

## Locally Enhanced Service for Specialised Diabetic Services in Primary Care

Reference: LES34

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## 1. Financial Details

This agreement is for the financial year 2008/09. However, the specification should also be seen as forming the description of the initial, primary care element of the patient pathway that will include the development of an integrated, PCT-wide specialist primary care services for Diabetes to be sited in the Porters Avenue Resource Centre by 2008/09. This should require the development of a specification at a more advanced level of service provision, most likely equivalent to one led by GPs and Nurses with Specialist Interest.

The service specification is configured to encourage and reward practices that have completed the insulin-for-life programme and are looking to re-locate service provision for patients with Type-2 diabetes from the acute setting to primary care. Where practices have initiated such a transfer, the proposal is to set a price tariff of £120 per eligible patient per annum.

## 2. Service Aims

This locally enhanced service is designed to cover Type 2 Diabetic patients now requiring conversion to insulin from other methods of control (e.g. diet, exercise, oral medication etc). Such patients have been identified by their acute consultant, in agreement with their GP, as eligible for this conversion (mostly assessed on basis of HbA1C status and maximum usage of oral medication) and for management within the primary care setting.

This service is designed to ensure that:

- Patients receive care in the most appropriate setting
- Patients are maintained and monitored by trained primary care clinicians

This should result in the hospital-based workload reducing as patients require fewer hospital attendances.

## 3. Service Criteria

Provision of this specification should include the following:

- Initial assessment appointment for patient
- Education and support for patient, empowering them to take control of own medication using daily injection. This could also include attendance on an *Expert Patient Programme* course.
- Ongoing, regular monitoring of patients, including availability of further education and support
- On-site education and training for patients as required

Participating practices may also consider providing such services for patients from other Barking & Dagenham practices (or on a locality basis, perhaps as a pilot). This could mean supporting primary care clinicians through the training programme and into service provision. This represents an advanced level of providing this service and may require further specification.

#### 4. Monitoring & Evaluation

Participating practices are expected to submit data on the number of patients under their care at regular intervals. For the purpose of this specification practices will only be required to submit information twice a year.

	End of 2 <sup>nd</sup> Quarter of the Year (April – Sept.)	End of 4 <sup>th</sup> Quarter (October – March)
Total Number of Patients	£120 per patient	£120 per <b>new</b> patient added during quarters 3 and 4

#### 5. Accreditation

At least one GP and practice nurse in the individual practice has completed the insulin-for-life programme. They may also be required to provide evidence of their training and CPD.

Please provide us with the name(s) of the practice nurse(s) who have completed the insulin for life programme:

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Please provide us with the name(s) of the GP(s) who have completed the insulin for life programme:

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## 6. Signature Sheet

This document constitutes the agreement between the practice and the PCT in regards to this nationally directed enhanced service.

### Practice Stamp

#### Signature on behalf of the Practice:

Signature	Name	Date

#### Signature on behalf of the PCT:

Signature	Name	Date