Service Specification No.	**Domain 3B**
Service	**Primary Care Enhanced Diabetes Service**
Commissioner Lead	**NHS East Lancashire Clinical Commissioning Group (CCG)**
Provider Lead	**GP Practices in East Lancashire**
Period	**1st April 2022 – 31st March 2024**
Date of Review	**March 2024**

1. Population Needs

1.1 National/Local Context and Evidence Base

Diabetes is a national, regional and local clinical priority. It is associated with significant morbidity and early mortality, with associated complications including cardiovascular disease, stroke, blindness, renal failure and lower limb amputation. Diabetes is a major chronic disease which has significant impact on mortality, morbidity and health costs in the UK.

Diabetes is one of the most common of all chronic medical conditions and is a growing problem for our health services. Over 90% of people with diabetes have type 2 diabetes which can result in severe complications, affecting the eyes, the nervous system and the kidneys.

A local place-based priority involved reviewing the current service models with the intention to transform diabetes care across East Lancashire through improving management within Primary Care enabling Secondary Care to focus on more complex patients. The review has highlighted challenges such as: reducing clinical variation in General Practice, improving access and uptake of patient education programs, improving care and outcomes for young people and patients with type 1 diabetes and ensuring the Primary Care workforce are trained and fully equipped to manage the new proposed model of care. **A key objective is to deliver enhanced diabetes care at place within PCNs to ensure patients have easy access to treatments and care.**

Prevalence of diabetes in Feb 2022 across the Pennine Lancashire PCN is:

PCN	Population	Diabetic Population	Prevalence %
Burnley East	51907	3348	6.4%
Burnley West	49611	3025	6.1%
Hyndburn Central	44975	3162	7.0%
Hyndburn Rural	33749	2041	6.0%
Pendle East	47038	2431	5.2%
Pendle West	50208	3740	7.4%
Ribblesdale	40662	2034	5.0%
Rossendale East	30324	1835	6.1%
Rossendale West	42557	2408	5.7%
ELCCG	**391031**	**24024**	**6.1%**

PCN	Population	Diabetic Population	Prevalence %
Darwen	31273	1774	5.7%
East	52871	3471	6.6%
North	51210	3708	7.2%
West	45529	3010	6.6%
BWD	**180883**	**11963**	**6.6%**

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

The service is designed around national best practice and clinical evidence to ensure safety, efficacy and cost effectiveness. The service is aligned with local priorities, NHS outcomes framework for England 2013-2016, and Quality and Outcomes for patients. The service is commissioned in line with NICE guidance and NICE quality standards:

Framework	Outcome domains and improvement areas
NHS Outcomes Framework	▪ Domain 1: Preventing people from dying prematurely ▪ Domain 2: Enhancing the quality of life for people with long-term conditions ▪ Domain 4: Ensuring that people have a positive experience of care

In addition to the National Outcomes Framework this service has been aligned with the following outcomes.

Framework	Outcome domains and improvement areas
CCG Priorities	▪ Domain 2: ensuring people feel supported to manage their condition ▪ Domain 2: improving functional ability in people with long-term conditions; people with diabetes who have received nine care processes; people with diabetes diagnosed less than one year referred to structured education programmes. ▪ Domain 2: reducing time spent in hospital by people with long-term condition; unplanned hospitalisation for diabetes

2.2 Local Defined Outcomes

Clinical and quality outcomes from the service include:

- Provision of all necessary nine elements (care processes) of diabetes care in a Primary Care setting with more than 85% of patients on the diabetes register achieving all 9 diabetes care processes annually
- Insulin start-ups and ongoing monitoring
- Access to individualised education equitably for all patients across all localities
- Prescribing in line with NICE clinical guidelines and local health economy joint formulary
- Reduced admissions and outpatient appointments to Secondary Care
- Quarterly submission of QOF data pertaining to diabetes
- Reduce percentage of exception coding and provide clear explanations for non-attendance of appointments and strategies used to encourage attendance.

2.3 Key Performance Indicators

- Quarterly QOF data submission for: HbA1C, BP, Lipids and BMI
- Submission of Confidence Scoring Tool
- Annual clinical audit demonstrating improved patient outcomes from baseline assessment
- Reduction in hospital admissions and outpatient appointments
- Reduction in exception coding and evidence of a multi-systems approach to contacting patients to attend

3. Scope

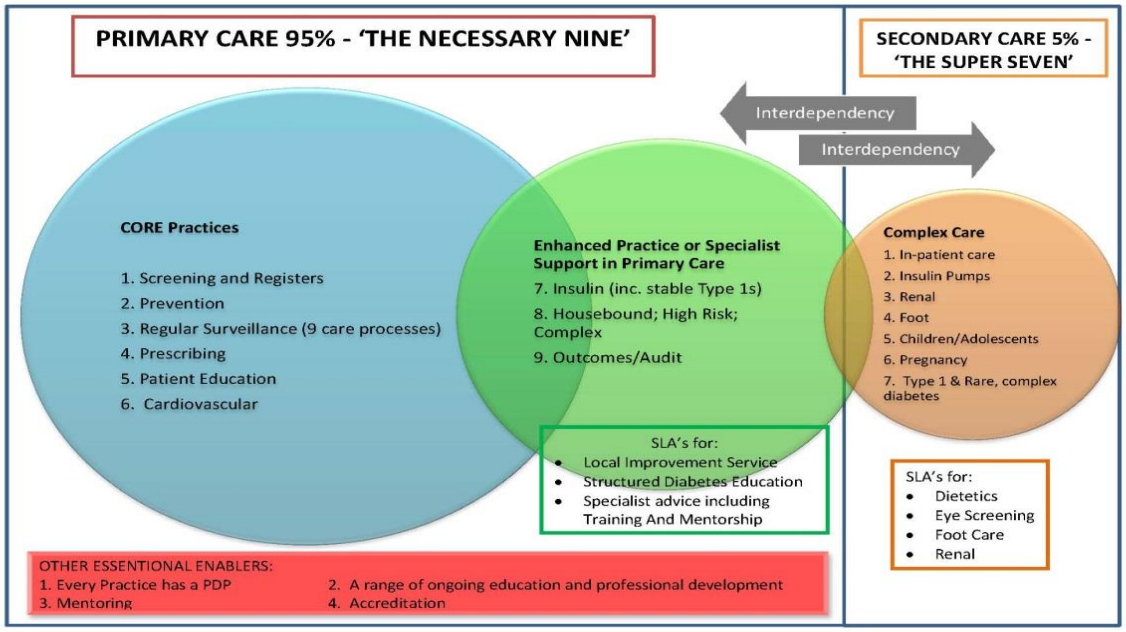
3.1 Aims and Objectives of Service

The aims of the service are to:

- Improve the quality of life of people with diabetes
- Educate patients through the provision of individualised education
- Increase the knowledge base and skill level of health professionals treating patients with diabetes
- Support health professionals in dealing with complex cases
- Ensure health professionals are aware of the services available to patients with diabetes, such as the diabetic foot pathway (see appendix1), and can assess patients effectively to determine suitability for onward referral
- Prevent unnecessary use of Secondary Care resources by ensuring that patients with diabetes are diagnosed early, are taught to manage their condition effectively and are managed optimally by Primary Care

3.2 East Lancashire Integrated Diabetes Service Model

East Lancashire Diabetes Service Model



3.3 Core Service Elements

This will be achieved through provision of Primary Care diabetes services to patients in East Lancashire at an enhanced level above that within the core contract. The core contract includes:

- **Registers**: Building and validating accurate diabetes registers against nationally expected prevalence rates
- **Screening**: Screening all patients at risk of diabetes including those eligible under the vascular checks programme and patients at high risk of diabetes

- **Prevention**: Provision of pragmatic and evidence-based interventions for those at risk of diabetes. This includes development of a 'pre-diabetes' register (ie. patients with non-diabetic hyperglycaemia at risk of developing Type 2 diabetes) with appropriate read code

At least annual surveillance of patients with diabetes including the **9 key care processes**:

a. HbA1c measured and managed according to NICE guidelines

b. Blood pressure measured

c. Cholesterol measured

d. Creatinine measured

e. Micro-albuminuria measured

f. Body Mass Index and waist circumference recorded

g. Eyes examined (including access to retinal screening programme)

h. Feet examined. This should include a first level diabetic foot screen (appendix 1). The referral pathway for treatment of the diabetic foot can be found in appendix 2.

i. Smoking status recorded

- Cardiovascular risk reduction. Reduction of risk factors including Blood pressure, lipids and smoking in line with NICE guidance using an appropriate risk reduction tool

- Prescribing: Evidence based prescribing including insulin, other injectable treatments, oral agents and home glucose monitoring

- Referral of newly diagnosed patients and patients with established diabetes to structured diabetes education programs (see alternative service specification plus on-line programme) to enhance self-management

- Identification of at-risk patients ('pre-diabetes') and provision of appropriate education to enhance self-management

- Annual audit of the above measures

- Referrals into the specialist team must meet the referral criteria indicated in appendix 3. This can be electronically through EMIS. The outcomes for primary care enhanced and specialist, intermediate can be found in appendix 4.

- The Provider(s) shall support an integrated approach between service provider(s) ensuring that patient records are transferred appropriately to support a seamless patient transfer and service provision.

- The service shall have equitable access, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals.

- The service will support high quality care for housebound patients (including those in Nursing/Residential homes).

3.4 Enhanced Service Elements

In addition to the core service as detailed within 3.3 the provider(s) will:

- Manage patients on insulin (and other injectable agents), including initiation and titration for type 2 patients with due regard for patients who are faced with employment issues (such as working shifts, night shifts etc. and insulin schedules, taxi and lorry drivers)

- Management of patients with diabetes according to the following criteria:

GROUP A [Primary Care]

  - May comprise of all those patients that do not meet Group B criteria
  - May include patients that should technically be in Group BA, but for the reasons of patient choice OR non-compliance/non-adherence to secondary treatment OR non-attendance in the hospital OP clinics, a choice to shift into Group B may be offered
  - Patients free of complications
  - Patients with no significant hypoglycaemia
  - Patients with no significant employment or lifestyle issues

- Initiation and management of all treatments in line with NICE Guidance, locally approved guidance and the Health Economy Joint Formulary

- Standardised patient education to enhance self-management

- Practice Nurses and/or GPs should attend regular meetings with the specialist team to build knowledge and expertise within the Primary Care workforce

- Provide proactive care for all patients, especially complex patients at high risk of acute hospital admission including the use of risk assessment and stratification tools

- Review of patients post discharge as clinically appropriate

- Timely management of more complex patients including those with poorly controlled HbA1c, those with co-morbidities

- Support high quality care for housebound patients (including those in Nursing/Residential homes). This includes home visits where appropriate especially for those patients on insulin

- **Housebound** - Where possible patients should attend the practice or PCN hub. The following definition will be applied "*a patient to whom the contractor would offer a home visit as this is the only practical means of enabling the patient to consult a clinician, face-to-face"*. The following housebound patient criteria will be applied to those patients:

  - Who do not have assistance that prevents them leaving their usual place of residence unaided
  - Who are so elderly, frail or infirm that prevents them leaving their usual place of residence unaided
  - With severe physical disability that prevents them leaving their usual place of residence unaided
  - With certain mental health problems that makes it difficult to leave their usual place of residence unaided

- With sensory disabilities especially severe visual impairment that prevents them leaving their usual place of residence unaided

- With profound or severe learning difficulties that prevents them leaving their usual place of residence unaided.

This definition includes patients living in a care home, who are registered with a GP practice and who meet the definition of a housebound patient. Patients with conditions for which leaving home is medically contraindicated are also considered housebound. It is the practices decision to determine if a patient is housebound.

- Ensure appropriate referral pathways are considered at all times to ensure a holistic approach to managing patients. These will include podiatry clinics, dietetic services, eye clinics and renal services.

The following group of patients fall into exclusion criteria and would be managed under specialist care:

GROUP B [Specialist Care]

- All newly diagnosed type 1 diabetes in their 1st year after diagnosis

- Age <20 years (as patients changing over from paediatric clinic to adult clinic may need to be transferred slowly into community)

- Patients on Pump therapy

- Patients who are contemplating pregnancy or are pregnant

- Patients with eGFR<30 (include dialysis)

- HbA1c < 48 mmol/mol and Type 1 and/or CKD Stage 3b or higher [EGFR <30]

- HbA1c >58 mmol/mol for >12 months despite interventions offered in group B (lack of good control)

- Patients reporting hypoglycaemic episodes on 2 or more occasions within 6 months

- Patients who resist being treated in the community and have made a clear choice of that (patient choice).

3.5 Requirements

The specification requires the provider(s) to:

- Each Practice/PCN providing the service will have a named lead clinician who will be responsible for ensuring all the necessary governance procedures are in place within the practice/PCN for safe and effective delivery of the service

- All providers must have received the appropriate qualification (clinical diploma in diabetes) and evidence of suitable training in insulin initiation, management of type 2 diabetes and management of stable type1 diabetes
- Newly qualified clinicians will receive 6 months (or more if required) of mentorship from experienced individuals in management of diabetes
- Evidence of Continual Professional Development (CPD) in diabetes management is required as part of ongoing education and training as per Band 6 Diabetes Nurse Competency Framework.

Competencies PN Feb 2022.docx

- Agreement to work with mentors in reviewing performance and service development and delivery

- Provide evidence of annual review of competency framework and assessment.
- Ensure defined, standardised care plans are available for all patients with diabetes. To ensure a consistent, standardized approach, practices are expected to use the locally agreed EMIS template.
- Practices are expected to add the SNOMED codes for enhanced service provision.
- Proactive management of patients with raised HbA1C, raised BP, raised lipids and/or other high-risk elements who may require more frequent review
- Evidence of clinical audit on diabetes care and changes implemented
- Evidence of a systematic approach to diabetes care including an organisational ability for call and recall of all patients suitable for repatriation
- Evidence of effective team working with respect to diabetes care. This includes integrated working with district nursing teams, care homes and other providers.
- Evidence of different approaches to reduce exception coding. These must include actual contact with the patient and may include letters, emails, telephone contacts, text messages etc.
- Practice commitment to peer review and sharing of anonymised audit data to facilitate quality improvement.

3.6 Accessibility

- The provider(s) will ensure that the service offered is respectful and does not discriminate on any grounds. The provider(s) should be sensitive to the needs of patients whose first language is not English, and those with hearing, visual or other disability.
- The chosen site(s) should be easily accessible by public transport and provide on-site/adjacent parking.
- All aspects of the service should be compliant with the Equality Act; ensuring disabled patients are able to access the service.
- The service will be located in an area that is accessible by all members of the community and should have good public transport links.
- The chosen site(s) should include adequate security arrangements to ensure the protection of patients attending the premise(s); the provider(s) shall inform the commissioner of any issues relating to security. There should be clear and appropriate signs for the entrance from the public highway.
- Waiting areas should have sufficient seating to accommodate the number of patients and their carers. Such areas should take into account the comfort of those waiting for others as they may experience an extended wait during a consultation or procedure.
- Patients should be seen within half an hour of their appointment time and flow through the clinic should be without undue delay.
- The provider(s) should provide clinics and treatment on site or via domiciliary visits at the patient's own home where appropriate. Management of patients being assessed at home remains the responsibility of the provider(s) and all dosing and decisions to treat should be made by the provider(s)

3.7 Population covered

All adult patients registered with an East Lancashire PCN/GP practice.

3.8 Any Acceptance and Exclusion Criteria

3.8.1 **Inclusion Criteria**

- Patients are registered with an East Lancashire PCN/GP Practice
- Patients over 20 years old (flexibility with respect to paediatric and adolescent services)
- Patients who are not clinically deemed to meet the criteria for the “Super 7” (unless patients decline treatment from Secondary Care).

3.8.2 **Exclusion Criteria**

The following list is not exhaustive and individual cases may be considered by the provider(s) for exclusion depending on clinical circumstances. The provider(s) should discuss these patients with the named Clinical Lead before referring the patient to another provider(s).

- Patients are not registered within the East Lancashire PCN/GP Practice
- Patients under 20 years old (flexibility with respect to paediatric and adolescent services)
- Patients who are clinically deemed to meet the criteria for the Super 7 (unless patients decline treatment from Secondary Care).

3.9 Interdependencies with other Services

The provider(s) will offer personalised care plans to all patients where appropriate and effective and clear communication is maintained with the following agencies, where applicable:

- Patient’s GP
- Secondary Care Diabetes Service
- Health and Social care Teams
- District Nurses
- Practice Nurses
- Podiatry Services
- Care and Residential Homes
- Clinician Mentors
- Medicines Management Teams
- Community Pharmacies
- Diabetic Specialist Nurses (DSNs)
- Dietetic Services
- Patient’s dentist
- Consultant diabetologist.

The provider(s) shall facilitate the transfer of patient care between service providers through the full disclosure of patient’s records, as and when required.

3.10 Clinical Audit

Patient safety is paramount in the delivery of this service. The provider(s) will be expected to oversee the performance of the service using the indicators set by the commissioner and include a review of these at clinical commissioning meetings. The provider(s) will be required to supply information to the ICB Clinical and Strategic Commissioning Leads on the quality and performance management.

The provider(s) is expected to:

- Nominate a named clinical lead
- Develop and maintain an action plan to continually improve performance and patient experience
- Review patient outcomes on a regular basis
- Monitor adherence to initiation and maintenance protocols and ensure compliance with NICE Guidance and the EL Joint Prescribing Formulary
- Monitor missed appointments and noncompliant patients

The provider(s) may be required to participate in quality audits which will need to be submitted to the commissioner and Quality Team accordingly.

3.11 Reporting Adverse Incidents

Provider(s) will report all significant and serious untoward incidents to the Incident Team and Quality Lead accordingly:

- Near misses and incidents – **72** hours
- Serious untoward incidents – **24** hours

Serious untoward incidents include patients that required hospital admission or have died as a result of mismanagement. Significant Event Analysis (SEA) should be undertaken with all key stakeholders, and a report with actions sent to the Quality Lead.

4. Applicable Service Standards

4.1 Applicable National Standards (eg. NICE)

The delivery of the commissioned service is underpinned by the appropriate standards, including but not limited to:

a) The domains published in the NHS Outcomes Framework relevant to the delivery of integrated services for older people with long term conditions

b) Domain 2: Care of older people with long term conditions and the delivery of integrated care. Overarching Indicator 2 - Health Related Quality of Life for people with long term conditions

c) Domain 4: Ensuring people have a positive experience of care through the Friends and Family Test

d) The NICE Quality standards on the development of integrated services for older people with long term conditions

e) The NICE Diabetes Clinical Guidelines and Technology Appraisals

f) Further relevant national standards include**:**

- End of Life Strategy Incorporating End of Life tools (DH 2008)
- Compliance with Care Quality Commission standards and guidance
- Seven Steps to patient safety (second print 2004)
- Dignity Challenge (DH 2007)

- Supporting People with Long Term Conditions DH (2005)
- The Health Act 2006: Codes of practice for the prevention and control of Health Care Associated Infections (revised 2008)
- Compliance with appropriate Health and Safety legislation (eg.HASWA 1974 Act, COSHH, RIDDOR 1995)
- Compliance with alert notices as stipulated by the MHRA (including Equipment Validation)
- National Carer's Strategy
- Nuffield trust and Kings Fund
- Diabetes UK "Commissioning Specialist Diabetes Services for Adults with Diabetes" (October 2010).

4.2 Applicable Standards set out in Guidance and/or Issued by a Competent Body

The provider(s) must adhere to the following standards from professional bodies and the Competency Framework for Diabetes Nursing:

a) GMC Guidelines

b) NMC Guidelines

c) HCPC Guidelines

d) An Integrated Career and Competency Framework for Diabetes Nursing. https://www.diabetes.org.uk/professionals/training--competencies/competencies

4.3 Additional Professional Competency Resources

a) NICE CG 138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services

b) NICE Clinical Guideline (NG17) Type 1 diabetes in adults: diagnosis and management

c) NICE PH 38 Preventing type 2 diabetes: prevention for people at high risk

d) Type 2 diabetes in adults: management NICE guideline [NG28]

e) Trend End Of Life Guidance For Diabetes Care https://diabetes-resources-production.s3.eu-west-1.amazonaws.com/resources-s3/public/2021-11/EoL_TREND_FINAL2_0.pdf

4.4 Applicable Local Standards

The provider(s) must ensure that the following local standards are adhered to:

a) East Lancashire Type 2 Diabetes Management Guidelines – www.elmmb.nhs.uk

b) East Lancashire Health Economy Joint Prescribing Formulary – www.elmmb.nhs.uk

It should be noted that the latest guidance and other sources of reliable evidence will also be used to ensure the quality of the service.

- The provider(s) will have robust arrangements in place for contingency planning and which ensures the resilience of the service being delivered.

- The provider(s) must ensure that they have available any recommended information leaflets for patients and carers.

5. Applicable Quality Requirements and CQUIN Goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts A-D)

The provider(s) must comply with all quality standards as per the quality schedule.

The provider(s) will ensure the service meets the required levels of safety, quality and effectiveness, whilst promoting innovative practice that leads to improved quality, safety and outcomes (which is in addition to those elements detailed in section 4 Applicable Service Standards) which includes:

- Patient experience
- Equality, Diversity and Human Rights
- NICE guidance
- Health and Social Care Act 2010
- Hygiene Code
- Duty of Candour.

The provider(s) will have suitable arrangements in place for quality assurance and clinical audit of the service provided.

Variation or deviation in the quality of the service being provided, as specified in the contract, must be notified in writing to the commissioner as soon as identified with proposed actions and timescales for rectifying this.

6. Location of Provider Premises

The Service can only be provided from premises that are fit for purpose and situated within the geographical area of the CCG.

7. Payment and Notice Period

Practices will be remunerated at £23.00 per registered diabetic patient annually for returning the completed sign up form (appendix 7) and delivering the Primary Care enhanced diabetes service specification for the full 12 months. Providers must give 3 months' notice of their intention to withdraw from providing the service.

Appendix 1

First Level Diabetic Foot Screening Form

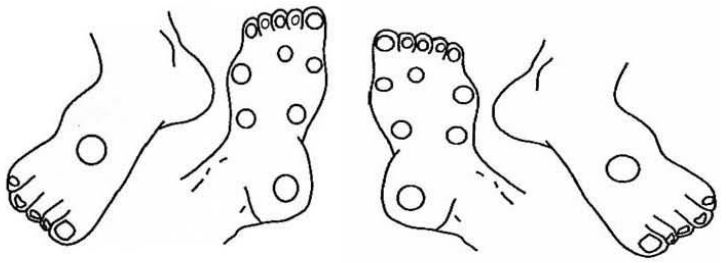
Name:	**Address:**
GP:	**Date of Birth:**

Does the patient already attend the Podiatrist? **Yes** / **No**

Inspection	**Right**		**Left**	
Deformities	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Callus	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Ulceration	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Amputation	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Palpable Pulses				
Dorsalis pedis	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Tibialis Posterior	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Pain in calf muscle when exercising	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

Neurological examination

☐ *Tick if all sites are present*



☐ *Tick if all sites are present*

Risk Category	0 - no problems identified on examination	*(Delete as appropriate)*
	1 - refer to Podiatry	*(Delete as appropriate)*

Any other problems/comments

Management

Advice leaflet given	☐ **Yes**	☐ **No**
Referral to podiatrist	☐ **Yes**	☐ **No**
To be recalled for annual assessment	☐ **Yes**	☐ **No**

Completed by:	Designation:	Date

Amended 9/12/05 2005/lm

First Level Diabetic Foot Screening Form

Notes to be used when completing the form

PROTOCOLS

Section 1:

Name and address etc as read

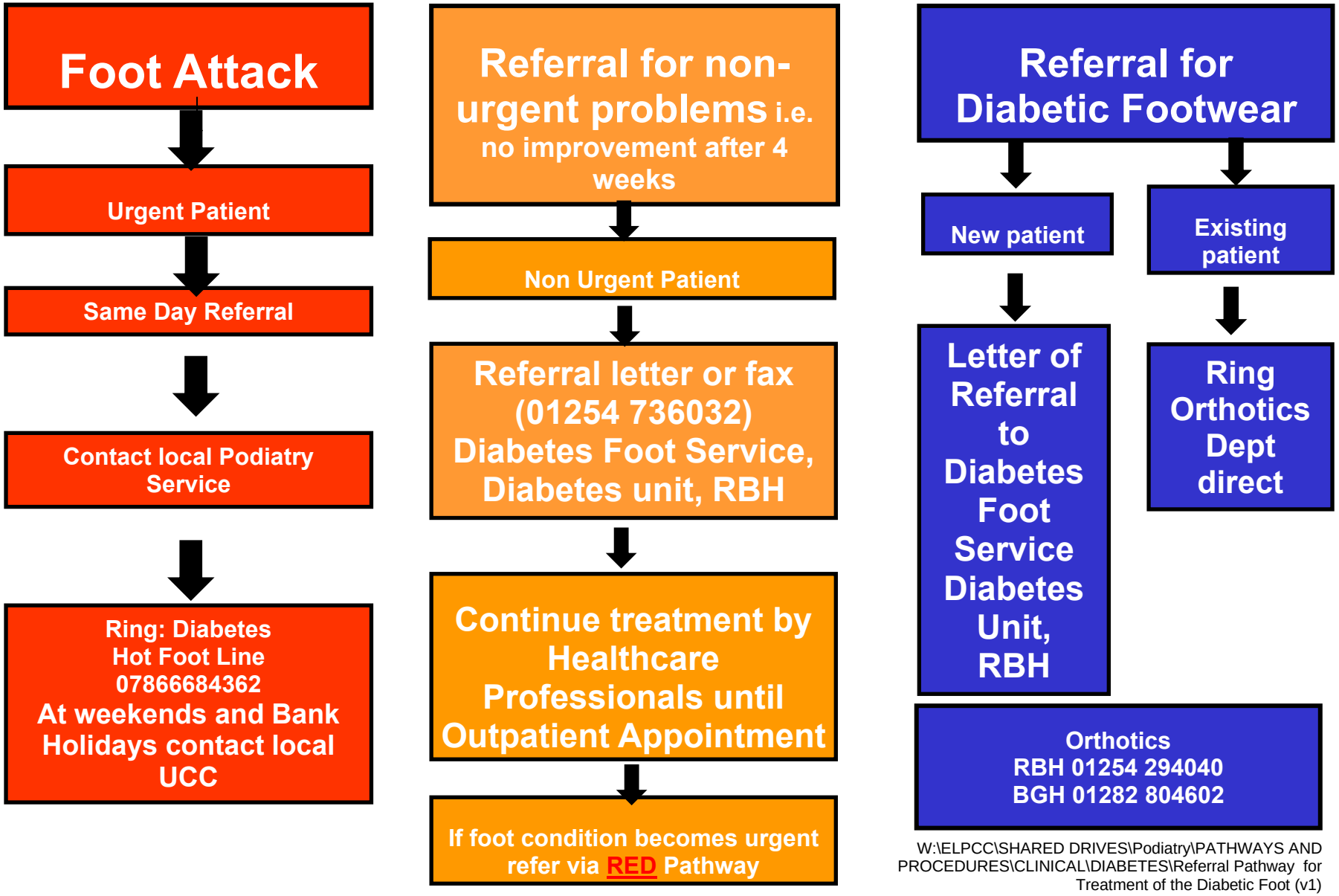
Section 2

- If the patient exhibits any of the following signs/symptoms, they should be referred according to the diabetic foot care pathway.
- Deformities: this is where there is any bony deformity of the foot present, e.g. hammer toes, hallux valgus (bunion), pes cavus (high arch foot). See training guide.
- Callus: this is any area of hard skin on any area of the foot.
- Ulceration: this is a break in the integrity of the skin with loss of tissue.
- Amputation: this can be at any level e.g. toe, foot, and is not necessarily due to diabetes.
- Pulses: non-exercise pulses
- These are the foot pulses which can be felt by hand, however if the foot is oedematous they may not be felt.
- Ask the patient whether they experience pain of the calf muscles during exercise, if they do, how far they have walked before they have to stop due to the pain.
- Neuropathy: use a 10 gram monofilament on all the sites marked (apex all toes, 1,3 and 5 met heads, medial and lateral arch and heel) Avoid all areas of callus as sensitivity is reduced. Refer to training guide for use of monofilament.
- Risk Categories: 0 is no problems
    - 1 refer to podiatrist

Any Other Problems: this is for anything that you or your patient has concern over e.g. problems with nails oedema.

Advice: this will need explaining. A contact telephone to be given for the local podiatry clinic.

Appendix 2: Referral Pathways for Treatment of the Diabetic Foot



East Lancashire Hospitals NHS Trust

W:\ELPCC\SHARED DRIVES\Podiatry\PATHWAYS AND PROCEDURES\CLINICAL\DIABETES\Referral Pathway for Treatment of the Diabetic Foot (v1)
Review September 2016

Safe | Personal | Effective

Appendix 3 – Diabetes Triage and Coding Criteria for Referral

Key Principles for Integrated Care

- Population and individualised approach
- Support self-management to empower patients
- Shared decision making
- Multi-professional care and support

Diabetes Prevention/Targeted Screening

General health education, including healthy schools, obesity strategies and public health. Enable self-care, NHS health checks

Core – Primary care Diabetes Care

- Screening of patients at risk of diabetes
- Management of prediabetes
- Long term conditions register and record maintenance and review
- Annual review to screen for complications, ie. retinal screening, foot assessment, microalbumin and CKD screening - all patients with diabetes
- Follow up of uncomplicated type 2 patients on diet only or oral therapies as per NICE guidelines including housebound.
- Information exchange to support patient management across pathway
- Healthy eating advice, and referral for group advice on dietary management
- Personalised care plan in collaboration with patient to support self-management
- Education/advice to support self-management (EMPOWER)
- Initiation and follow up of patients on injectable GLP1's or alternative oral agents recommended by NICE.
- Comprehensive cardiovascular risk assessment
- Medicines use review as part of annual diabetes review
- Clinical audit of referrals to enhanced service and advice received
- Educate patients on blood glucose monitoring if required
- Offer patient choice of intervention or support when problem or need arises (shared decision making)

Enhanced Primary Care diabetes care (includes all elements of above)

- Support and follow up for patients with more complex needs than cannot be met in core primary care
- Support patients to self- manage their conditions using care planning and motivational interviewing techniques during consultations
- Initiation and follow up of patients requiring basal inulin or bd mixed insulin regimens.
- Educate patients on correct use of appropriate equipment and devices including injection technique and patterns of blood glucose monitoring
- Routine supportive management and monitoring of patients with well-controlled type 1 diabetes and type 2 diabetes on injectable treatments (insulin or complex regimens)
- Provision of care in line with management plans from enhanced GPSI/DSN-led and consultant led care, including patients with suboptimal but individualised care
- Early follow up and advice following hospital admission
- Referral to dietician for 1:1 advice in appropriate patients
- Individualised support for patients who DNA standard care
- Initial follow up of patients with diabetes following Bariatric surgery

Enhanced GPwSI and DSN led, Consultant supported community (Intermediate) service

- Support to Core and Enhance primary care practices for advice, audit and skill development
- Intensive intervention and support for patients not achieving NICE outcomes or individualised glycaemia goals which cannot be achieved in core and enhanced primary care.
- Suspected or possible newly presenting Type 1 Diabetes over the age of 25 years
- Intensified insulin or multiple therapies that cannot be managed in core or enhanced primary care, including Basal Bolus insulin regimens with carbohydrate counting
- Follow up and support for people with uncommon types of diabetes eg. secondary to pancreatic disease, MODY
- Patients with type 1 diabetes who are confident in self-management post DAFNE education
- Patients at high risk of diabetes complications, or with complications and uncontrolled risk factors including raised blood pressure and lipids
- Patients on complex or unconventional treatment regimens
- Patients with CKD stage 3b and uncontrolled risk factors, or worsening CKD stage 3.
- Patients at high risk of Non-Alcoholic Fatty Liver Disease (NAFLD)
- Stable Claudication (podiatry)
- Stable foot ulcer (podiatry)
- Follow up of patients with loss of hypoglycaemia awareness
- Early follow up post hospital discharge for patients whose GP practice is not delivering enhanced care
- Individualised assessment and planning for people who DNA standardised care

Consultant led diabetes care

- DAFNE type 1 structured education
- Support to inpatients with diabetes
- Support to patients with diabetes undergoing procedures
- Young people (aged <25) with diabetes
- Insulin pump therapy
- Planning pregnancy
- Pregnancy with diabetes
- New or active Foot Ulcer (HOT foot line)
- Stage 4-5 CKD and diabetes
- People with diabetes and complex multimorbidity
- Initial assessment and management of people with loss of hypoglycaemia awareness
- Patients with symptomatic autonomic neuropathy

Appendix 4: KPIs and Outcome Measures for Integrated Primary Care and Specialist, Intermediate Service

Service Specification	Process Outcomes	Clinical Outcomes
Integrated Primary Care Outcomes	▪ Number of practices signed up to deliver enhanced service specification ▪ Number of practices that have received diabetes training according to competency framework highlighted in service specification ▪ Number and % of newly diagnosed type 2 diabetic patients referred into SDE (existing patients identified who have not been referred may be included) ▪ Diabetes register validation ▪ Development of 'pre-diabetes' register (non-diabetic hyperglycaemia) through screening using appropriate tools. ▪ % of diabetics with written individualised diabetes care plans ▪ % of diabetics with written individualised care plans with evidence of use ▪ Number and % of Type 2 diabetics initiated on insulin. ▪ Number and % Type 2 diabetics initiated on GLP1s ▪ Number and % of patients with Type 2 diabetes exception coded for: BP; HbA1c; Cholesterol; Microalbuminurea; Referral in to SDE	▪ **DM017** The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed ▪ **DM006** The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) ▪ **DM022** The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease 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) ▪ **DM023** The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin ▪ **DM012** The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months ▪ **DM014** The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register ▪ **DM019** 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 140/80 mmHg or less. ▪ **DM020** The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months. 17 35-75% ▪ **DM021** The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months ▪ Number and % of CVD diabetes hospital admissions. ▪ Number and % hospital admissions due to hypoglycaemic episodes ▪ Number and % hospital admissions due to DKA and hyperglycaemia

Specialist Team Outcomes	▪ Number and percentage of clinical sessions attended by consultant within locality hub. ▪ Number and percentage of clinical sessions delivered by specialist service in locality hub and GP practice. ▪ Number and % patients referred into specialist team for enhanced level of care. ▪ Number and % patients referred into specialist team for core services discharged back to practice. ▪ Number of practices to whom diabetes training delivered according to competency framework highlighted in service specification. ▪ % diabetics with written individualised diabetes care plans. ▪ % diabetics with written individualised care plans with evidence of use	▪ Number of patients with HBA1c more than 75mmol/mol (9%) ▪ Number of patients with HBA1c less than 59mmol/mol (7.5%) BP less than 140/80: cholesterol:HDL Ratio less than 5mmol/l ▪ Number and % of Type 2 diabetics initiated on insulin. ▪ Number and % Type 2 diabetics initiated on GLP1s ▪ Number and % of CVD diabetes hospital admissions. ▪ Number and % hospital admissions due to hypoglycaemic episodes ▪ Number and % hospital admissions due to DKA and hyperglycaemia

Appendix 5: Diabetes Primary Care Enhanced Service

Specification Supplement

Practices signed up to deliver the enhanced service are expected to provide core GMS plus the additional specialist elements outlined below. The enhanced service specification outlines the more specialised enhanced service to be provided in primary care for patients with diabetes. The following guidance contains expected processes and outcomes as part of this enhanced service.

Practices are expected to:

1) Develop and Validate Diabetes Registers

SNOMED ID 170774007 Diabetes: practice program to identify the extra work undertaken as part of the enhanced service for people with diabetes. Routine core work and general QOF reviews undertaken for diabetes care should not be coded SNOMED ID 170774007 Diabetes: practice program.

SNOMED ID 170775008 Diabetes: shared care program to identify shared care arrangements with intermediate and acute services

2) Code related activity

The following SNOMED ID codes should be used to code additional related activity:

- **345041000000101 - Insulin treatment initiated**
- **719566006 - Diabetic on non-insulin injectable medication** e.g. GLP-1s
- **700449008 - Non-diabetic hyperglycaemia**
- **170777000 - Diabetic annual review**
- **198501000000100 - Diabetic 6-month review** (additional interim face to face reviews)
- **703040004 - Agreeing on diabetes care plan** (where a care plan is updated or reviewed)

3) Maintain Diabetes Care Diary Entries

Patients should have a clear record in the Patient Medical Record of dates of annual, interim reviews, monitoring and follow-up as necessary for individual patients.

4) Undertake audits & data collection

The practice will deliver to the nGMS Quality and Outcomes Framework standards. Audit data collection detailing QOF outcomes will take place automatically via the MLCSU Data Quality Team based on data as at 1st April, 1st July, 1st October and 1st January annually. This will enable the capture of clinical outcomes broken down by level of care.

A clinical audit should be produced annually analysing the care of the Diabetic population and discussed with the GPwSI and the Diabetes Specialist Team.

Appendix 6: Recommended processes:

Clinical services	Regular face to face reviews for patient provided the GP Enhanced service using the care planning approach, for people with either type 1 or 2 diabetes who are using insulin and/or GLP-1. These should be a minimum of 6 monthly or as frequently as clinically indicated. Other interim review can be telephone reviews. Alongside the annual diabetes reviews these patients will receive: • HbA1c blood tests, as frequently as clinically indicated • Blood pressure checks • Cholesterol & blood lipids tests • Kidney tests • Weight & BMI checks • Smoking advice where appropriate • Foot checks • Comparison with previous tests if available • Review of blood glucose testing frequency, test records & hypoglycaemic episodes • Advice re dosing & switching types • Check of injection sites • Information regarding discuss sharps disposal • Discuss hyperglycaemia & sick day rules • Discuss driving implications and hypos. DVLA advice given should be coded: 700414001 - Education about diabetes and driving 183077002 - Patient advised to inform DVLA • Ensure Insulin Passports are in place and coded: 804881000000105 - Insulin passport given 821501000000107 - Insulin passport checked 805021000000104 - Informed dissent not to carry insulin passport
Individual care plans	A clear summary of care plan (results, agreed priorities and goals) should be recorded on the medical record and relevant sections completed in the local Diabetes Record Booklet
Reducing iatrogenic harm	The changes in QOF seek to address the problems with 'one size fits all' approach: the potential over-treatment of frail patients and under-treatment of patients without frailty. Intensive glucose lowering treatment of Type 2 diabetes in older people is of limited benefit and there is increasing evidence of harm, including severe hypoglycaemia and congestive heart failure, which outweighs potential benefits. In the previous indicator set incentivising a range of glucose targets. As these are not stratified to patient groups, they risk rewarding under-treatment of younger adults who are at greater risk of the macro and microvascular complications of diabetes. The changes should address this by focusing achievement of lower glycaemic targets upon this patient population. It is anticipated that the resulting improvements in glycaemic control will lead to improved patient outcomes, reduced complications and associated health care utilisation;
Protected time	The practice has a diabetes clinic set up which allows protected time for both nurse and doctor consultation. Insulin initiation would be expected to require an initial appointment of 1 hour and a 6 monthly follow-up appointment of at least 30 minutes.
Call and Recall	Minimum 6 monthly systematic recall in place, or more frequently if clinically indicated.
Patient Education	There is a selection of written educational material are available for patients in practices and practice clearly documents when these are supplied. A variety of insulin pen devices should also be available for demonstration. Where initiating

	insulin in people with type 2 diabetes there should be a comprehensive educational session to include: • Diet • Blood glucose monitoring • Disposal of sharps following guideline • Use of insulin device and injection technique • Hypoglycaemia • Self-adjustment of doses • Driving implications • Managing insulin when unwell • Insulin Passports - free from Primary Care Support http://secure.pcse.england.nhs.uk
Professional Links & Referral Policies	Work together with other professionals when appropriate. Establish close links with the Diabetes Specialist Nurses Diabetes Refer appropriately to dieticians, podiatrist, and retinal screening service.
Annual Service Review	The practice should make arrangements to meet with Diabetes Specialist Team and/or GPwSI annually as part of quality improvement and development. The report should detail: • How many people using insulin for whom the practice have been solely responsible • In how many of those have had insulin initiated by the practice • A review of clinical data for patients using the service
National Audits	Participate in the National Diabetes Audit is a contractual requirement from July 2017. An automated extraction of the required data will be arranged via MLCSU Data Quality Team.
Untoward Events	The practice would be expected to report any adverse events involving service users to CCG.

Appendix 7: Sign Up Form

Primary Care Enhanced Diabetes Service 2022-23
Confirmation of intention to participate

Name of practice(s):

Practice Code(s):

PCN(s):

GP Practice/PCN Diabetes Lead

Name:
Diabetes Qualifications:
Contact Details/email address:

Practice Diabetes Practice Nurse(s)

Name:
Diabetes Qualifications:
Diabetes Nurse Competency Framework completion date:
Contact Details/email address:

Name:
Diabetes Qualifications:
Diabetes Nurse Competency Framework completion date:
Contact Details/email address:

Name:
Diabetes Qualifications:
Diabetes Nurse Competency Framework completion date:
Contact Details/email address:

The practice confirms its agreement to deliver all elements of the Primary Care Enhanced Diabetes Service 2022-23 as set out in the Service Specification.

The practices agrees that it will notify the CCG of any changes in service provision relating to this service specification.

Name:

Position in practice:

Signed:

Date:

This form is to be completed and sent to Carolyn.coughlan@nhs.net and elccg.adminmmt@nhs.net to confirm practice agreement to participate in the Primary Care Enhanced Diabetes Service 2022-23