Service Specification

Service Specification No.	
Service	GP Diabetes Champion
Commissioner Lead	
Provider Lead	All GP practices in Eastern locality of NEW Devon CCG
Period	1st January 2018 – 31st December 2019
Date of Review	1st December 2018

1. Population Needs

1.1 National/local context and evidence base

1.1.1 The National Context

Diabetes is both common in the UK and increasing in prevalence inexorably. National prevalence in adults >17 years is 7.4% in 2010, predicted to increase to 8.5% by 2020 and to 9.5% by 2030 (Association of Public Health Observatories data, 2010).

Estimates from the UK suggest that in 2009 10% of the budget of the NHS was spent on the health needs of people with diabetes and 5% of the budget is directly attributable to the costs of diabetes. This is equivalent to £173 million a week (Diabetes UK: NHS Confederation (key statistics on the NHS 2007)). This figure may not include loss of earnings and hidden costs to unpaid carers. The direct and indirect costs of diabetes will therefore continue to increase in the context of severely constrained health spending.

1.1.2 The Local Context

Within NEW Devon CCG there is an approximately 50,000 people GP registered with diabetes (QOF).

Results from the 2016/17 National Diabetes Audit (NDA) indicate that on average approximately only 38% of patients within Eastern Devon practices achieve all 3 of the NICE recommended treatment targets for HbA1c (blood sugar), cholesterol and blood pressure. It is recognised the data supporting the NDA results may not be completely indicative of the practice achievements however it is noted that there is room for improvement.

NEW DEVON CCG were successful in their bid to receive national funding for the transformation of diabetes services within the Diabetes Transformational Fund for two years from April 2017 – March 2019.

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**	**X**

2.2 Local defined outcomes

- To promote wellbeing, reduce health inequalities and improve health outcomes for local people
- Appropriate management of diabetes patients within practices contributing to achievement of the three NICE recommended treatment targets and reduction in diabetes related complications such as amputations, heart

disease, obesity and diabetes retinal disease.
- To promote and improve the care of diabetes patients

3. Scope

3.1 Aims and objectives of service

The aim of the service is to:

- promote good diabetes care within each practice
- support practice staff in their management of diabetes patients
- increase the achievement of the three NICE recommended treatment targets for all patients
- reduce diabetes related complications

The objectives of the service are to have a GP diabetes champion in each GP practice.

3.2 Service description/care pathway

Have a named GP champion for Diabetes:

Named GP diabetes champions will be required to:

- Take a lead in their practice for the delivery of services for people with diabetes
- Review their practices arrangement for the care of diabetes
- Utilise the resources within the locality and CCG to develop good practice e.g. the community diabetes consultant lead, educational resources, workshops, peer discussions, etc

3.3 Monitoring and evaluation of the service

Practices will provide the name of their GP diabetes champion who will be:

- the single point of clinical contact for development and progression of diabetes management
- be the conduit for information
- lead on investigating adverse incidents and SEAs re patients with diabetes

Practice will also be required to:

- participate in the national diabetes audit
- provide a succinct annual report on progress in practice, approx. one side of A4.

3.4 Key Performance Indicators

NEW Devon CCG will monitor achievement of the 2017/18 NDA treatment targets results in November 2018.

3.5 Payment for Service

There will be a one off payment for each practice of £400 per each financial year.

NEW Devon CCG will take into consideration where there is no improvement in achievement in any 'one' of the treatment targets as reported in the 2017/18 NDA and the practice report of explanation for the payment of year 2 monies.

3.5 Populations covered

The practice's registered population.

3.6 Inclusion and exclusion criteria

None

3.7 Interdependence with other services/providers

Community diabetes consultant lead

4. Applicable Service Standards

Guidelines and Joint Formulary:

NICE

National guidelines:

NICE guideline [NG17] Type 1 diabetes in adults: diagnosis and management https://www.nice.org.uk/guidance/ng28

NICE guideline [NG28] Type 2 diabetes in adults: management

https://www.nice.org.uk/guidance/ng28

5. Location of Provider Premises

The provider premises