SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Pre-Diabetes (PreDM)**
Commissioner Lead	
Provider Lead	
Period	1st April 2019 – 31st March 2020
Date of Review	March 2020

1. Background

The terms pre-diabetes (PreDM) is the collective term used to describe the presence of impaired fasting glycaemia (IFG), impaired glucose tolerance (IGT), HbA1c IFCC of 42-47mmol/mol and/or history of gestational diabetes. These are intermediate states of abnormal glucose regulation that exist between normal blood glucose levels and Type 2 diabetes.

An estimated 7 million people in the UK have early warning signs of diabetes. PreDM tends to occur in people who are overweight or obese, those with FH or in certain ethnic groups.

People with PreDM have a 12 times increased risk of developing type 2 diabetes (Santaguida et al 2005). Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. Life expectancy can be reduced by up to 15 years, with individuals largely dying due to macrovascular complications including cardiovascular disease and amputations. Half of those who are diagnosed with Type 2 diabetes present with advanced complications. In the absence of intervention, the majority of PreDM patients are likely to develop Type 2 diabetes within five to ten years (Nathan et al 2007).

Various studies have shown that intervention can significantly reduce the risk of developing diabetes. The identification and management of PreDM therefore provides a substantial opportunity for preventing the future burden of Type 2 diabetes. Evidence suggests personalised lifestyle and educational interventions can delay or even reverse the disease process in patients with PreDM.

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) identifies those at high risk of developing type 2 diabetes and refers them onto a behaviour change programme. The NHS DPP is available for all patients in Berkshire to access for support.

As CVD accounts for much of the morbidity and mortality associated with Type 2 diabetes, even small reductions in cardiovascular risk would be clinically significant. The Wanless Report (2004) noted there is scope for significant cost savings through the prevention of diabetes, earlier diagnosis and better management.

It is envisaged that this CES will continue for a period of at least 3 years starting from April 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	x

	following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

Nationally, the NHS requires CCGs to commission services which will contribute to the achievement of the objectives of the NHS Outcomes framework. Below it can be demonstrated that this CES scheme aims to tackle all 5 domains of the outcome framework

3. Details of service

3.1 Aims

Practices will be expected to create and manage a PreDM register. The overall aim is to provide advice & support to patients and prevent them developing T2 diabetes. Current evidence suggests about 60% will progress over a 10 year period. Patients should be advised about the NHS Diabetes Prevention Programme (NHS DPP) & referred into this if appropriate (see exclusions below).

3.2 Objectives

Reduce incidence of diabetes and associated complications

Support and refer patients to the NHS DPP in Berkshire

3.3 Service Requirements

To be eligible to provide this Community Enhanced Service the practice must be providing a full range of core services in accordance with established Berkshire West practice

3.4 Service description/care pathway

- The CES will support and promote the creation and maintenance of the Pre-diabetes register with the use of the appropriate codes
- Practices will invite eligible patients for an annual review which will be carried out following the summary of procedures highlighted in Annex 1
- Practice will actively refer patients to the NHS Diabetes Prevention Programme (NHS DPP) to increase number of practice patients participating (use code provided below).
- Practices will submit an annual audit
- Practices will promote self-management and agree a care plan with each patient on the register (code with 8cs).

3.5 Any acceptance and exclusion criteria and thresholds

The register is to include patients with:

- A history of gestational diabetes,
- Impaired fasting glycaemia (>6 to < 7mmol/l) Impaired glucose tolerance (7.8-11.0mmol/l)
- HbA1c IFCC 42 to 47 mmol/mol

Inclusion criteria for PreDM register:

- HbA1c IFCC 42-47 mmol/mol
- Impaired Fasting Glucose

- Impaired Glucose Tolerance
- History of Gestational Diabetes At risk of Diabetes Mellitus
- Diabetes Resolved codes (may be resolved but will be at higher lifetime risk of recurrence)

Exclusion criteria for IGR register:

- Patients diagnosed with diabetes

Exclusion criteria for NHS Diabetes Prevention Programme:

Patients should:

- Not be diagnosed with Type 2 diabetes / have a previous diagnosis
- Not be pregnant at time of referral
- Have no ongoing serious illness or undergoing palliative care
- Not be housebound or in a residential care home

3.5 Accreditation requirements

Not Applicable

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Not Applicable

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not applicable

4.3 Applicable local standards

Audit register of patients prescribed drugs, complications and significant events.

5. Monitoring and payment

5.1 Monitoring

- Practices to invite patients with PreDM for their yearly review and fill in and submit quarterly manual returns to bw.gp-enhancedservices@nhs.net. In order for practices to have a static cohort of patients on their list to invite, the quarterly searches will produce cumulative figures but the payment will reflect the activity for the quarter.
- It will remain the responsibility of practice staff to code invitations, reviews and referrals to NDPP, run the searches and submit the manual return to bw.gp-enhancedservices@nhs.net .
- Each quarter the CCG will collate a report containing activity from all the practices. Progress will be shared with the Diabetes Lead in Berkshire West CCG
- In March 2019 practices will submit number of patients with an agreed care plan to bw.gp-enhancedservices@nhs.net.

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5.2 Payment

- Practices will receive £27.83 per each patient who attends the review [coded as 6AC]. The review amounts can only be claimed once for each patient annually.
- The fee for inviting the patient is being removed & added to the consultation amount.
- The payment will be quarterly and follow submission of the manual return.
- In order for the payment to be confirmed, practices will submit an annual audit as per point 5.3 below and Annex A. Failure to meet the audit's requirement will result in payment being recalled.

The CCG may choose to conduct Post Payment Verification checks.

5.3 Audit

Providers to perform an annual audit as per Annex A. The Audit is to be returned to bw.gp-enhancedservices@nhs.net by the date stated on the Annex.

Practice IT systems include a clinical audit system which identifies some of these patients using either searches based on the values above, or Read code entries:

R10E.00	Impaired glucose tolerance
C11y300	Impaired fasting glycaemia
R10D00	Impaired fasting glycaemia
L180811	Gestational diabetes
L1809	Gestational diabetes
C11y5	Pre-diabetes
14O8	At risk of Diabetes Mellitus (Those with normal BS but HbA1c 42-47) (Please note that **the O in 14O8 is the letter**, not the number zero)

Patients already diagnosed with diabetes are of course to be excluded.

Practices are to build a register of pre-diabetes patients and ensure it is updated as appropriate. Some practices may already have a register in place.

Register the patients as 14O8 At risk of diabetes

Annual Review

The patients on the PreDM register are to be invited for an annual review which may include: blood tests, history taking, measurements, alcohol assessment, CVD risk, advice giving, referrals, patient education and treatment as appropriate (see annual review section in appendix 1).

6. Diabetes Prevention Programme

Practice to actively promote the NHS Diabetes Prevention Programme (NHS DPP) to increase number of practice patients participating.

During / after a review appointment there should be the option to refer suitable patients to the NHS DPP. The referral can be made using the Referral Form 'NHS Diabetes Prevention Programme

Referral' found in DXS.

Practices should also review their Pre-diabetes register and invite patients to join the NHS DPP, a minimum of twice a year. The medium for contacting the patients could be by letter, telephone or digital. (Iplato, text service). Please liaise with the Diabetes Prevention Programme Lead for Berkshire West in relation to inviting patients on mass – Jenny Wilson Jenny.Willson@westberks.gov.uk.

Read codes:

Practices will be sent quarterly read code reports from the local provider of the NHS DPP. Please code your patients accordingly using the following codes:

679m4 Referral to NHS DPP

679m3 NHS DPP patients who have declined / opted out

679m2 NHS DPP Started

679m1 NHS DPP completed

679m0 NHS DPP Not Completed

Appendix 1: Annual Review

Summary of procedure

Identifying those with Pre-DM	
Blood tests	
HbA1c IFCC (see exclusions)[3]	**FBG**
>47mmol/l: Probable diabetes, follow up with repeat HbA1c if borderline	≥ 7mmol/l: Probable diabetes, follow up with HbA1c or FBG or both
42 to 47mmol/mol: PreDM confirmed. Place on register and invite for annual review.	>6 to < 7mmol/l: Possible PreDM, follow up with HbA1c. If PreDM confirmed (42-47mmol/mol), place on register and invite for annual review. If result does not confirm, give appropriate lifestyle advice and review in 2 years' time.
<ensure individual understands their diabetes risk and received appropriate lifestyle advice (see 'lifestyle advice' section below)	ensure individual understands their diabetes risk and received appropriate lifestyle advice (see 'lifestyle advice' section below)
PreDM Review	
Place patient on PreDM register and commence call and recall	PreDM patients to be invited to attend.
Annual review to include as clinically appropriate	Blood tests: Require offer of HbA1c, cholesterol, serum creatinine/eGFR if not had within 3 months of the review (ideally arranged before the review appointment to facilitate discussion) Referral to Diabetes Prevention Programme (NDPP): Make referral to the NDPP using the referral form in DXS called 'NHS Diabetes Prevention Programme Referral' Basic history: Smoking Status if not previously recorded as never smoked or ex smoker, Alcohol status, Physical activity, Family History Measurements: Body Mass Index, Blood Pressure, Waist measurement CVD risk assessment: as per NHS Health Check guidance Lifestyle Advice: Please give lifestyle advice as appropriate using the following information: **Reading Practices:** Please visit the Reading Services Guide **West Berkshire Practices**: Please visit the Healthy Eating and Physical Activity web pages **Wokingham Practices**: Please visit WEBSITE TBC Treatment: as appropriate Pharmacological review: as appropriate Women of child bearing age: consider pre-conception counselling via

Annex A

Patient ID	Date added to the Pre Diabetes Register	Date of Annual Review	Date Annual Diabetic Check Completed	Date of Blood tests	Date Basic History as per Annex 1 obtained

Please return the completed proforma to the bw.gp-enhancedservices@nhs.net email account no later than Friday 27th March 2020.