SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	**03_CVDS_40**
Service	Diabetes – new model
Commissioner Lead	CVDS CCP
Provider Lead	
Period	1 April 2015 – 31 March 2017
Date of Review	31 March 2016

1. Population Needs

1.1 National/local context and evidence base

At March 2014, there were 38,200 patients aged 17+ registered with diabetes in Dorset, accounting for nearly 6% of the aged 17+ population. The prevalence is expected to rise, associated with higher levels of obesity, to 9% by 2025.
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 complications; 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 7.6% 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

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, 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 have 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.

3. 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

4. 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 and up to a limit of the 80% target. See current expected v actual prevalence in Appendix 2.

	2012 Expected population with Diabetes 16+	Prevalence	Lower uncertainty limit	Upper uncertainty limit
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

5. Diabetes as a cardiovascular disease
Practices should do an annual pulse check on people over 45 with diabetes as a screening tool to detect atrial fibrillation as diabetic patients are at greater risk. 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. Practices should aim for 50% of people over 45 having a pulse check.

For Type 1 & 2 diabetics the lipid modification NICE guidelines, CG181, will be applied. QRISK2 risk assessment tools will be used. Primary prevention of CVD and the consideration for statins treatments will be made for all adults with Type 1 diabetes and for Type 2 diabetics who have a 10% or greater risk of developing CVD.

It is recommended that consideration is given to assess diabetic patients over the age of 65 against the New York Heart Association (NYHA) breathlessness scale. For patients that are assessed as being in Class II or above, it is recommended that consideration of Brain natriuretic peptide (BNP) testing be undertaken. Practices should aim for 50% of people over 65 being risk assessed.

For people who have a BMI higher than 30, practices should offer lifestyle advice, support and assessment to control obesity. Bariatric Surgery should only be considered where patients are prepared to make considerable changes to their eating patterns and commit to attend and successfully complete the Tier 3 weight management programme (Weight Management Tier 3 programme)

6. Foot care training
Practice nurses delivering diabetic care should attend an annual foot care review training session (held four times per year) or undertake on-line training at www.diabetesframe.org and submit a certificate to demonstrate completion.

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

- Ulcerated or Charcot
- High risk (i.e. Have had an ulcer)
- At increased risk (i.e. 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.

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).

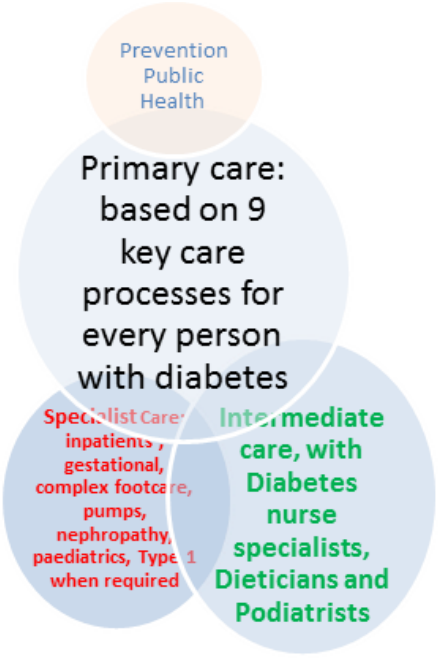

Diagram 1: Dorset Tiered model of care for people with Diabetes

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

3.4 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 (e.g. NICE)

National Diabetes Audit 2012-13, 9 Care processes and Treatment targets

The 15 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 (e.g. 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 e.g. Dieticians, podiatry. The action plan will be shared with the CCG.

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

Not applicable

Appendix 1

Percentage of all patients in Dorset receiving NICE recommended care processes by care process type.

RAG - Individual Care Processes	RAG - All eight Care processes
■ <90%	■ <55%
■ 90% - 95%	■ 55% - 65%
■ >95%	■ >65%

A red, amber, green scale has been used in Table 3 to indicate the level of achievement.

Table 3: Percentage of patients in NHS Dorset CCG and England and Wales receiving NICE recommended care processes (excluding eye screening) by care process, diabetes type and audit year

		All diabetes[a]			Type 1			Type 2		
		2010-2011	2011-2012	2012-2013	2010-2011	2011-2012	2012-2013	2010-2011	2011-2012	2012-2013
HbA1c[b,c]	CCG/LHB	94.1% ■	91.6% ■	93.0% ■	90.2% ■	88.4% ■	86.1% ■	94.9% ■	92.3% ■	94.1% ■
	England & Wales	92.5% ■	90.3% ■	92.4% ■	86.0% ■	83.0% ■	80.5% ■	93.5% ■	91.3% ■	93.8% ■
Blood pressure	CCG/LHB	95.4% ■	95.1% ■	94.5% ■	90.7% ■	90.8% ■	88.4% ■	96.1% ■	95.8% ■	95.3% ■
	England & Wales	95.0% ■	95.0% ■	95.3% ■	88.7% ■	88.4% ■	88.8% ■	95.9% ■	95.8% ■	96.1% ■
Cholesterol	CCG/LHB	92.8% ■	92.1% ■	91.4% ■	86.1% ■	84.2% ■	82.2% ■	93.9% ■	93.2% ■	92.6% ■
	England & Wales	91.6% ■	90.9% ■	91.1% ■	78.8% ■	77.8% ■	78.0% ■	93.1% ■	92.4% ■	92.5% ■
Serum creatinine	CCG/LHB	94.4% ■	94.2% ■	93.5% ■	87.9% ■	87.2% ■	85.7% ■	95.3% ■	95.0% ■	94.5% ■
	England & Wales	92.5% ■	92.5% ■	92.5% ■	81.2% ■	81.1% ■	81.0% ■	93.8% ■	93.8% ■	93.7% ■
Urine albumin[d]	CCG/LHB	80.1% ■	80.5% ■	76.7% ■	62.9% ■	64.5% ■	59.2% ■	82.5% ■	82.5% ■	78.8% ■
	England & Wales	75.1% ■	76.0% ■	73.6% ■	58.4% ■	59.2% ■	57.1% ■	77.1% ■	77.9% ■	75.4% ■
Foot surveillance	CCG/LHB	85.5% ■	86.9% ■	85.9% ■	74.0% ■	76.7% ■	75.3% ■	87.2% ■	88.4% ■	87.4% ■
	England & Wales	84.3% ■	85.3% ■	85.1% ■	71.5% ■	72.8% ■	72.3% ■	86.1% ■	87.0% ■	86.7% ■
BMI	CCG/LHB	90.1% ■	91.1% ■	90.7% ■	85.3% ■	89.2% ■	88.3% ■	91.0% ■	91.5% ■	91.3% ■
	England & Wales	89.9% ■	90.3% ■	90.7% ■	83.4% ■	83.7% ■	84.1% ■	90.8% ■	91.3% ■	91.5% ■
Smoking	CCG/LHB	86.4% ■	86.8% ■	87.0% ■	84.8% ■	84.4% ■	83.6% ■	86.8% ■	87.2% ■	87.5% ■
	England & Wales	84.8% ■	85.1% ■	86.1% ■	78.6% ■	79.0% ■	79.8% ■	85.7% ■	85.9% ■	86.8% ■
Eight care processes[c,e]	CCG/LHB	67.4% ■	67.0% ■	65.4% ■	50.7% ■	49.7% ■	46.6% ■	69.9% ■	69.2% ■	67.7% ■
	England & Wales	60.6% ■	60.5% ■	59.9% ■	43.3% ■	43.2% ■	41.3% ■	62.8% ■	62.6% ■	61.9% ■

[a] All diabetes includes maturity onset diabetes of the young (MODY), other specified diabetes and not specified diabetes.

[b] For patients under 12 years of age, 'all care processes' is defined as HbA1c only as other care processes are not recommended in the NICE guidelines for this age group.

[c] There has been an issue identified with the data supplied to the HSCIC for the 2011-12 Audit, which was restricted to HbA1c (blood glucose) recording across a number of practices in this CCG. This did not materially affect the findings in the National report. Caution should be taken when comparing data, for HbA1c and all eight care processes.

[d] There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR); please see the NDA Methodology section of the main report.

[e] The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care processes that are listed above.

Source: National Diabetes Audit 2012/13: Report 1: Care Processes and Treatment Targets

Appendix 2 – Practice list size for those under 80% of expected prevalence (based on QOF data 2013/14)

GP Practice	Locality	Number of registered patients age 17+ (end March 2014)	Registered diabetes patients per practice (March 2014 from QOF data)	Expected register size	% Expected prevalence achieved
Y02650 - Weymouth Community Hospital Walk-in Health Centre	Weymouth & Portland	401	9	30	30%
J81645 - Boscombe Manor Medical Centre	East Bournemouth	2,453	75	186	40%
J81033 - Talbot Medical Centre	Bournemouth North	15,286	542	1162	47%
J81072 - Panton Practice	Central Bournemouth	10,233	392	778	50%
J81003 - Alma Partnership	Bournemouth North	7,831	308	595	52%
J81024 - Holdenhurst Road Surgery	Central Bournemouth	8,314	345	632	55%
J81634 - Providence Surgery	East Bournemouth	7,723	321	587	55%
J81004 - Poole Road Medical Centre	Poole Bay	7,490	340	569	60%
J81078 - Bute House Surgery	North Dorset	4,450	207	338	61%
J81647 - Lyme Bay Medical Practice	Dorset West	1,839	86	140	62%
J81637 - Prince of Wales Surgery	Mid Dorset	4,351	207	331	63%
J81616 - Puddletown Surgery	Mid Dorset	3,359	160	255	63%
J81067 - Littledown Surgery	East Bournemouth	3,420	165	260	63%
J81074 - Barton House Medical Practice	Dorset West	4,857	237	369	64%
J81086 - Evergreen Oak Surgery	Poole Central	4,137	202	314	64%
J81613 - Dorchester Road Surgery	Weymouth & Portland	3,897	192	296	65%
J81018 - Beaufort Road Surgery	East Bournemouth	8,959	444	681	65%
J81624 - Crescent Surgery	East Bournemouth	1,728	86	131	65%
J81054 - Lilliput Surgery	Poole Bay	8,081	404	614	66%
J81012 - Parkstone Health Centre	Poole Bay	8,354	425	635	67%
J81626 - Fordington Surgery	Mid Dorset	3,138	160	238	67%
Y03661 - Lyme Regis Medical Centre	Dorset West	3,685	192	280	69%
J81042 - The Village Surgery	Bournemouth North	7,662	401	582	69%
J81625 - Denmark Road Medical Centre	Central Bournemouth	5,843	306	444	69%
J81644 - Old Dispensary Medical Practice	East Dorset	2,710	142	206	69%
J81059 - Southbourne Surgery	East Bournemouth	6,979	367	530	69%
J81021 - Shelley Manor	East Bournemouth	9,842	521	748	70%
J81016 - Queens Avenue Surgery	Mid Dorset	5,922	315	450	70%
J81609 - Portesham Surgery	Dorset West	2,379	128	181	71%
J81082 - Cornwall Road Medical Practice	Mid Dorset	5,240	282	398	71%
J81066 - Stour Surgery	Christchurch	8,060	437	613	71%
J81019 - Whitecliff Group Practice	North Dorset	13,135	713	998	71%
J81048 - Wessex Road Surgery	Poole Bay	5,015	273	381	72%
J81076 - Maiden Newton, Pound Piece	Dorset West	4,738	258	360	72%
J81062 - St Albans Medical Centre	Central Bournemouth	8,414	460	639	72%
J81026 - Abbey View Medical Centre	North Dorset	12,102	665	920	72%
J81014 - Westbourne Medical Centre	Poole Bay	14,198	781	1079	72%
J81029 - Apples Medical Centre	North Dorset	4,376	242	333	73%
J81053 - Cerne Abbas Surgery	Mid Dorset	3,390	188	258	73%
J81628 - Charmouth Littlehurst Surgery	Dorset West	1,886	105	143	73%
J81075 - Cross Road Surgery	Weymouth & Portland	3,902	218	297	74%
J81005 - Bridport Medical Centre	Dorset West	15,406	861	1171	74%
J81087 - Birchwood Medical Centre	Poole North	7,228	404	549	74%
J81047 - James Fisher Medical Centre	Central Bournemouth	10,479	586	796	74%
J81034 - Quarter Jack Surgery	East Dorset	10,720	601	815	74%
J81031 - Eagle House Practice	North Dorset	6,657	375	506	74%
J81058 - Cranborne Practice	East Dorset	7,692	448	585	77%
J81027 - Royal Crescent and Preston Rd Surgery	Weymouth & Portland	15,176	896	1153	78%
J81041 - Hadleigh Practice	Poole North	16,133	953	1226	78%
J81068 - Atrium Health Centre	Mid Dorset	6,171	365	469	78%
J81049 - Marine And Oakridge Surgeries	East Bournemouth	8,535	505	649	78%
J81046 - Harvey Practice	Poole North	9,835	583	747	78%
J81032 - New Land Surgery	North Dorset	5,213	310	396	78%