A Suite of Enhanced Services for

Prudent Structured Care for Adults with Type 2 Diabetes

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 patients with diabetes, particularly for those with Type 2 disease.

"Our plan for a primary care service for Wales up to March 2018" described how patients with chronic conditions would receive more of their care in the community from skilled multi-disciplinary teams based in primary care and lead by GPs. The All wales Diabetes Group has set up a working group, with a wide range of stakeholders, to develop new models of diabetes care outside of hospital.

Previously, the Quality and Outcomes Framework (QOF) has rewarded practices for ensuring that systematic care has been provided; this enhanced service intends to remunerate practices who offer care beyond the requirements of QOF. This suite of enhanced services consists of a foundation or 'gateway' module (a *Directed* Enhanced Service or DES), which all practices providing the enhanced services will undertake, to deliver enhanced reviews for patients with diabetes, and a series of separate optional modules (*National* Enhanced Services) which can only be adopted if the gateway module is in operation.

The purpose of this suite of enhanced services 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. Successful outcomes include the reduced rate of diagnosed diabetic patients being admitted as an inpatient or needing to see a secondary care consultant as an outpatient. Improved preventative care and self-care of diabetes, properly resourced, will ultimately reduce diabetic complications.

This suite of enhanced services follows prudent health care principles;

- An emphasis on co-produced management plans at an holistic annual review
- Recognition that not all patients require the same intensity of support from the practice team so those with the greatest need are offered the greatest input through the year.
- Do only what is needed, and not just tick boxes,
- An evidence based approach to care, participating in National Diabetes Audits and following RCGP Year of Care approaches

This more personalised approach to diabetic care, prioritising those patients with greatest need has been highlighted (as per the 4 principles illustrated above) as part of a prudent healthcare promoted by Welsh Government.

2. Background

This Suite of Enhanced services provides an incentive to practices to manage **adult patients with Type 2 diabetes largely within primary care,** with only those patients at high risk, or with complicated diabetes, being cared for in secondary care. Thus, these Enhanced Services do **not** apply to patients with Type 1 Diabetes Mellitus, children and adolescents, or pregnant women. There is no patient exception reporting as part of these enhanced services as practices are only expected to care for patients within their level of competence and not to meet a particular percentage.

Practitioners are reminded that Enhanced Service audit standards should not replace or supersede JBS or NICE guidance. Practitioners should continue to work towards ideal personalised treatment targets for individual patients. Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the national and local Diabetes Delivery Plan standards and promote a safe, coordinated shift of patients and resources from secondary care to primary care.

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 outside of hospital and enable the referral and discharge of patients from Secondary Care in accordance with appropriate clinical guidance.
3. To support all patients being cared for in Primary Care to receive a holistic Annual Review conducted by the practice,
4. Using prudent healthcare principles, to provide the necessary supportive monitoring reviews according to clinical guidance.
5. To ensure that all newly diagnosed patients with diabetes receive an enhanced review promoting awareness of the condition, self-care, on-going education and monitoring.

6. To provide data to clusters, LHBs and Welsh Government to inform the design and development of services for patients with Type 2 Diabetes Mellitus.

4. Modular Structure

This Suite of Enhanced Services has a modular structure, with one compulsory 'gateway module' (DES) and 4 optional modules (NESs).

"Gateway" Module: Prudent Enhanced Reviews of adults with Type 2 Diabetes
The 4 optional modules (NESs)

1. Monitoring of patients on Incretin Mimetics (GLP1s)
2. Initiation of Incretin Mimetics (GLP1s)
3. Monitoring of Insulin in adults with Type 2 Diabetes
4. Initiation of Insulin in adults with Type 2 Diabetes

The "Gateway module" (DES) being a *Directed Enhanced Service* must be offered to all practices at the stated payment rate. The 4 optional modules (NESs) being *National Enhanced Services* will be offered by Health Boards where local needs are identified, and when offered must as a minimum be paid at the nationally negotiated rate. Health Boards may wish to offer local enhanced services at higher rates than the National Enhanced Services (but *not* at lower rates).
Where existing local enhanced service arrangements for one or more of the optional modules are well established in a health board area and meet the healthcare needs of patients , health boards are expected to continue the local enhanced service provision, unless there is engagement and negotiation with the Local Medical Committee
The "Gateway" module (DES) must be delivered by all practices who undertake this enhanced service. The other 4 modules (NESs) are optional and cannot be provided without already delivering the "Gateway" module.

The "Gateway" module is paid according to the size of the population of registered patients with a Type 2 diabetes diagnosis. The other modules are paid on a fee-for-service basis.
The details on payments are given in each module.

5. Conditions for Service Delivery

Funding for any of the modules will be conditional on all the following criteria being achieved before commissioning:

1. **Maintenance of an accurate Diabetes Register:** The practice must be able to produce an up to date register of all patients with diabetes, whether the patient is managed exclusively in Primary Care or by Shared Care.
2. **Consistent Read coding:** The practice must ensure consistent coding of each care episode on the clinical IT system using approved Read codes (based on QOF Read codes). Use of National Templates is strongly encouraged.
3. **National Diabetes Audit:** All Practices delivering any modules of the Enhanced Service will be required to actively engage with the data submission and review process of the National Diabetes Audit. This means that practices must allow data extraction using Audit Plus software.
4. **Sharing Data:** Practices must agree to share data collected in the course of providing this enhanced service suite with clusters, the local Health Board and Welsh Government for the purpose of informing the design and development of diabetes services. For example; clusters may wish to use the data to support a business case for recruitment of community diabetes specialist nurses, or LHBs may wish to determine whether patients seen in outpatient clinics actually receive a full annual review.

5. **Practice leads for Diabetes:** All practices will have a named GP lead for diabetes and a named Practice nurse lead for diabetes (note the educational accreditation required in section 6)
6. **Practices will have the responsibility for selection of patients to have personalised care and extra reviews.** Practices will describe their methods of prioritising intervention to those patients who will benefit most and share those methods in peer discussions at the cluster meetings.

6: Accreditation

A practice may be accepted for the provision of a module or modules in this Enhanced Service only if it has a GP Principal or Salaried GP who has the necessary skills and experience to carry out the contracted care. The minimum level of skills and experience will vary between the modules.

Gateway Module: Prudent Enhanced Reviews of adults with Type 2 Diabetes;
The practice GP lead must be able demonstrate that they have adequate knowledge and skills through their annual appraisal. They will be expected to undertake regular educational updates and self-directed learning. Practice Lead nurses will also be expected to engage in updates to maintain their clinical knowledge every year and discuss their role as diabetes practice nurse 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.
Educational update courses should be provided by the Local Health Board.

It should be noted that each individual clinician undertaking the enhanced service 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.

Optional Modules 1 to 4:
Practice lead GPs must demonstrate their competence by satisfactory completion of a recognised training course in diabetic care, or by recording an aspiration to complete such a course within 2 years of initiating the enhanced service. 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
Bradford University ‘Diabetes Care in Clinical Practice’ or ‘Evidence-based Diabetes’ courses or their equivalent agreed by the Health Board/Associate Medical Director for Primary Care
Other courses, attending and online, are available as agreed by the Health Board/ Associate Medical Director for Primary Care and examples are listed in the appendix.

If a Practice Lead GP has been undertaking the services described within a module for several years, but does not possess an accredited qualification, then the Local Health Board/ Associate Medical Director for Primary Care will consider each application to conduct the enhanced service on its merits.

All practice lead GPs and lead Nurses 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 the practice initiates insulin, the Practice Nurse (or person initiating insulin with the patient) will need to ensure that they have also satisfactorily completed the MERIT (or equivalent) course.

It should be noted that each individual clinician undertaking these enhanced services 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.

7: Collaboration

Practices can collaborate with neighbouring practices to provide this service to patients. The practice (‘primary practice’) at which the patient is registered holds clinical governance responsibility. The ‘primary practice’ must ensure that the clinicians of the second practice are accredited to provide this enhanced service by the LHB. The ‘primary practice’ must advise the LHB of any such arrangements in their application to provide any module of the enhanced service **before** any service is provided. The LHB must agree to any collaborative arrangements **before** they commence, including that the clinicians are suitably accredited, and advise the practices on claiming and payment mechanisms in these individual cases.

8: Verification

A ‘high trust, low touch’ culture will prevail in the administration of this enhanced service. Claims may be subject to established post-payment verification check mechanisms.

9: Notice period

The contractor or the local health board may terminate the contracts by giving three months’ notice in writing.

Where care of the patient would need to be continued after the termination of this contract under a specialist (whether by a secondary care service or a cluster service or community service), the practice will take the responsibility to notify the patients of the new service, after discussion with the Local Health Board.

10: Significant events

The contractor will give notification to the Unit Medical Director or Head of Primary Care of the LHB within 72 hours of the information becoming known to the contractor of all emergency admissions or deaths of any patient covered under this contract, where such admission or death is or may be due to the performance of the contract in question or directly attributable to the underlying medical condition.

11; Indemnity

The contractor must ensure that its practitioners are adequately indemnified/insured for any liability arising from the work performed under the enhanced service.

Gateway Module: Prudent Enhanced Reviews of adults with Type 2 Diabetes

Introduction to the Gateway Module:

All practices contracting to deliver these Enhanced Services must undertake this core module, whether or not they deliver any other modules.

This core module is a Directed Enhanced Service which means that all contractors must be offered the opportunity to provide it at the stated payment rate.

Patients included in the Gateway Module:

All adults with Type 2 Diabetes Mellitus.

Patients who have the following criteria will be expected to be seen and appropriately reviewed by secondary care teams (so-called 'Super Six' patients), unless by agreement with the practice:

a. Pregnant
b. Severe Renal Disease
c. Children and Young people
d. Active Severe Foot disease
e. Insulin Pumps
f. Current Hospital Inpatients

A contractor is free to seek specialist advice on a patient if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist.
A contractor is free to use the skills of the LHB diabetic specialist nurse should this be in patient's best interest and according to prudent care principles.

Aim of the Gateway module:
This module is designed to reward practices that provide a level of personalised care above that provided under GMS Essential Services. The extra care includes a proactive personalised diabetic care package including promotion of self-management and holistic approach to the patient. Using nationally agreed templates, practices will collect data that can be used by clusters, LHBs and Welsh Government to plan future Diabetes Services.

(a) The Holistic Annual Review

All patients with Type 2 Diabetes can benefit from such an enhanced annual review (as decided by the practice) that goes beyond the recording of QOF indicators. The holistic nature of the review could involve the discussion of topics reflecting the impact of diabetes in the patient's life. E.g. DVLA advice, sick day rules, sign-posting to local support, and monitoring of emergency admissions for diabetes-related problems. A key feature will be to support early management of lifestyle issues.

(b) Co-produced Management Plan

All patients will have an agreed management plan to support their self-management of the condition for the rest of the year. This will help move away from a 'one-size fits all' approach of QOF targets. The plan may consist of

personalised goals
using online resources from Diabetes-UK
using existing resources embedded in GP Clinical systems that can be shared and personalised,
viewing Educational Videos,

undertaking educational courses (e.g. *X-PERT*),
joining support groups or events (e.g. '*Living with Diabetes' Day, Local Support Group),*
planned medication changes
referral for exercise/lifestyle advice
an agreement for further review(s) in the practice, if clinically necessary, as advised by the practice clinicians

(c) Extra reviews

Many patients will be well-controlled and their management plan will not require further management reviews that year. However, a large proportion of patients with Type 2 Diabetes Mellitus will not be well controlled will need a further review within the year according to their management plan. The practice will be responsible for exercising clinical judgement to identify patients who may need to be reviewed more often by the practice according to clinical need.

The reviews can be virtual, by email or by telephone, need not be face-to-face, and need not be with a GP if a nurse or health care support worker can safely deliver the management plan. Some practices may wish to offer group reviews, which recognise that patients and carers have their own expertise and experiences and can share these with others. This is in keeping with prudent health care principles.

(d) Data Collection

Using nationally agreed Diabetes Computer templates (Read codes), and allowing the data to be extracted anonymously from practice computer systems via Audit Plus, the data can be analysed by Cluster, LHB and national groups. This will allow service planning at cluster, LHB and national levels, with minimum workload for practices in the creation and extraction of data. Participation in the National Diabetes Audits will be mandatory.

(e) Feedback & Learning

The practice can use feedback from patients and the National Diabetes Audit to share lessons with Clusters, and inform the LHB if there are inadequate reviews occurring in secondary care.

Outcomes:

Patients should experience a more personalised approach to diabetes care, with improved outcomes such as fewer symptoms, fewer complications and greater activation and confidence in self-management of their condition. This is in keeping with Prudent healthcare principles. As a consequence of a practice adopting this module, the health board would expect to record a reduction in the number of patients being referred to outpatient Diabetologists, a reduction in the number of hospital admission or emergency attendances at the emergency department for hypo- or hyperglycaemic episodes, and a reduction in ambulances called out for the same emergencies. The practice would be able to prioritise how it uses it resources to provide the best value health care for those patients at greatest need.

Service Requirements of the Gateway Module:

The Holistic Annual review

1. All patients with type 2 Diabetes have appropriate recording of diabetic consultations using approved Read Coding via **nationally agreed Diabetes Templates for Vision/EMIS.**

2. Where the practice believes it is likely to help an individual patient, the **RCGP Year of Care model** could be considered patients have a two-stage *annual* review, with blood and urine tests, and other annual review parameters, checked at an initial visit, and the results shared with the patient (by letter, text, email or online) prior to or at their second visit to see the practice nurse or GP, typically two weeks later. This supports the evidence that the consultation with the GP or nurse is more effective as it is focussed on the patient's priorities, and is a more prudent use of the clinician's time. At the first visit, the parameters can be measured by a suitably trained Health Care Support Worker.
3. Where clinically indicated**, a Cardiovascular Risk assessment**, using a validated tool, should be conducted and recorded at least annually.
4. Where clinically indicated, **Medication reviews** will occur in line with NICE guidance, the BNF and/or the local health board formulary.
5. Where clinically indicated, the practice will undertake an holistic review that goes beyond QOF indicators, and may include the following;
    a. **Sick Day rules** (when to start and stop diabetes medication during inter-current acute illness) will be explained if appropriate.
    b. **DVLA advice** will be explained if appropriate.
    c. Patients should be **signposted to their local pharmacy** should they have any questions or queries regarding their medication or advice and help with their blood sugar monitoring equipment.
    d. Patients will be asked if they have had an unscheduled attendance at the emergency Department or of an admission to hospital for **hypoglycaemia or hyperglycaemia**. The practitioner will consider what further changes to medication or lifestyle advice are required, and record a plan.
6. All patients will have an **Co-produced Management Plan** to support their self-management of the condition for the rest of the year

The Co-produced Management Plan (Care Plan)

7. A **care plan** will be co-produced and shared with the patient, using a format discussed with the patient.
    a. This could take the form of an **online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or printed from on-screen forms/literature.
    b. **Information Prescriptions**, supported by Diabetes UK, can be shared or printed from within GP Clinical IT systems, and form part of the agreed care plan
    c. **Pocket Medic** videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes
8. Where a patient's management requires support from other agencies**, referrals to outside agencies** should be appropriately recorded in the care plan and within the nationally agreed Diabetes computer template; such as
    a. X-Pert or equivalent educational programme
    b. Expert Patient Programme
    c. Dietetics
    d. Podiatry
    e. Retinal Screening
    f. Exercise & Weight Programme
    g. National Exercise Referral Scheme
9. **Referrals to secondary care** for complex cases, or if very unstable, should also be Read coded in the computer record using agreed read codes;
    a. Pregnant
    b. Severe Renal Disease

   c. Children and Young people
   d. Active Severe Foot disease
   e. Insulin Pumps

10. Where clinically indicated, **Medication reviews** will occur in line with NICE guidance, the BNF and/or the local health board formulary.
11. As required by their clinical need, patients may be reviewed more often by the practice. However, the reviews can be virtual or by telephone, need not be face-to-face, and need not be with a GP if a nurse or health care support worker can safely deliver the management plan. Some practices may wish to offer group reviews, which recognise that patients and carers have their own expertise and experiences and can share these with others. This is in keeping with prudent health care principles.

Call & Recall

12. A robust **call and recall system** will be in place to facilitate an annual face to face review of all diabetic patients. This must be offered to all diabetic patients and the invitation recorded within the patient record.
13. A **second review** within the year should be offered to all diabetic patients, and these invitations should be recorded within the patient record.
14. **Further reviews** should be offered according to the patient’s clinical need.
15. Where a patient **does not respond** to an invitation for review, the practice will ensure that there is robust evidence of the attempt to contact the patient recorded in the patient’s clinical record. E.g. phone call, text, letter etc

Data Collection & Extraction

16. The practice must agree that data collected in the nationally agreed template can be extracted via Audit Plus Software for the purpose of **supporting planning of services** by clusters, the LHB and Welsh Government.
17. The practice must participate in the **National Diabetes Clinical Audits,** which involve automatic clinical data extraction via *Audit Plus Software.*

Feedback and Learning

18. At least once per year, the contractor will invite patients to give **feedback** on the service.
19. The practice will use the results of the National Diabetes Clinical Audit, and also the annual patient feedback, as the basis of a **discussion within the practice on the effectiveness, efficiency and value** of their practice services.
20. The practice will **share any learning points or action points** from this discussion with other practices in their **cluster**.
21. The practice, should it choose to offer the gateway module to patients under secondary care, may choose to inform the LHB if the patient is **not receiving adequate review** (see template letter in appendix).

Payments:

Payment will be based on the total number of patients in the practice with Type 2 diabetes at the end of each quarter. The annual payment will be based on £22.00 per patient with Type

2 Diabetes Mellitus per year. **Practices should claim on a monthly basis using Open Exeter. The OE code is ZDDIA2, the monthly payment will be £1.84 per patient paid in arrears.**

Optional Module 1: Monitoring of Injectable or oral Incretin Mimetics (GLP1s)

Introduction to Module 1:

This Module is a National Enhanced Service paid at the nationally negotiated rate.

This module outlines a more specialised service to be provided to those adult patients with Type 2 Diabetes who may benefit from continuing injectable or oral Incretin Mimetics (GLP1s).

Population to whom the Module 1 service will be offered

All patients with Type 2 Diabetes Mellitus aged 25 years or over who are likely to benefit from continuing Incretin Mimetics, excluding patients in the 'Super Six' categories.

Aim of Module 1:

To increase the proportion of patients with Type 2 Diabetes Mellitus who receive care and medication appropriate to their clinical need in a setting closer to home.

Clinical Governance:

The GP who performs the service under this module will hold medical responsibility for the patient. Any patient who receives the service from the contractor under this module must not concurrently be seeing a consultant diabetologist, or on the waiting list to be seen in an outpatient diabetologist clinic.

This means that the contractor must liaise with the consultant who is currently providing outpatient diabetes services and inform the consultant of the transfer of diabetes care and clinical responsibility for the monitoring of GLP1 medication to the GP. A template letter (Appendix X) should be used for this purpose. If the patient is not currently under a diabetologist, then the GP already holds full clinical responsibility.

If the services of a Diabetes Specialist Nurse are used to support a patient, then the overall clinical responsibility for the patient must rest with the contractor, not a secondary care specialist.

Subject to local agreement with secondary care colleagues, consultants may be willing to provide specialist advice lines to support GPs to manage these patients. These are not required to be in place for this module to be used.

A contractor is free to seek specialist advice if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist.

Service Outline:

1. Monitoring of Incretin Mimetics (e.g. GLP-1 drugs) in line with NICE guidance, the BNF and/or the local health board formulary
2. The contractor will write a letter (based on the template in Appendix X) to the secondary care consultant, if necessary, to inform him/her that the GP is taking over diabetes care from secondary care before commencing this enhanced service module for a patient.
3. The contractor will inform the patient of the transfer of diabetes care if necessary, and will record the conversation, or letter if needed (see Appendix Y for template letter), in the GP clinical record.

Accreditation for Module 1:

See section 6 in the main introduction.

Any such accredited doctor will work in line with the principles of the generic GPs with special interests (GPwSI) guidance (see https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf) or as deemed appropriate by the LHB.

Patient Documentation & Information

A **care plan** will be co-produced and shared with the patient (based on a national template).

- This could take the form of **an online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or printed from **on-screen forms/literature**.
- **Information Prescriptions**, supported by Diabetes UK, can be shared or printed from within GP IT systems, and form part of the agreed care plan
- **Pocket Medic** videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes

Record-Keeping

The contractor will record all clinical encounters in the lifelong computer clinical records of the patients held by the practice, using Read codes agreed with the Local Health Board or in a national template.

Payment

- For each patient undergoing incretin mimetics monitoring, exclusively managed by the contractor - £36.00 per person per year, paid quarterly in arrears
- The contractor will be deemed to be monitoring a patient if all of the following conditions apply
  - The contractor has the full clinical responsibility for the care of the patient's diabetes , AND…
  - The contractor has issued a prescription for an injectable or oral incretin mimetic (GLP1) in the preceding quarter
- The practice shall submit a claim each quarter with the number of patients it has monitored in that quarter. The contractor cannot claim for monitoring in the same quarter as initiation.

Optional Module 2: Initiation of Injectable or oral Incretin Mimetics (GLP1s)

Introduction to Module 2:

This Module is a National Enhanced Service paid at the nationally negotiated rate.

This module outlines a more specialised service to be provided to those adult patients with Type 2 Diabetes who may benefit from starting injectable or oral Incretin Mimetics (GLP1s).

Population to whom the module 2 service will be offered

All patients with Type 2 Diabetes Mellitus aged 25 years or over who are likely to benefit from starting Incretin Mimetics, excluding patients in the 'Super Six' categories.

Aim of Module 2:

To increase the proportion of patients with Type 2 Diabetes Mellitus who receive care and medication appropriate to their clinical need in a setting closer to home.

Clinical Governance:

The GP who performs the service under this module will hold medical responsibility for the patient. Any patient who receives the service from the contractor under this module must not concurrently be seeing a consultant diabetologist, or on the waiting list to be seen in an outpatient diabetologist clinic.

This means that the contractor must liaise with the consultant who is currently providing outpatient diabetes services and, and inform the consultant of the transfer of diabetes care and clinical responsibility for the initiation of GLP1 medication to the GP. A template letter (Appendix X) should be used for this purpose. If the patient is not currently under a diabetologist, then the GP already holds full clinical responsibility.

If the services of a Diabetes Specialist Nurse are used to support a patient, then the overall clinical responsibility for the patient must rest with the contractor, not a secondary care specialist.

Subject to local agreement with secondary care colleagues, consultants may be willing to provide specialist advice lines to support GPs to manage these patients. These are not required to be in place for this module to be used.

A contractor is free to seek specialist advice if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist.

Service Outline:

1. Initiation of Incretin Mimetics (e.g. GLP-1 drugs) (with reviews at 3 and 6 months) in line with NICE guidance, the BNF and/or the local health board formulary

Accreditation for Module 2:

See section 6 in the main introduction.

Any such accredited doctor will work in line with the principles of the generic GPs with special interests (GPwSI) guidance (see https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf) or as deemed appropriate by the LHB.

Patient Documentation & Information

A **care plan** will be co-produced and shared with the patient (based on a national template).

This could take the form of **an online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or **printed from on-screen forms/literature**.

Information Prescriptions, supported by Diabetes UK, can be shared or printed from within GP IT systems, and form part of the agreed care plan

Pocket Medic videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes

Record-Keeping

The contractor will record all clinical encounters in the lifelong computer clinical records of the patients held by the practice, using Read codes agreed with the Local Health Board or in a national template.

Payment

For each patient undergoing GLP1 (Incretin Mimetic) initiation exclusively managed by the contractor – a single payment per year £130.00 per person, paid one quarter in arrears.

The practice shall submit a single claim for each such patient (with the patient's NHS number) for each patient it has initiated in the preceding quarter

Only one claim for initiation of GLP1 (Incretin Mimetic) per patient can be made per year. The contractor cannot claim for monitoring in the same quarter as initiation.

Module 3: Monitoring of Insulin

Introduction to Module 3:

This Module is a National Enhanced Service paid at the nationally negotiated rate.

This module outlines a more specialised service to be provided to those adult patients with Type 2 Diabetes who may benefit from continuing insulin

Population to whom the module 3 service will be offered

All patients with Type 2 Diabetes Mellitus aged 25 years or over who are likely to benefit from continuing insulin excluding patients in the 'Super Six' categories (pregnancy, severe renal disease, active foot disease, children/young people, type 1 diabetes, current inpatients).

Aim of Module 3:

To increase the proportion of patients with Type 2 Diabetes Mellitus who receive care and medication appropriate to their clinical need in a setting closer to home.

Clinical Governance:

The GP who performs the service under this module will hold medical responsibility for the patient. Any patient who receives the service from the contractor under this module must not concurrently be seeing a consultant diabetologist, or on the waiting list to be seen in an outpatient diabetologist clinic.

This means that the contractor must liaise with the consultant who is currently providing outpatient diabetes services and inform the consultant of the transfer of diabetes care and clinical responsibility for the monitoring of insulin medication to the GP. A template letter (Appendix X) should be used for this purpose. If the patient is not currently under a diabetologist, then the GP already holds full clinical responsibility.

If the services of a Diabetes Specialist Nurse are used to support a patient, then the overall clinical responsibility for the patient must rest with the contractor, not a secondary care specialist.

Subject to local agreement with secondary care colleagues, consultants may be willing to provide specialist advice lines to support GPs to manage these patients. These are not required to be in place for this module to be used.

A contractor is free to seek specialist advice if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist.

Service Outline:

1. Monitoring of insulin in line with NICE guidance, the BNF and/or the local health board formulary
2. The contractor will write a letter (based on the template in Appendix X) to the secondary care consultant, if necessary, to inform him/her that the GP is taking over diabetes care from secondary care. before commencing this enhanced service module for a patient.

3. The contractor will inform the patient of the transfer of diabetes care if necessary, and will record the conversation, or letter if needed, (see Appendix Y for template letter), in the GP clinical record.

Accreditation for Module 3:

See section 6 in the main introduction.

Any such accredited doctor will work in line with the principles of the generic GPs with special interests (GPwSI) guidance (see https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf) or as deemed appropriate by the LHB.

Patient Documentation & Information

A **care plan** will be co-produced and shared with the patient (based on a national template).

The contractor shall provide an *Insulin passport* to the patient

The care plan could take the form of **an online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or **printed from on-screen forms/literature**.

Information Prescriptions, supported by Diabetes UK, can be shared or printed from within GP IT systems, and form part of the agreed care plan

Pocket Medic videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes

Record-Keeping

The contractor will record all clinical encounters in the lifelong computer clinical records of the patients held by the practice, using Read codes agreed with the Local Health Board or in a national template.

Payment for module 3:

For each patient undergoing insulin monitoring, exclusively managed by the contractor - £100.00 per person per year, paid quarterly in arrears

The contractor will be deemed to be monitoring a patient if all of the following conditions apply

- The contractor has full clinical responsibility for the care of the patient's diabetes, AND…
- The contractor has issued a prescription for insulin in the preceding quarter

The practice shall submit a claim each quarter with the number of patients it has monitored in the preceding quarter

The contractor cannot claim for monitoring a patient in the same quarter that the contractor has also claimed for initiation.

Optional Module 4: Initiation of Insulin

This Module is a National Enhanced Service paid at the nationally negotiated rate.

Introduction to Module 4:

This module outlines a more specialised service to be provided to those adult patients with Type 2 Diabetes who may benefit from starting insulin

Population to whom the module 4 service will be offered

All patients with Type 2 Diabetes Mellitus aged 25 years or over who are likely to benefit from starting Insulin, excluding patients in the ‘Super Six’ categories.

Aim of Module 4:

To increase the proportion of patients with Type 2 Diabetes Mellitus who receive care and medication appropriate to their clinical need in a setting closer to home.

Clinical Governance:

The GP who performs the service under this module will hold medical responsibility for the patient. Any patient who receives the service from the contractor under this module must not concurrently be seeing a consultant diabetologist, or on the waiting list to be seen in an outpatient diabetologist clinic.

This means that the contractor must liaise with the consultant who is currently providing outpatient diabetes services and, and inform the consultant of the transfer of diabetes care and clinical responsibility for the initiation of insulin medication to the GP. A template letter (Appendix X) should be used for this purpose. If the patient is not currently under a diabetologist, then the GP already holds full clinical responsibility.

If the services of a Diabetes Specialist Nurse are used to support a patient, then the overall clinical responsibility for the patient must rest with the contractor, not a secondary care specialist.

Subject to local agreement with secondary care colleagues, consultants may be willing to provide specialist advice lines to support GPs to manage these patients. These are not required to be in place for this module to be used.

A contractor is free to seek specialist advice if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist.

Service Outline:

1. Initiation of Insulin in line with NICE guidance, the BNF and/or the local health board formulary
2. The contractor will write a letter (based on the template in Appendix X) to the secondary care consultant, if necessary, to inform him/her that the GP is taking over diabetes care from secondary care. before commencing this enhanced service module for a patient.
3. The contractor will inform the patient of the transfer of diabetes care if necessary, and will record the conversation, or letter if needed (see Appendix Y for template letter), in the GP clinical record.

Accreditation for Module 4:

See section 6 in the main introduction.

Any such accredited doctor will work in line with the principles of the generic GPs with special interests (GPwSI) guidance (see https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf) or as deemed appropriate by the LHB.

Patient Documentation & Information
A **care plan** will be co-produced and shared with the patient (based on a national template).

The contractor shall provide an *Insulin passport* to the patient
The care plan could take the form of **an online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or **printed from on-screen forms/literature.**
Information Prescriptions, supported by Diabetes UK, can be shared or printed from within GP IT systems, and form part of the agreed care plan
Pocket Medic videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes

Record-Keeping
The contractor will record all clinical encounters in the lifelong computer clinical records of the patients held by the practice, using Read codes agreed with the Local Health Board or in a national template.

Payment
For each patient undergoing Insulin initiation exclusively managed by the contractor – a single payment per year £225.00 per person, paid one quarter in arrears.
The practice shall submit a single claim for each such patient (with the patient's NHS number) for each patient it has initiated in the preceding quarter
Only one claim for initiation per patient can be made per year. The contractor cannot claim for monitoring in the same quarter as initiation.

History of review and amendment of Specification

Date of Review	Amendment to specification	Reference	Author	Date of next review
16/08/21	Updated for 2021/22	Effective date removed (no other change to current specification)	KK	08/22