Hywel Dda Health Board
Local Enhanced Service for Structured Diabetic Care

1. Introduction

All practices are expected to provide the essential and additional services they are contracted to provide to all their patients. This specification outlines a more specialised service to be provided. The specification of this service is designed to cover enhanced aspects of clinical care of the patient, that go beyond the scope of essential services. No part of this specification by commission, omission or implication defines or redefines essential or additional services.

Diabetes mellitus is a common endocrine disease affecting all age groups. Effective monitoring and control of risk factors can reduce morbidity and mortality. General practitioners and their primary care teams can undertake most of the monitoring and management of diabetic patients, particularly for those with Type 2 disease. The Quality and Outcomes Framework (QOF) rewards practices for ensuring that systematic care has been provided.

The specification of this service, therefore, outlines a more specialised service to be provided, beyond the scope of GMS and the QOF. The purpose of this enhanced service is to enable the delivery of a more comprehensive, structured package of care to patients in primary care. The intention is to improve access to diabetic care closer to home and to reduce the number of routine patients seen and reviewed by Consultant Diabetologists and their teams within secondary care. The aim is to release specialists to provide rapid response to appropriate complicated patients.

2. Background

There is an increasing prevalence of long-term conditions in general and diabetes in particular. This places significant demands upon all health services but particularly in primary care. Patients with long term conditions:

- Account for 60 per cent of GP consultations[1];
- Occupy over 60 per cent of hospital beds provision;
- Are more likely to be admitted as emergency admissions;
- Need ongoing care that is coordinated across primary, community and secondary care as part of a 'whole systems' approach.

The national prevalence is 4.9% of the total population (Diabetes UK); HDHB prevalence was 4.98% in 2010-11 (QOF data / CMWeb).

Diabetes care can be provided effectively and efficiently within primary care providing that patients have easy access to high quality local services.

The enhanced service provides an incentive to practices to manage diabetic patients largely within primary care. As such, only some patients at high risk or with complicated diabetes will need hospital attendance. It is recognised therefore that the Diabetes Reference Group and Diabetologists must be confident in primary care's ability to care for this client group. The training and development of competent clinicians will be the responsibility of the practice aspiring to support the LES.

[1] Office for National Statistics quoted in *Chronic disease: the hidden health agenda,* NHS Confederation, June 2003
[ii] Disease Prevalence in Wales: General Medical Services Quality and Outcomes Framework

Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the National Service Framework (NSF) standards and promote a safe, coordinated shift of patients from secondary care to primary care. The Health Board are committed to supporting the shift of resource from secondary care into primary care and will secure the appointments of Diabetic Nurse Specialists in each of the Health Board's Counties as well as providing dietetic and administrative support to compliment service delivery. As pressure on secondary care diabetic services eases, the Diabetologists will work in the community alongside localities and practices in a supportive role as appropriate to the case.

All such developments should be undertaken in partnership with colleagues in the practice's localities as well as the multi disciplinary team to ensure integrated service provision

Practitioners are reminded that there is no implication in the setting of enhanced service audit standards that they supersede JBS or NICE guidance. Practitioners should continue to work towards ideal treatment targets for individual patients.

3. Service Aims

1. To continue to support the development and maintenance of high quality care for people with diabetes in primary care.
2. To increase the proportion of people with diabetes being cared for in the community.
3. To increase the number of Annual Reviews conducted by the practice. (There are only a few reasons why an annual review needs to be routinely carried out in secondary care.)
4. To ensure that all routine care and follow up of clients with diabetes occurs in the practice setting, with appropriate clients being referred to secondary care as per referral guidelines.

This scheme seeks to ensure that there is the opportunity to provide optimum care in the primary care sector for clients identified from the above.

4. Requirements of Service Delivery

Funding will be conditional on the following criteria :

- **Minimum Standard of QOF Achievement:** There will be two thresholds of service delivery, both will require the practice to have achieved 85 QOF points in the diabetes clinical domain in the preceeding year.
    - **Level 1 :** For practices undertaking the LES for the first year or those currently still working to achieve full accredited status – the practice can claim for up to 60% of patients on the diabetes register who are managed by the practice as part of this LES
    - **Level 2 :** For practices who have undertaken the LES in previous years and who meet the full requirements for accreditation – the practice can claim for up to 85% of patients on the diabetes register who are managed by the practice as part of this LES
- **Further Development and Maintenance of a Register:** The practice must be able to produce an up to date register of all patients with diabetes with details on where the patient received the majority of their care. The practice must maintain adequate records of each patient's attendance and the service provided on the clinical IT system via an LHB approved template and using approved Readcodes. Full records should be maintained in such a way that aggregate data and details of individual patients are readily accessible.

  Readcodes to be used for ALL patients to identify care arrangements:
    - Diabetic Practice Programme **66AP**
    - Diabetes shared care programme **66AQ**
    - Diabetes care by hospital only **66AU**

- Adverse Incident **– to be coded based on type**
- Non urgent diabetes admission **8H3O**
- Admitted – Diabetic emergency **8H2J**

- **Maximising the Local Delivery of Diabetes Management and Services**
  - **Annual Review :** General Practice already offer high quality and comprehensive annual reviews as part of QOF and it is an essential component of this LES that these are read coded in the patient clinical record. The Annual Review should as a minimum follow the QOF requirements and should be read coded as Diabetes Annual Review. It is a requirement that all those patients on the Diabetic Practice Programme receive a read coded Annual Review.
  - **Follow Up Review :** A minimum of two reviews per year is a requirement of this Enhanced Service (Annual Review and Follow Up) although all patients should receive as many reviews as their condition requires. It is expected that even well controlled patients should have a check of their blood pressure and HbA1c control every six months and this should be the minimum for a follow up review, this could be GP or nurse led as appropriate.
  - **Exceptions :** The core aim of this LES is to provide robust, co-ordinated care for all patients with diabetes and where clinically appropriate to bring this closer to home. It is expected that practices will work proactively to engage with patients beyond the requirements of QOF however, it is acknowledged that, in some cases exception reporting patients is unavoidable or clinically appropriate. The LHB would seek to work with practices who experience significant challenges engaging with their patients with diabetes.

  Readcodes for Management of Care are :
  - Diabetes Annual Review **66AS**
  - Diabetes Follow Up Review **66A2**
- **Appropriately Accredited Clinicians** (see further information below)
- **Sufficient Clinical and Administrative Support to Deliver Robust Primary Care Management**
  - A call / recall system for diabetes clinic appointments which should include robust follow up where the patient does not attend (DNA
  - Health promotion and the provision of appropriate diabetes literature to support self-care
  - Appropriate clinical care

  Readcodes for Organisation of Care are :
  - Diabetes 1st Invite **9OL4**
  - Diabetes 2nd Invite **9OL5**
  - Diabetes 3rd Invite **9OL6**
  - Diabetes DNA **9N4I**
- **National Diabetes Audit:** All Practices delivering the LES will be required to actively engage with the data submission and review process.
- **Audit Standards & Evaluation:** The data standards below will be used to support the Practice's end of year submission and claim for payment, it will also be used to support further development of diabetes management in primary and community care. Read codes have been provided as part of this document to aid consistent coding and audit at year end. Progress is being made on developing an automated tool for audit reporting and it is hoped that this will be made available to support practices in conducting the audit. The audit and data should be submitted to the Local Health Board no later than 30th April in year immediately following year of service provision to ensure timely and accurate achievement payment. The following

information will need to be demonstrated as part of the audit and will support further development of the primary care diabetes service:

- Total number of patients on QOF diabetes register
- Number of patients registered with Type 1 Diabetes
- Number of patients registered with Type 2 Diabetes
- Number of registered patients in the Practice Diabetes Programme
- Number of Patients receiving Shared Care
- Number of Patients receiving Secondary Care management
- Number of patients receiving Annual Review in Primary Care
- Number of Follow Up/Management appointments in Primary Care
- Number of Adverse Incidents, planned admissions and emergency admissions by key care provider (i.e. primary, shared or secondary care)
- Audits must reflect that you have reflected, reviewed and acted on current practice to ensure effective and improved service delivery.

5. Accreditation

A practice may be accepted for the provision of this LES if it has a GP Principal who has the necessary skills and experience to carry out the contracted care. GPs must demonstrate their competence by satisfactory completion of a recognised training course in diabetic care: For example:

- Chronic Disease Management of Diabetes, Multidisciplinary Masters Module, Swansea University/University of Wales;
- All Wales Foundation Course in Diabetes for General Practitioners, University of Wales College of Medicine;
- Warwick CDIC course or equivalent as agreed by the Health Board

Other courses, attending and on line are available.

All practices will be expected to engage in appropriate updates to maintain their clinical knowledge every year and discuss their role as diabetes practice lead, annually with their appraiser.

Where routine diabetes care is delivered by a Practice Nurse, it is expected that they also undertake the Swansea or equivalent course.

Where the practice initiates insulin or incretin mimetics, the Practice Nurse (or person initating insulin with the patient) will need to ensure that they have also satisfactorily completed the MERIT (or equivalent) course.

- **Level 1 :** Practices can undertake the LES at this level if they are currently engaged in completing the appropriate training or undertake to complete the training within the first 18 months of delivering the LES.
- **Level 2 :** Practices can undertake the LES at this level where they have fully satisfied the accreditation requirements outlined above.

Practices should note that insulin initiation is the subject of a separate Local Enhanced Service.

It should be noted that each individual clinician undertaking the LES will be required to meet the accreditation standards. It is the responsibility of the Practice to ensure that accreditation is sought as appropriate in order to provide the services.

6. Pricing & Payment

Practices not providing the additional structured care as outlined in this document will be receiving adequate funding through the QOF. In order to receive payment for the LES from 1st April in the current year of provision, practices will need to :

- Submit accreditation forms to the Health Board no later than 30th June in the current year of provision.
- Practices will need to register their intention to participate by indicating to the Health Board their aspiration level for the year. This will need to confirm the number of patients on the diabetic register, the % aspiration and the previous years diabetes QOF points.
- Submit an audit no later than 30th April in year immediately following year of service provision

Payment will be made on a sliding scale which aims to reflect the increased time required by the Practice to deliver care to more complex patients. Aspirational fees will be payable based on the number of patients on the diabetes QOF register at 31st March in the year immediately preceding the current year of provision and the percentage aspired to for the LES:

Level	% of Patients on Diabetic Practice Programme	Aspirational fee per Patient 50% of annual fee	Achievement fee per Patient 50% of annual fee	Total per Patient
1	First 60%	£12.00	£12.00	£24
2	First 60%	£12.00	£12.00	£24
2	61 – 70%	£25.50	£25.50	£51
	71 – 75%	£33.50	£33.50	£67
	76 – 80%	£38.00	£38.00	£76
	81 – 85%	£45.50	£45.50	£91

Aspiration Payment : will usually be made at the end of July following submission of Accreditation Forms

Achievement at the end of the year will be based on receipt of an appropriate audit as outlined above. The audit report should confirm :

- Total number of patients on the Practice Diabetes Programme who have had the minimum of an Annual Review and Follow Up Review coded in their clinical record.
- Total number of patients on the Practice QOF Diabetes Register (excluding those who have been exempted as per guidance above, please specify the number of patients exempted) as at 31st of March in the current year of delivery.

Achievement payment will be based on the percentage of patients on the Practice QOF Diabetes Register who are also on the Practice Diabetes Programme and paid according to the sliding scale above. Practices who fail to achieve, or exceed, their aspiration will be paid at their achievement level. The aspiration payment will be deducted from this final total payment and the balance will be paid to practices at the end of May following successful submission of the audit. It should be noted that in order to qualify for payment it is the responsibility of the practice to submit an adequate audit which demonstrates delivery of the services defined within this LES.

Hywel Dda Health Board

Appendix 1 : Accreditation Standards

Local Enhanced Service
Application for Accreditation as a Provider of Structured Diabetic Care Service

Background

This form is to be used by a person wishing to be accredited as a service provider to provide a structured Diabetic Care service under a Local Enhanced Service Scheme.

Definition

A "Service Provider" for the purpose of the structured Diabetic Care service Local Enhanced Service means any person who has the necessary skills and experience to carry out the contracted services in line with the principles of the generic GPs with special interests (GpwSI) guidance (see www.gpwsi.org) or as deemed appropriate by the LHB.

Accreditation

LHBs are responsible for ensuring that enhanced services are delivered by professionals who are properly qualified to do the job. The new GMS contract states that those doctors who have previously provided a similar enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as necessary to enable them to contract for enhanced services, shall be deemed professionally qualified to do so.

It is expected that the level of training required for a GP and other health professionals providing an enhanced service is identified in that person's continuous personal development plan (CPD) and, where additional training is required, local mechanisms are found to address this.

Accreditation of the service should be based upon a consideration of the service outline, as set out in the application for approval, and should be determined by the LHB Primary Care Development Lead upon the advice of the Medical and Nursing Directors. Practice visits will provide the opportunity to explore in more detail any issues which might arise in the provision of the service.

All doctors directly involved in the provision of an enhanced service should be required to identify that responsibility within their CPD plans and discuss the related professional development with their appraiser. They need to assure the Medical Director of the LHB that this has been done and the appraisal signed off. A similar model will apply for any practice nursing staff providing direct enhanced services.

Objective

To provide a means whereby only accredited persons will actually provide a structured Diabetic Care service Local Enhanced Service on behalf of the practice.

Details of Provider

Title	Dr/Sister/Mr/Mrs/Ms/Miss		
Surname		**Forename(s)**	
Date of first full registration with a professional body		**Registration Number**	
Name of Professional Body			

RELEVANT POST GRADUATE QUALIFICATIONS

Title of Qualification	Date Awarded

RELEVANT EXPERIENCE

Please give information about all relevant experience in the last five years *(N.B. any references held should be supplied)*

In hospital and/or community posts

From	To	Post	Employing Authority

Providing a structured Diabetic Care service in general practice

From	To	Practice Address	Summary of Service

RELEVANT COURSES

From	To	Title of Course	Organiser

APPRAISAL, REVALIDATION AND CONTINUOUS PERSONAL DEVELOPMENT PLAN

Please attach any relevant documentation to support this application.

Agreement and Declarations

The Practice will deliver the structured Diabetic Care service according to the LES service specification at (please tick ONE box as appropriate):

☐ **Level 1** – this is the **first year** we have offered the LES and we either meet the accreditation standards or commit to meeting them within the next 18 months

☐ **Level 1** – this is a **subsequent year** we have offered the LES and we do not currently meet the accreditation standard but will within the next 18 months (where this is met within the first 6 months of the LES, consideration will be given to the Practice delivering Level 2 if appropriate)

☐ **Level 2** – this is a subsequent year we have offered the LES and we full meet the accreditation standard

The total number of patients registered on the QOF Diabetic Register at 31st March 2012 are

…….

The Practice aspires to deliver the structure diabetic care service to ……% of registered patients with diabetes.

We declare that we :

- Have read and will meet the requirements of the Practice under the LES service specification.
- Will provide an appropriate audit according to the terms outlined in the LES no later than 30th April in year immediately following year of service provision in order to be eligible for an achievement payment.
- We will complete a further accreditation form if full accreditation is met within the year where the Practice has previously delivered the LES and would like to be considered for Level 2.
- To give notification, within 72 hours of the information becoming known to me, to my LHB's Medical Director of all emergency admissions or deaths of any patient covered under this scheme, where such admission or death is or may be due to the performance of the LES in question or attributable to the underlying medical condition.
- The information on this form is correct.

I will claim the appropriate payment for the structured Diabetic Care service Local Enhanced Service. An audit trail will be available at the practice for inspection by the LHB's authorised officer or officers acting on its behalf by BSC Wales and auditors appointed by the LHB and Audit Commission.

Applicant's Signature _____ Date _____

Practice Stamp:

OFFICIAL USE ONLY

Application Checked By		**Date Received**	
Application Approved		**Application NOT Approved**	
Reason for NOT approved			
Signed		**Date**	