SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	11J_0217
Service	Diabetes Care
Commissioner Lead	Service Delivery Team
Provider Lead	Primary Care
Period	1ST April 2017 – 31st March 2018
Date of Review	31.3.18

1. Population Needs

1.1 National/local context and evidence base

At March 2016, there were 40,300 patients aged 17+ registered with diabetes in Dorset, accounting for just over 6% of the aged 17+ population. The prevalence is expected to rise, associated with higher levels of obesity, to 9.7% by 2035.

Type 2 diabetes accounts for 90% 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.

The CCG has experienced a lower than the national average participation rate (and second lowest in Wessex) in the National Diabetes Audit (NDA). This has resulted in difficulty understating the needs of our local population as well as rating the CCG as “requiring improvement” for diabetes care in its Improvement and Assessment Framework (IAF).

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.

The service aims to incorporate all elements of the overleaf model. 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).

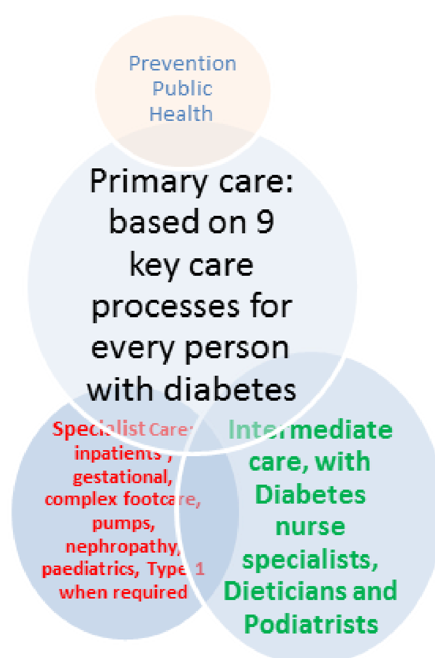

Diagram 1: Dorset Tiered model of care for people with Diabetes

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.

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.

3.2 Service description/care pathway

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

1. Data transparency and reporting

The results of this service will be shared across all providers of the service and locality working arrangements and commissioning teams. This shall be via agreed local mechanisms that support service improvement such as PRIMIS.

GP Practices shall ensure that they fully support and enable the annual "take" of the National Diabetes Audit (NDA) data each year from the information that they have available. This is a mandatory requirement for all practices. Further information and detail on the NDA and the actions to be undertaken by practices can be found in Appendix 3 and at http://www.hscic.gov.uk/nda

2. Improve consistently high standards of diabetic care by:

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

Mandatory participation in the annual National Diabetes Audit.

Conducting reviews every 6 months with patients who have Type 2 diabetes on insulin.

Conducting reviews every 6 months for people age 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.

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.

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.

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 prevalence in Appendix 2.

	2017 Expected population with Diabetes 16+	Prevalence	Lower uncertainty limit	Upper uncertainty limit
NHS Dorset CCG	59,692	9.0%	5.6%* TBC	11.1%* TBC

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.

3.3 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, all such practice nurses shall be 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 confirm that there is a practice nurse lead for the service who has a Diploma in Diabetes on an annual basis.

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.

This will contribute to locality based arrangements to support effective provision as part of the Dorset STP and utilise the opportunities presented through the use of PRIMIS/GRASP

tools at both practice and locality level.

Action plans will be shared with the CCG to support the development of improved clinical models as part of a Dorset wide approach.

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.

1a) 2010/11 to 2012/13

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

1b) 2014/15 and 2015/16

		Type 1		Type 2	
		2014-15	2015-16	2014-15	2015-16
HbA1C	CCG	89.0	89.1	94.7	95.1
	England	84.0	84.5	94.9	95.1
Blood Pressure	CCG	91.1	91.5	95.8	95.8
	England	89.3	89.4	96.2	95.8
Cholesterol	CCG	81.5	84.7	92.9	93.2
	England	79.5	80.0	93.2	93.1
Serum Creatinine	CCG	86.3	87.6	95.3	95.5
	England	81.1	82.1	94.6	94.8
Urine Albumin	CCG	63.8	59.9	76.8	70.2
	England	56.7	51.0	74.9	66.8
Foot Surveillence	CCG	73.9	75.2	87.6	88.3
	England	73.4	73.7	87.2	87.1
BMI	CCG	83.7	85.4	85.1	86.6
	England	75.4	75.8	83.2	82.8
Smoking	CCG	83.2	85.6	88.3	89.6
	England	78.3	79.0	85.3	85.4
All Eight Care Processes	CCG	47.3	47.0	63.6	60.4
	England	39.6	37.3	59.0	53.9

Source: National Diabetes Audit 2014/15 and 2015/16 Report 1: Care Processes and Treatment Targets

Appendix 2 Practice list size and % expected prevalence (based on QOF data 2015/16)

		2015-16 QOF Data (End March 2016)		
Practice code	Practice Name	Number of Registered Patients Age 17+	Registered Diabetes Patients age 17+ per Practice	% Expected Prevalence Achieved
J81002	ORCHID HOUSE SURGERY	7,532	616	91.17
J81003	ALMA PARTNERSHIP	7,395	333	57.70
J81004	POOLE ROAD MEDICAL CENTRE	7,772	356	100.00
J81005	BRIDPORT MEDICAL CENTRE	15,360	910	98.90
J81006	THE ADAM PRACTICE	25,644	1,892	100.00
J81009	ROYAL MANOR HEALTH CARE	9,964	749	97.65
J81010	SWANAGE MEDICAL PRACTICE	9,872	726	98.21
J81011	WAREHAM SURGERY	6,759	504	94.38
J81012	PARKSTONE HEALTH CENTRE	8,434	446	99.78
J81013	CANFORD HEATH GROUP PRACT	9,472	611	97.14
J81014	WESTBOURNE MEDICAL CENTRE	15,061	796	100.00
J81016	QUEENS AVENUE SURGERY	6,137	329	95.62
J81017	YETMINSTER MEDICAL CENTRE	3,075	202	87.24
J81018	BEAUFORT ROAD SURGERY	9,068	465	97.62
J81019	WHITECLIFF GROUP PRACTICE	13,229	794	96.59
J81020	BERE REGIS SURGERY	3,052	204	98.20
J81021	SHELLEY MANOR MEDICAL CENTRE	10,220	510	96.83
J81022	WEST MOORS GROUP PRACTICE	4,478	319	100.00
J81024	HOLDENHURST ROAD SURGERY	8,490	371	98.66
J81025	THE WELLBRIDGE PRACTICE	5,165	333	80.94
J81027	ROYAL CRESCENT SURGERY	15,272	972	100.00
J81028	HIGHCLIFFE MEDICAL CENTRE	9,111	671	97.45
J81029	THE APPLES MEDICAL CENTRE	4,437	259	95.22
J81030	THE VERWOOD SURGERY	6,693	434	99.69
J81031	EAGLE HOUSE SURGERY	6,649	420	100.00
J81032	NEWLAND SURGERY	5,154	333	89.81
J81033	TALBOT MEDICAL CENTRE	16,341	595	87.52
J81034	QUARTERJACK SURGERY	10,965	614	100.00
J81035	MILTON ABBAS SURGERY	2,995	185	99.77
J81036	THE ROSEMARY HEALTH CTR	6,442	433	100.00
J81038	NORTHBOURNE SURGERY	4,801	342	97.90
J81039	MOORDOWN MEDICAL CENTRE	6,654	414	100.00
J81040	STALBRIDGE SURGERY	3,762	271	96.74
J81041	THE HADLEIGH PRACTICE	16,236	1,006	99.28
J81042	VILLAGE SURGERY	8,155	419	100.00
J81043	THE BARN SURGERY	5,546	402	76.97
J81044	HEATHERVIEW MEDICAL CTR.	8,095	505	96.19
J81045	KINSON ROAD MEDICAL CENTRE	6,558	519	89.45
J81046	THE HARVEY PRACTICE	9,904	633	100.00
J81047	JAMES FISHER MEDICAL CENTRE	10,312	594	97.00
J81048	WESSEX ROAD SURGERY	5,051	280	100.00
J81049	THE MARINE & OAKRIDGE PARTNERSHIP	8,502	528	91.58

J81050	BURTON & BRANSGORE MEDICAL CENTRE	7,374	510	73.15
J81051	WYKE REGIS MEDICAL PRACTICE	6,491	457	96.45
J81052	CARLISLE HOUSE SURGERY	4,905	335	99.72
J81053	CERNE ABBAS SURGERY	3,414	193	100.00
J81054	LILLIPUT SURGERY	8,056	387	100.00
J81055	ABBOTSBURY ROAD SURGERY	7,654	544	92.20
J81056	THE ORCHARD SURGERY	6,035	429	98.77
J81057	FARMHOUSE SURGERY	5,413	387	99.16
J81058	THE CRANBORNE PRACTICE	7,962	518	100.00
J81059	SOUTHBOURNE PRACTICE	7,166	401	84.44
J81061	PENNY'S HILL PRACTICE	7,459	582	100.00
J81062	ST ALBANS MEDICAL CENTRE	8,317	474	91.45
J81063	DURDELLS AVENUE SURGERY	2,464	196	100.00
J81064	POOLE TOWN SURGERY	3,190	287	99.76
J81065	MADEIRA MEDICAL CENTRE	6,618	478	100.00
J81066	STOUR SURGERY	8,045	455	100.00
J81067	LITTLEDOWN SURGERY	3,644	190	97.50
J81068	ATRIUM HEALTH CENTRE	6,569	402	83.50
J81069	LONGFLEET HOUSE SURGERY	3,737	254	80.86
J81070	THE BANKS & BEARWOOD MEDICAL CENTRE	7,731	496	100.00
J81071	LEYBOURNE SURGERY	3,283	236	100.00
J81072	THE PANTON PRACTICE	11,286	404	94.36
J81073	THE BRIDGES MEDICAL CTR.	11,496	852	89.05
J81074	BARTON HOUSE MED PRACTICE	4,868	255	99.99
J81075	CROSS ROAD SURGERY	3,989	240	93.84
J81076	THE TOLLERFORD PRACTICE	4,859	280	99.99
J81077	WALFORD MILL MEDICAL CENTRE	5,356	321	98.60
J81078	BUTE HOUSE	4,653	235	93.50
J81081	GILLINGHAM MEDICAL PRACTICE	9,925	752	99.16
J81082	POUNDBURY DOCTORS SURGERY	5,439	328	90.92
J81086	EVERGREEN OAK SURGERY	4,282	234	96.27
J81087	THE BIRCHWOOD PRACTICE	7,310	444	100.00
J81090	THE LANEHOUSE SURGERY	2,638	213	77.33
J81609	MALTHOUSE MEADOWS SURGERY	2,501	134	79.48
J81612	CORFE CASTLE SURGERY	1,992	149	100.00
J81613	THE DORCHESTER RD SURGERY	4,139	224	96.84
J81616	PUDDLETOWN SURGERY	3,450	191	100.00
J81620	BLACKMORE VALE PARTNERSHIP	19,707	1,223	98.87
J81621	THE MEDICAL CENTRE (CORBIN AVE)	4,582	276	100.00
J81624	CRESCENT SURGERY	2,184	105	63.85
J81625	DENMARK ROAD MEDICAL CENTRE	6,393	322	72.74
J81626	FORDINGTON SURGERY	3,405	197	100.00
J81628	CHARMOUTH MEDICAL PRACTICE	1,953	108	81.15
J81631	SANDFORD SURGERY	1,871	140	99.67
J81632	HERBERT AVENUE	2,776	206	100.00
J81633	WOODLEA HOUSE SURGERY	3,159	214	100.00
J81634	PROVIDENCE SURGERY	8,052	362	62.13
J81637	THE PRINCE OF WALES SURGERY	4,754	245	95.77
J81640	VILLAGE MEDICAL PRACTICE	1,673	143	79.40
J81644	THE OLD DISPENSARY	2,871	144	100.00

J81645	BOSCOMBE MANOR MEDICAL CENTRE	2,546	91	85.69
J81646	GROVE SURGERY	4,392	282	100.00
J81647	LYME BAY MEDICAL PRACTICE	1,965	99	100.00
J81648	DR NEWMAN	2,930	187	99.53
Y02650	WEYMOUTH COMMUNITY HEALTH CENTRE	323	8	87.21
Y03661	LYME REGIS MEDICAL CENTRE	3,496	189	83.02

Appendix 3 National Diabetes Audit (NDA) Submission Supporting Information

The National Diabetes Audit (NDA) is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales.

The National Diabetes Audit (NDA) answers four key questions:

- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
- What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
- For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

Through participation in the audit, local services are able to benchmark their performance and identify where they are performing well, and improve the quality of treatment and care they provide.

The National Diabetes Audit (NDA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme (NCA) and delivered by the Health and Social Care Information Centre in partnership with Diabetes UK and the National Cardiovascular Intelligence Network (part of Public Health England). The NDA receives expert input from clinicians and people with diabetes across England and Wales. The audit is supported by the National Clinical Director for Obesity and Diabetes, Professor Jonathan Valabhji and the Royal College of General Practitioners.

The results of the audit are used to inform national, regional and local improvement planning and more specifically the Right Care programme and the CCG's rating in its Improvement and Assessment Framework for Diabetes (currently assessed at Needs Improvement). As part of NHS Dorset CCG, you therefore play a key role in enabling us to plan future commissioning and support for patients in Dorset.

You will also be able to use your participation in the NDA as evidence under the new regulatory requirement by the CQC for practices to undertake a programme of audits.

The most recent NDA results for Dorset are based upon a participation rate of 69.4% of practices and we are require your support to achieve 100% participation.

The timescales for the 2016-17 collection of the NDA are still to be finalised nationally but we anticipate that if it is the same as previous years, this will be for a 6 week period between June and August.

So that you can keep up to date with the latest information about the audit and how to participate or what support is available to help your practices to participate, please register your contact details

with the NDA team ahead of the next collection of the audit by e-mailing diabetes@nhs.net. Please include the following in your email: - *name, email address, job title, practice name/CCG name, practice code/CCG code, clinical system (if applicable)*.

The participation method will be specific to the clinical system you are using:-

- TPP practices participate via your system settings. This means that your data will be automatically extracted by TPP. You will need to make sure that your settings are correct by a specific date (to be advised by the national NDA team) to be included in the extraction.
- Practices using EMIS Web are required to register for an account with the HSCIC website; an NHS.net email address is required to begin the registration process. Practices are able to access the NDA data through a report in their EMIS Web clinical systems and once the NDA data is extracted this can then be submitted to the HSCIC website.
- Practices using other clinical systems require an Open Exeter account to submit MiQuest queries. Practices require a Data Guardian to be registered for their practice before they can register for an Open Exeter account. Once both registrations are in place, practices can run MiQuest queries and submit their downloaded data to the NDA through Open Exeter.

More detailed information about running queries is available on the hscic website and will be shared with registered practices by the national team.

Fair processing

As the HSCIC has approval by the Confidentiality Advisory Group (CAG) of the Health Research Authority to collect patient identifiable data under Section 251. This means that patients do not have to give their consent for their data to be submitted to the NDA. So there are no legal obstacles to GP practices submitting their patient's data to the NDA.

However, people with diabetes who are registered with your practice should be made aware that their service is participating in the NDA. This is known as 'fair processing'.

An NDA poster and patient information leaflet are available for download to support your fair processing activity.

We suggest that all GP practices:

- display the NDA poster in waiting areas and relevant clinical areas
- make the NDA patient information available at reception and other relevant areas
- provide information and a link to the NDA patient information leaflet on their practice website

Further information and updates can be found on the NHS Digital website:

http://www.hscic.gov.uk/nda

Activity Report Template, 2017-18

1. **Improving consistently high standards of care: 9 Care Processes**

   There is a MIQUEST query that can be used for data capture and sent to Dorset CCG. The MIQUEST query will be summarised by Dorset CCG and returned to the GP practice to enable practices to be able to complete the practices' funding claims.

   Alternatively the practice level reporting mechanism available in PRIMIS can be used.

   % of people with diabetes aged 17+ with the 9 care processes recorded in previous rolling 12 month period:

	Initial %, on commencement	% at 6 months	% at 12 months
HbA1c			
Blood pressure			
Cholesterol			
Serum creatinine			
Urine albumin			
Foot surveillance			
BMI			
Smoking			
Eye screening			
All 9 care processes recorded			

2. **Promoting Shared care with Diabetes Nurse Specialists**

	Type 2 non-insulin		Type 2 insulin		Type 1	
	End Q2	End Q4	End Q2	End Q4	End Q2	End Q4
Number of people with diabetes receiving shared care: READ codes **66AQ:** Diabetes: shared care programme (Practice Nurse and DNS in primary care) , or **9NN9:** Under care of diabetes specialist nurse (care of DNS in the community)						

3. **Expected registers sizes are (*See Appendix 2*):**

	Number on diabetes register at commencement	% of practice population with Diabetes at commencement	End Q4:numbers added to registers	Final register size as % of practice population
People with Diabetes aged				

17+				

4. **Pulse Checks:**

Number of annual pulse checks	Number with arrhythmia (new diagnosis)	Number with AF (new diagnosis)

5. **Confirmation of practice submission to annual National Diabetes Audit (DNA)** ☐

6. **Quality Standards: to submit at end Q4:**
   1. Qualifications of Lead Practice Nurse for Diabetes and other Practice nurses with Diabetes qualifications
   2. Annual diabetes update training events and supervision attended by practice nurses
   3. Practice Diabetes Action Plan for 2018-19, having reviewed the following: emergency admissions, 9 care processes, foot referrals including the use of the required pro-forma and Hypo SWAST call outs.

Diabetes Annual Review (possible format)

Item	**Please comment**
Qualifications To be completed if lead nurse has changed since last year	
Training Annual diabetes update training events and supervision attended by practice nurses. Foot care: attach details of training attended by nursing staff	

Action Plan
Primary Care
What actions have you agreed in your team in relation to:
- Improving the recording of the 9 care process
- Improving the number of people within the recommended treatment targets for:
    o BP
    o Cholesterol
    o HBA1c
- Reducing emergency admissions
 	
Shared Care
 	
How many patients are recorded under shared care with the Diabetes Nurse Specialist?
Is the recording accurate?
Do you plan to change this in the coming year?
 	
Cardiovascular Risk Management
 	
Did you manage to reach the target of 50% of people over 45years having a pulse check?
 	
Did you manage to reach the target of 50% of people over 65yrs having a New York Heart Association (NYHA) breathlessness assessment?	

PMS Practices with Diabetes Care in their baseline:

Those practices with Diabetes care in their baseline budget are requested to submit the above information

Diabetes Pricing Structure

		Pricing Structure for quarter 4 update
1	8 care processes (Not Urine Albumin) (extracted via MIQUEST)	49% and under = 0
		50-54% : £1/registered patient with Diabetes
		55-59 : £2/registered patient with Diabetes
		60-64% : £3/registered patient with Diabetes
		65-69% : £4/registered patient with Diabetes
		70-74% : £5/registered patient with Diabetes
		75-79% : £6/registered patient with Diabetes
	Maximum £7.00 per diabetes patient	80%+ : £7/registered patient with Diabetes
2	Foot Care **Maximum £0.50 per Diabetes patient**	Annual attendance of the practice nurses delivering diabetic foot care, at the foot care review training (held four times per year) or submission of certificate to demonstrate completion of on-line training undertaken at www.diabetesframe.org 50p/registered patient with Diabetes
3	Shared care **Maximum £1.00 per Diabetes patient**	Practices have regular in-house clinics with the DNS, as defined by READ codes 50p/registered patient with Diabetes (Type 1 or 2) Annual review of practice diabetes service as detailed 50p/registered patient with Diabetes
4	Cardiovascular risk management **Maximum £1.00 per Diabetes patient**	Information to be provided in the annual review, detailing the number of pulse checks undertaken for diabetic patients over 45 50p / registered patient with Diabetes (Type 1 or 2) Information to be provided in the annual review, detailing the NY breathlessness score for patients over 65, demonstrating cardiovascular risk management 50p / registered patient with Diabetes (Type 1 or 2)
5	Early identification of disease	For practices with register size <80% of expected, £10 per new diabetes patient added will be paid. Payment will not be made for patients added to the register, when the register has reached or is over 80% of expected value