Fit for the Future

Working together to keep people well

Appendix D – Reporting Template for Diabetes LES 2017-19

Name of Practice ……………………………………………….

Date ………………………………………………………………….

Please submit this form to sally.berry1@nhs.net ***on the following dates:*** **15th April 2018, 15th October 2018, and 15th April 2019.**

By signing up to the Diabetes LES, Practices will be expected to:

1. **Nominate Clinical Diabetes Lead(s) for the Practice** – *provided via application form*
2. **Provide name of the clinicians(s) and date of the diabetes training undertaken**

   OR

   Provide name(s) of staff members who have completed at least 2 modules of the Cambridge Diabetes Education Programme (CDEP) training, and the modules completed

Name: **Date of training:** **OR** **Name:** **CDEP Module 1:** **CDEP Module 2:**

3. **The CCG is exploring ways of obtaining more timely information regarding achievement of treatment targets, and the Practice commits to engage with the CCG (Primary Care Information Team) to determine how best this can be done. The CCG commits to working with the LMC to ensure IG requirements are met, and workload for Practices is kept to a minimum.**

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Fit for the Future

Working together to keep people well

<table>
<tr><th>Objectives</th><th>Measure and further details</th><th>Evidence
Practice Responses</th></tr>
<tr><td colspan="3">1. DELIVERING TREATMENT TARGETS: BLOOD PRESSURE CONTROL, HbA1C, CHOLESTEROL</td></tr>
<tr><td colspan="3">1.1 CASE FINDING & INTEGRATED WORKING</td></tr>
<tr><td rowspan="5">Case finding and integrated working between primary, community and acute services:

a) To identify undiagnosed people with diabetes (case finding)
b) To proactively manage:
- patients with diabetes ensuring that blood pressure, HbA1c and cholesterol are optimally controlled
- patients at risk of developing diabetes</td><td rowspan="5">Practices should specify what work has been done to achieve this. Methods may include, but not be limited to:

▪ Electronic searches to identify high risk patients suitable for diagnostic testing such as previous gestational diabetes or pre-diabetes and proactive care
▪ Follow up from NHS Health Checks
▪ Designing and implementing systematic processes e.g. call and recall systems to enable the activities above to be regularly undertaken and consistently implemented
▪ Engagement and co-operative working with existing and new staff in the community diabetes team to optimise control of blood pressure, HbA1c and cholesterol</td><td>Please provide a brief description to explain the processes in place at the Practice to support the following:</td></tr>
<tr><td>Ensure systematic call and recall processes to identify high risk patients e.g. previous gestational diabetes, prediabetes and proactive care:</td></tr>
<tr><td>NHS Health Checks follow up:</td></tr>
<tr><td>Engagement and co-operative working with the community diabetes team to optimise control of blood pressure, HbA1c and cholesterol:</td></tr>
<tr><td>To improve on 2015/16 NDA baseline:</td></tr>
</table>

	▪ Aim to improve on 2015/16 National Diabetes Audit baseline ▪ Refer eligible patients to the local NHS DPP programme where clinically appropriate.	Identify and refer eligible patients to the **NHS DPP**:
1.2 INTEGRATED WORKING WITH COMMUNITY & SECONDARY CARE		
<u>Attend at least one Virtual Clinic(s):</u> Support the Clinical Diabetes Lead and others to attend the VCR clinics with the community diabetes team, and, subject to availability or where the practice has been prioritised for support, Consultant Diabetologist.	▪ Practice to confirm date of VCR booking(s). ▪ Work with clinical team on areas of need individual to surgery and caseload ▪ Focus on improving NICE recommended treatment targets, particularly optimising blood pressure ▪ Additional focus on discussing patients with more than 2 diabetes related admissions in the last year.	***Please provide the following information:*** **Date** of VCR booking: Confirm **attendees** and **role:**
<u>Practice visit:</u> Arrange a one hour practice visit with the diabetes specialist nurse / diabetes technician and local GP lead, and, subject to availability or where	▪ One visit per year expected. Practices may wish to arrange a joint visit with a nearby practices in their locality ▪ Visit discussion to be decided by practices and diabetes team in advance. Suggested areas practices may wish to focus on include discussion of practice	***Please provide the following information:*** **Date** of practice visit: Confirm **attendees** and **role:**

the practice has been prioritised for support, consultant diabetologist.	National Diabetes Audit results, difficult cases, clinical guidelines and local challenges.	**Topics** discussed:
2. PATIENT EDUCATION		
Self-Management: Support Diabetic patients to be engaged in self-management of their condition, and make best use of psychological services where appropriate.	▪ Practice to refer at least 90% of all newly diagnosed diabetics to a Diabetes Education Programme and ensure accurate coding within the clinical system using the national guidance.***(DESMOND is now available to those within first 2 years of diagnosis – part of bid).*** ▪ Practice to follow up patients who do not attend a Diabetes Structured Education Programme, with the aim of increasing the number of patients attending.	***Please provide a brief description to explain the processes in place at the Practice to support the following:*** **Referral** to **Diabetes Structured Education Programmes** and **ensuring accurate coding** in the Practice clinical system: **Ensuring** people who have not yet attended are offered referral to **DESMOND** within the **first two years** of diagnosis:

	▪ Practice to provide numbers of patients who have been referred to the CPFT Psychological Wellbeing Service (formerly IAPT) where appropriate to encourage management of an underlying psychological problem and engagement with self-management of their long term condition(s).	
		Process for **follow up** patients who **do not attend**:
		Numbers of patients who have been **referred** to the CPFT Psychological Wellbeing Service **(PWS)**:
Practice staff to engage in training on motivational interviewing and health coaching	▪ Name and date(s) of staff attendance at health coaching training.	***Please provide the following information:***
		Confirm **attendees** and **role:**
		Date(s) of training:
3. PATIENTS AT RISK OF DEVELOPING DIABETES		
	▪ Practice to provide number of relevant patients who have been offered referral to local NHS DPP, how	***Please provide the following information:***

NHS Diabetes Prevention Programme: Offer referral to all relevant patients where clinically appropriate.	many have accepted; how many were referred following a Diabetes UK website self assessment (when available). ▪ Practice to undertake retrospective search for pre diabetic patients in line with CCG guidance, clinically check that patients are appropriate for referral to the NHS DPP, and provide the search results to ICS (local NHS DPP provider) to send invitation letters on behalf of the practice – Practices may decide to write to patients directly if they wish. ▪ Please give examples of reasons given for patients not wanting to participate in the programme.	**Number** of patients **offered** referral, how many **accepted**, and how many referred following **DUK self assessment (when available)**:
		Confirm **retrospective search** completed, and whether **ICS** or **Practice** has sent invitation letters: OR provide details of the equivalent **practice led process** that achieves the same aim:
		Non patient identifiable **examples** why patients do not want to participate:

I confirm that the above information is accurate and a true reflection of the work undertaken by the Practice.

Completed by:

Name: **Signature:** **Date:**