SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	03_CVDS_21
Service	Diabetes – new model
Commissioner Lead	CVD CCP
Provider Lead	
Period	1st April to 31st March 2017
Date of Review	31st March 2015

1. Population Needs

1.1 National/local context and evidence base

At March 2013, there were 37,000 people registered with diabetes in Dorset, accounting for nearly 5% of the population. The prevalence is expected to rise, associated with higher levels of obesity, to 9% by 2025 i.e a doubling of the numbers of people with diabetes
Type 2 diabetes accounts for 92% of the people with diabetes. The majority of these people will be able to have their diabetes care in primary care supported, where appropriate by the Intermediate Diabetes Nurse specialists (DNS)

Many diabetic compilations; blindness, end-stage renal failure, amputation, cardiovascular disease and gestational diabetes can be positively influenced by appropriate therapies. Early identification and achievement of good glycaemic control and management of the side effects of diabetes will improve life expectancy and quality of life.

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 or 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**	

2.2 Local defined outcomes

- Increased number of patients receiving shared care with the DNS, and Read coded within primary care
- 80% of all patients with diabetes will have all 9 care processes recorded in previous 12 months
- Increased number of patients on the GP practice diabetes registers so that Dorset CCG achieves 6.5% diabetes register of the population
- Admissions to hospital non-electively for conditions defined as 'diabetes complications' (in the national ACS definitions) will decrease for Dorset CCG ref here

3. Scope

3.1 Aims and objectives of service

This service aims to improve the diabetic control for people with diabetes, to encourage appropriate joint working with the Intermediate Diabetes service (DNS and Dieticians) and to promote practice diabetes registers towards 100% of the expected prevalence

This service is to address the registered population aged 17+ years with type 2 diabetes (except for numbers 5 & 6 below), whether they receive their diabetes care in primary or secondary care or shared care.

More specifically the service aims:

1. To enable people with Type 2 diabetes to receive a maximum level of diabetes care in primary care
2. To enable enhanced levels of diabetes care in primary care up to and including insulin conversations on shared care arrangements.
3. To further enhance the collaborative working between the DNS (who also work alongside secondary care) and primary care
4. To conduct 6 monthly reviews on people with Type 2 diabetes on insulin
5. To work towards all people with diabetes having all 9 care process recorded annually in the primary care record (Type 1 and 2)
6. To conduct shared care reviews every 6 months for people aged 17 years + with Type 1 diabetes who do not engage with secondary care services as the patient may be more willing to engage in primary care
7. To increase the early diagnosis of diabetes as the earlier treatment and awareness will increase years of life and morbidity free years for the patient and reduce the burden of disease for the health and social care community
8. To ensure that patients only attend a secondary care outpatient appointment for their diabetes care if clinically needed when it is outside the scope of the DNS supported primary care service.

The aims of the service will be addressed by dividing the requirements into the following 6 objectives:

1. Data transparency

The results of this service will be shared across all providers of the service and locality commissioning teams.

2. Improve consistently high standards of diabetic care: 9 care processes.

To increase the number of people with diabetes (Type 1 and Type 2) who have had all the 9 care process carried out (National Diabetes Audit) and recorded in the previous rolling 12 months period.

The majority of patients with Type 1 diabetes will be under the care of secondary care or shared care. However, the practice will ensure that the diabetes practice patient record for such people, records the monitoring of the 9 core process in order to maintain the highest standards of care. Type 1 patients who choose not engage with secondary care will be supported through this service.

3 Incentivise improvements in standards of care for recording of care processes

Practices should select two of the bottom four performing areas in the 9 care processes for improvement and to show an improved uptake. Practices will be incentivised for improved recording for 2 care process areas
Practices at or over 80% in all indicators will not be required to engage in an improvement plan and will already have achieved the maximum contract value.

4 Promote shared care arrangements

To provide more specialist interventions in primary care for the people with diabetes, including working alongside the Intermediate Diabetes Service to improve diabetic controls on oral and injectable medications. This is for the whole practice diabetic populations, and not restricted to those under primary care management. Those patients who are jointly seen/reviewed by the practice nurse/GP and the DNS will be recorded as 'shared care' on the practice system

5 Early identification of disease: For practices to have diabetes registers where the incidence more closely matches the expected prevalence.

This element will only be open to practices with a diabetes register of less than 80% of the expected prevalence. These practices will be incentivised to increase their diabetes register towards the expected value. See current expected v actual prevalence at Appendix 3.

	2012 Expected population	**Prevalence**	**Lower uncertainty limit**	**Upper uncertainty limit**

	with Diabetes 16+			
NHS Dorset CCG	48,811	7.6%	5.6%	11.1%

The data above gives estimates of the number of people age 16 years or older who are likely to have diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation. The lower and upper uncertainty limits define the range of values in which it is plausible that the true prevalence of diabetes lies. For further details of the model methodology see http://www.yhpho.org.uk/default.aspx?RID=81090.
Ref: National Diabetes Information Centre: YHPHO

6. Diabetes is a cardiovascular disease
Practices should do an annual pulse check on people over 45 with diabetes as a screening tool to detect atrial fibrillation. Practices should report the number of annual pulse checks on people over 45 with diabetes that have led to a positive diagnosis of Atrial fibrillation.

3.2 Service description/care pathway

In Dorset the care of people with Diabetes is described in a 3 tier model, below. This specification seeks to define the enhanced expectations within the Primary Care circle (black writing) and its shared care relationship with the Intermediate care circle (green).

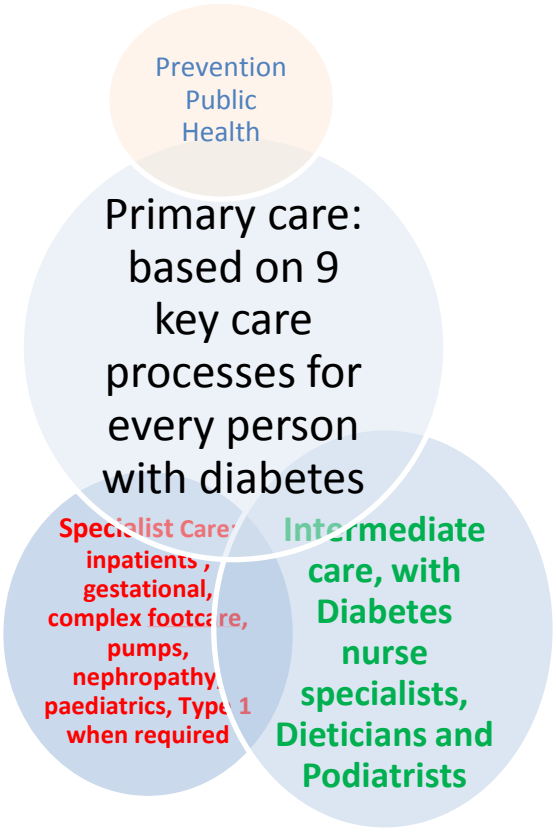

Diagram 1: Dorset Tiered model of care for people with Diabetes

For those patients who are requiring shared care, GP practices will make suitable arrangements with the DNS for patients from their practice to be assessed and reviewed in the practice and for the results to be entered on the practice system. This will usually be alongside the practice nurse. The DNS will also be available for telephone advice for the GP or PN.

3.3 Any acceptance and exclusion criteria and thresholds

Acceptance criteria: People aged 17 + with diabetes registered with a GP practices in Dorset, Bournemouth and Poole

3.5 Interdependence with other services/providers

- Diabetes Nurse Specialists
- Secondary care
- Diabetic eye screening programme
- Podiatry
- Diabetes education programmes
- Dieticians
- Cardiac services, particularly Heart Failure

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

National Diabetes Audit 2011-12, 9 Care processes and Treatment targets

The 13 healthcare essentials care standards set out by NICE and NHS Quality Improvement that all people with diabetes should know that have been checked at least annually

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

Where the person with diabetes is regularly seen by the practice nurse, Dorset CCG aspires to have all such practice nurses trained to Diploma level in Diabetes care.

All practice nurses who regularly see patients with Diabetes will receive regular professional supervision.

All practice nurses will attend an annual education on diabetes to remain abreast of national and local developments.

5. Applicable quality requirements and CQUIN goals

Applicable quality requirements (See Schedule 4 Parts A-D)

The practice will advise the CCG on the practice nurse lead for the service on an annual basis and advise if they have a Diploma in Diabetes.

The practice will confirm that all practice nurses delivering this service have attended an annual diabetes update.

The practice will meet annually with the DNS, lead practice nurse and lead GP to reflect on the service and agree an action plan to support robust primary care services for people with diabetes and decrease hospital emergency admissions and clinic attendances. This may involve other members of the Diabetes intermediate team eg. Dieticians, podiatry. The action plan will be shared with the CCG.

Following foot examination, patients will be categorised in line with NICE Guidance into:

- Ulcerated or Charcot
- High risk (ie. Have had an ulcer)
- At increased risk (ie. have not had ulcer but have an increased risk due to neuropathy, absent pulse etc)

This classification will be used in referrals to intermediate and specialist services.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not applicable

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement