) and Wales (3) participated in the pilot.

Each site was responsible for collating evidence against the standards and completing the assessment process. Upon completion, services were not awarded full accreditation, however, they still reported certain benefits to participating. Participation in the pilot allowed services to gain a 'head start' on meeting the standards and served as a springboard to begin making improvements within their service.

Assessments

Pilot assessments were completed in spring 2023; details of these are given below. The assessments demonstrated that there is substantial variation between hospitals in their approach to managing diabetes care and what constitutes good quality of care. Some units have well-staffed services with an ability to work on quality improvement and training as part of their daily work. Other hospitals have fewer staff, so were able to deliver clinical care but not provide other key aspects of the role. It is important to mention that although there are large differences in service delivery, all of the pilot sites have seen significant improvement in recent years and all the sites are committed to continued improvements. This is a positive position and strongly indicates the time is right for the accreditation programme.

The pilot assessments were all delivered remotely. The inspecting teams and sites assessed all felt this gave a fair impression of the service. It is possible that there are some aspects of services that we are unaware of using this process, but the advantages of remote delivery are significant. On balance we feel that this outweighs the disadvantages and plan to continue with remote delivery. There remains the possibility of supporting the process with a site assessment if circumstances suggest this would be needed but this is likely to be exceptional.

Overall learnings

There is almost universal use of the JBDS guidance, although there are large differences in how the documents have been applied locally. Some hospitals use the JBDS guidance as a basis for developing their own guidelines and measure themselves using internally developed standards. However, the majority of hospitals simply reference the JBDS document without providing evidence of how it is being used to provide high-quality care. We can confirm that simply referencing a JBDS document will not be enough to meet the standard for accreditation.

A recurring theme from the pilot sites is that the local diabetes teams are keen to provide high-quality care and develop the service but have poor lines of communication with senior management teams. This was clearly frustrating for both the clinical teams and the senior managers. Demonstrating good lines of communication has now become an important element within the standards.

A key contributing factor to care delivery is the considerable variation in staffing levels and skill mix. However, at the start of the pilot a national staffing standard document was not available to refer to. JBDS has since produced a guide on optimal staffing for a good inpatient diabetes service and a staffing calculator, which DCAP will reference. As most of the pilot sites would not meet the recommendations, we need to be discuss and agree where the bar should to be set to achieve accreditation.

Participating services

The tables below summarise participation in the pilot and progress with recruitment of assessors to assist with both the pilot and eventual programme. All sites received a report detailing their key actions, congratulations and recommendations, which were shared with senior management.

East of England (EoE)	Assessment date
Ipswich Hospital	08/11/22
Southend Hospital	22/11/22
James Paget Hospital	24/11/22
Addenbrooke's Hospital	01/12/22
Milton Keynes Hospital	31/03/23
Norfolk and Norwich Hospital	12/05/23

Pilot sites in EoE	Total
Number of sites that agreed to participate	9
Number of sites that had a pilot assessment	6
Number of sites that did not have an assessment	3

Wales	Assessment date
The Grange Hospital	09/12/22
Singleton and Morriston/ NPT Hospitals	14/12/22
Llandough and Cardiff Hospitals	09/03/23

Pilot sites in Wales	Total
Number of sites that agreed to participate	6
Number of sites that had a pilot assessment	3
Number of sites that did not have an assessment	3

Number of assessors who agreed to participate in the pilot:

Specialty	Number
Doctors	10
Specialist nurses	7
Pharmacists	5
Podiatrists	1
Dieticians	0
People with diabetes/lay assessors	6
Total no. of assessors	**29**

Number of assessors who took part in assessments:

Specialty	Number
Doctors	8
Specialist nurses	5
Pharmacists	5
Podiatrists	1
Dieticians	0
People with diabetes/lay assessors	4

Summary of feedback and learnings from participating organisations:

Specific feedback from participating services has been used to adapt the programme throughout. Generally, feedback about the process was very positive.

Quotes from services include:

'The process itself was a lot of work and very detailed but it was clearly something we needed to do. It confirmed some gaps in our service and raised areas where we could work smarter.'

'It was a steep learning curve…Everyone found it to be a positive experience. The team interviewing was supportive and understanding.'

'I thought the whole process was very well organised. The training on how to access the system to upload data/evidence was straightforward and the system itself was easy to use.'

'The process provided us with a framework of standards for the service, allowed us to structure and recognise where we could do things better. Your team were great and put the diabetes teams at ease during the interview process.'

Examples of other learning are listed below:

The standards and admin process

- Standard audit and governance questions need to be included within each standard.
- Consultant input should be clarified (eg hours per week) in delivering inpatient specific diabetes care and developing the service.
- DCAP team should make services aware that presentations should be 40–45 mins and allow 15 mins for Q&A sessions.

- DCAP team to send out meeting invites and interview questions early to allow clinical teams to free time in their diary.
- It is helpful to have a project lead within the diabetes service who has oversight of the expected timelines and evidence preparing and uploading process, but it needs involvement from the whole team to gather the evidence.
- It should be made clear to teams that the assessment is of inpatient services only, as many services included information about the outpatient services that are not being assessed within DCAP.

Assessment questions and feedback

- There was a need to develop a structured proforma for the lead assessor to complete, in preparation for the feedback meeting to the service at the end of the assessment.
- Non-diabetes team interviews should be included to test the experience of ward staff, ensuring that processes are understood, and work as expected.
- The list of patient interviews should be increased to ensure all types of diabetes and a variety of experiences across the hospital are considered.
- Interviews with junior doctors should be included within the process.
- More robust questions around training for insulin should be included, eg staff having access to a mandatory e-learning package would not be enough for meeting a standard without adequate staff numbers receiving the training and evidence of resulting improvement.
- Ensure that questions relating to dietary provision, foot care and prescribing safety are formulated and asked in the absence of dietetic, podiatry or pharmacy colleagues on the day of the assessment.
- Careful consideration should be given for larger trusts/health boards that include several hospital sites, with development of criteria that will need to be met in order to be assessed as one service.

Provision of evidence

- As well as providing evidence that guidelines are in place, teams need to evidence that guidelines are being followed.
- The evidence provided by the hospital needs to give some background about the challenges faced overall by the hospital and how diabetes services fit within that. Evidence that might be helpful would include regulatory reports for the whole hospital.
- Services need to upload evidence of how the accreditation standards are being met with a 5-year cycle of audits to demonstrate clinical effectiveness.
- There needs to be evidence that the senior management team are aware of the issues relating to diabetes care in hospital and are supportive of the team delivering care.
- It needs to be clear to teams what types of documents should be supplied to evidence the standards. To support this, we have developed some resource documents with the types of evidence the assessment team would be looking for.

Changes to the programme

Developing guidance templates for the standards

The diabetes standards used in the pilot assessments have changed very little as a consequence of the pilot process. However, it is clear that the standards themselves did not give enough detail to allow pilot sites to provide the evidence required. To provide clarity, and opportunity for teams to allocate areas of standards to those best placed to complete, the standards have been updated by separating the clinical and operational processes. This has reduced the points in a single standard and aims to give services more guidance and definition to support them to complete. Access the DCAP accreditation standards.

In parallel to the final pilot assessments, a series of working groups have developed resource documents with examples of both mandatory evidence the assessment team would expect to have and other documents that could be used to evidence the standards. This will help sites to produce and collate the evidence and, importantly, present it in a way that is consistent between hospitals. The guidance documents are nearing completion at the time of this report and will be available soon on the DCAP website.

Development of a national calculator for staffing numbers

An assessment of staffing will be a key part of the accreditation process, to ensure diabetes teams have access to the specialist expertise required to safely manage the complex needs of people with diabetes in hospital. At the time of the pilot there was no national standard defining optimal staffing. The JBDS has now produced a staffing calculator and an accompanying guidance document. The abstract from the associated paper is presented here: https://onlinelibrary.wiley.com/doi/10.1111/dme.15151

Developing an electronic dataset

NaDIA has previously shown that simply measuring quality of care and comparing between units leads to a significant and continued improvement in care quality. A criticism of NaDIA is that it was labour intensive and therefore expensive. One of the key aims of DCAP will be to automate data collection and allow for routine reports to be produced digitally.

This will give participating hospitals important performance information as well as providing a regular national measure of care quality. We have started a conversation about how this might be delivered but this is at an early stage.

Stakeholder relationships

Engaging with people living with diabetes

The experiences and perspectives of people living with diabetes are crucial to understanding whether the standards we've developed are fit for purpose and will effectively meet the needs of people with diabetes in hospital. Too often we hear that people with diabetes do not feel safe in hospital.

We have been working with a small group of people living with diabetes who have supported the assessments as lay assessors and have reviewed the standards. Their insights and contribution have helped ensure that we are assessing not only the standard of care but the way in which care is delivered and how it is experienced by people with diabetes during their time in hospital. More work is required to further engage and involve people living with diabetes in the programme. The Accreditation Unit will be working with Diabetes UK to expand this group and their voice, and create meaningful involvement opportunities to ensure that DCAP is ultimately driven by the needs of people with diabetes.

Connecting with national regulators

Although JBDS has previously had regular communication with the CQC in England there has only been one meeting in the past 3 years and one since the accreditation process was introduced. This was a briefing meeting provided by DCAP but has not led to any further interaction. We have not had any specific meetings with national regulators for Wales, Scotland or Northern Ireland. This is an important area that requires further work in the next 12 months.

Online training events – Introduction to DCAP

This introductory session is designed for services who have recently signed up for accreditation and are currently going through the initial self-assessment and service improvement phase of accreditation. We recommend services attend this training session within 3 months of registering.

The session will focus on:

- the accreditation pathway and timelines
- practical tips on gathering and uploading evidence
- an overview of our resources and guidance
- a glance at the DCAP website and where to start
- a talk from our clinical leadership team on the benefits of accreditation
- Q&A session

Preparing for level 1 accreditation

We will be holding a session aimed at services preparing to submit against the level 1 standards. This would be useful for any services who are preparing to submit in the next 6 months.

This session will focus on:

- The accreditation pathway and timelines
- GAP analysis
- Gathering and uploading evidence
- Peer review support
- Tips for success

Next steps for 2024

Our priority for 2024 is to concentrate on onboarding services into DCAP. We will be providing training and support for teams, including 1:1 sessions. These will focus on how to upload evidence to the website, what they can expect on their accreditation journey and where to begin. We want to focus our attention on services that have recently registered, to help them achieve the level 1 standards in the first instance.

Having success stories to share with services will be essential to our growth. We'll also be writing directly to hospital CEOs to encourage sign up and organising refresher training sessions for assessors who would like to continue with the programme.

Further information

For further information on DCAP visit **www.dcap.org.uk**

If you have any queries about the work of DCAP, please email us at **askDCAP@rcp.ac.uk**

Royal College of Physicians

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