OCCG Primary Care Contract 2021-22

Oxfordshire Diabetes Locally Commissioned Service (LCS)

Summary

Commencement date: 1 June 2021
End date: 31 March 2022

<table>
<tr><th>Section</th><th>Practice Requirement</th></tr>
<tr><td>Diabetes Multi-Disciplinary Team (MDT) Meetings at Primary Care Network level</td><td>Each practice will participate in diabetes multi-disciplinary team meetings (MDTs) within their Primary Care Network. The meetings will include secondary and community care clinicians specialising in diabetes care with the aim of improving the care of people with diabetes. Each Practice will take part in 3 MDT meetings within the period 1st June 2021 – 31st March 2022. Patients discussed in the PCN MDT should have the Snomed code 170775008 ‘Diabetes: shared care programme’ applied.

These meetings will take place virtually using MS Teams.</td></tr>
<tr><td>Insulin initiation</td><td>Each practice will provide initiation of insulin for all people with Type 2 Diabetes requiring conversion. Primary Care Networks can decide that a practice will deliver the service on behalf of the network. The Snomed code that must be used to ensure payment for insulin initiation is 345041000000101 ‘Insulin treatment initiated’.</td></tr>
<tr><td>Completion of the 8 Care Processes</td><td>To move towards the recovery of individuals living with diabetes following the impact COVID-19 there will be a focus on completing the 8 Care Processes. This will be for those people with type 2 diabetes only and will not include treatment targets as done in previous LCSs.

All Practices to achieve a target of 60% of people with type 2 diabetes completing all 8 care processes.

Any individuals living with diabetes who also present with foot problems should be treated as a priority for receiving care and support. These have also been grouped into Red, Amber and Green categories with the recommendation that Practices focus on the Red and Amber categories.

<table>
<tr><td>Risk Group</td><td></td></tr>
<tr><td>RED – High risk or active disease</td><td>Current foot ulceration / Charcot’s foot.
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</table>
</td></tr>
</table>

Year of Care Planning	Each practice will need to continue implementation of the Year of Care (YoC) model to support the implementation of Care and Support Planning, now described as Personalised Care and Support Planning (PCSP). PCSP annual review consultations will 'move on' from the focus on type 2 diabetes and include other long term conditions. This holistic, multi-morbidity approach, to personalised review consultations will generate the most efficiencies and benefit for practices and patients. For support contact: occg.yoc@nhs.net
Other essential items	Each practice will also: a) Ensure the accurate recording of ethnicity for individuals living with diabetes within GP systems. b) Apply complete coding for all diabetes structured education activity using nationally standardised codes[1] (see pages 7-8 below). c) Apply complete diabetes eye screening coding (see page 8). d) Make data available for the Oxfordshire Diabetes Dashboard. e) Ensure a lead GP and lead Practice Nurse for Diabetes are nominated as main points of contact for the CCG, with contact details provided. f) Ensure full submission to the National Diabetes Audit. g) Completion of the Training Needs Assessment survey. This will be sent out separately by the YoC team.

[1] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-structured-education-data

NHS
Oxfordshire
Clinical Commissioning Group

OCCG Primary Care Contract 2021-22

Oxfordshire Diabetes Locally Commissioned Service (LCS)

Commencement date:	1 June 2021
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1. Oxfordshire Diabetes Transformation – aims and objectives

The overarching aim of diabetes transformation in Oxfordshire is to establish an integrated diabetes service which focuses on the needs of the whole person, empowering people with diabetes to live healthy lives, and which provides timely support when issues arise. The purpose of this LCS is to encourage recovery of people with diabetes following the pandemic and to ensure that those patients impacted are supported and receive the care they require. It is hoped over the next year 8 Care Processes and Treatment Targets will begin to normalise to pre pandemic figures. **All parts of the LCS must be completed to receive the funding, there will be no split of funding per individual requirement**.

The objectives, and therefore the scope of the transformation programme are to:

- Improve outcomes and reduce unwanted variation of care for people with diabetes across Oxfordshire.
- Improve patient experience of diabetes care and achieve high satisfaction against patient experience measures to be agreed as part of the project.
- Reduce complications arising from diabetes, in particular in renal replacement therapy and heart failure.
- Reduce the rate of growth in the costs of care for people with diabetes to support Oxfordshire's health care system. Informed by experience, to agree future investment based on the growing predicted prevalence of diabetes, taking into account predicted savings.

With the focus on people living with diabetes to live longer and healthier lives, the Year of Care (Personalised Care and Support Planning) approach is a key element to the effective clinical management of those people living with type 2 diabetes and other long term conditions in Oxfordshire, the ethos and process having been adopted by up to 87% of practices prior to the COVID-19 pandemic. This personalised, holistic and evidenced based approach to care is 'moving on' so annual reviews should consider other long term conditions alongside type 2 diabetes. This more holistic approach to personalised care strongly supports the NHS Long Term Plan (NHSE, 2019) and details set out in the Universal Personalised Care (NHSE, 2019) delivery programme, a national move to adopt a stronger, more personalised approach when caring and interacting with patients.

2. Practice requirements and payments

The **Sign Up Form (Appendix C)** needs to be completed and submitted to **occg.plannedcare@nhs.net** to confirm participation and enable payment. If sign up has already been completed via the Primary Care LCS sign up then no action is required. **NB:** The previous payment for **'Year of Care Planning'** has now been absorbed within the '**Reviews of individuals with Diabetes'** payment as it is understood the Year of Care Planning is now a system wide implemented programme.

Section	Practice Requirement	Payment	Information reporting
3.1 Diabetes multi-disciplinary team meetings at Primary Care Network level	Each practice will participate in diabetes multi-disciplinary team meetings (MDTs) within their Primary Care Network. The meetings will include secondary and community care clinicians specialising in diabetes care with the aim of improving the care of people with diabetes. Each Practice will take part in 3 MDT meetings within the period 1st June 2021 – 31st March 2022. These meetings will be held virtually using MS Teams. Meeting and preparation/follow up time is expected to be up to 3 hours with 1 GP plus 1 Practice Nurse participating from each practice. The MDT is to review the diabetes dashboard, review complex diabetes patients with specialist diabetes clinicians to improve patient care, share best practice and ensure best health outcomes for their diabetic population. One of the practices in the Primary Care Network will be responsible for hosting the meeting, producing high level notes (patient identifiable information removed) and sharing the notes with the diabetes specialists. Each practice is responsible for running relevant searches in preparation for the meeting and taking away and following up on their own actions from the meeting.	This is a set payment irrespective of practice size, and it is based on the practice taking part in 3 meetings in the 2021/22 year. The total payment for 3 meetings is **£884**.	A record of the meetings that documents: date/time of meeting, attendance, issues discussed and number of patients discussed (patient identifiable information not to be included). Record of meeting to be sent through to: **occg.plannedcare@nhs.net** Patients discussed in the PCN MDT should have the code **170775008** 'Diabetes: shared care programme' applied.

Section	Practice Requirement	Payment	Information reporting
3.2 Insulin initiation	Each practice will provide initiation of insulin for all Type 2 Diabetes patients requiring conversion. Detailed criteria for the insulin initiation service are included in **Appendix B**. Primary Care Networks can decide that a practice will deliver the service on behalf of the network to provide resilience and capacity. OCCG needs to be formally notified of the agreement of all practices in the network to this arrangement when decided. All people with Type 1 Diabetes are to be either seen at OCDEM[2] or, if stable (achieving good NICE standards, i.e. good glycaemic control, personalised HbA1c and low hypoglycaemia) discussed with an OCDEM consultant twice a year and actions implemented. (Insulin initiation in pregnancy (for both GDM and for pre-existing T2DM) is excluded and should not be initiated by Primary Care)	Per patient payment for insulin initiation: **£122.15** Insulin initiation payment will be paid on a per patient basis. The amount practices are paid in total for insulin initiation will therefore vary according to the number of patients initiating insulin in the year. As numbers are anticipated to be relatively low, payment for insulin initiation will be made as part of the final reconciliation process for locally commissioned services at financial year end.	Snomed coding of all patients initiated on insulin. The read code that must be used to ensure payment is **345041000000101** 'Insulin treatment initiated'. This will be verified through a quarterly search. For those patients attending OCDEM/Horton apply code **312887003** 'attends outpatients'. For those patients not willing or not appropriate to attend OCDEM/Horton apply code **279291000000109** 'Diabetes Type 1 Review'. Email verification of attendance at insulin initiation training to: **occg.plannedcare@nhs.net**
3.3 Reviews of individuals with Diabetes	To move towards the recovery of individuals living with diabetes following the impact of COVID-19 there will be a focus on completing the 8 Care Processes. This will be for those with type 2 diabetes only and will not include treatment targets as in previous LCSs. All Practices to achieve a target of 60% of people with type 2 diabetes completing all 8 care processes. Any individuals living with diabetes who also present with foot problems should be treated as a priority for receiving care and support. These have also been grouped into Red, Amber and	Payment per registered Type 2 diabetes patient (verified through the Diabetes Dashboard): **£8.37** Please refer to **Schedule of Payments (Appendix A)** for the anticipated values for each practice. Payments will be made at the end of the financial year as long as the LCS Sign Up Form has	

[2] For patients resident in North Oxfordshire under the care of OCDEM, they will be seen in the Horton Diabetes Clinic.

<table>
<tr><th>Section</th><th>Practice Requirement</th><th>Payment</th><th>Information reporting</th></tr>
<tr><td></td><td>Green categories with the recommendation that Practices focus on the Red and Amber categories.

<table><tr><td>Risk Group</td><td></td></tr><tr><td>RED – High risk or active disease</td><td>Current foot ulceration / Charcot’s foot.
Previous foot ulceration / Charcot’s.</td></tr><tr><td>AMBER – increased risk</td><td>Foot pulses NOT palpable or peripheral neuropathy affecting the feet</td></tr><tr><td>GREEN – low risk</td><td>Palpable foot pulses AND no evidence of peripheral neuropathy affecting the feet</td></tr></table></td><td>been signed (Appendix C) and returned to the CCG at occg.plannedcare@nhs.net.</td><td></td></tr>
<tr><td>3.4 Year of Care Planning</td><td>Oxfordshire CCG continues to support the implementation of the Year of Care (YoC) model. This nationally identified, evidence based, approach to delivering Care and Support Planning (C&SP) is promoted in the NHS Long Term Plan.
C&SP along with Personalised care is a key element to the effective clinical management of people with long term conditions.

Each practice will need to continue implementing Year of Care (YOC) / C&SP for the management of diabetes patients. The practice can extend this to all patients living with long term conditions generating the most efficiencies and benefit.

Each practice will need to ensure the following remains in place from initial implementation, or ensure completion plans are conveyed.

a) Complete the YoC Planning Practice Checklist*
b) For auditing purposes tick “Agreement of care plan” box when care plan agreed with patient. (Located under the YoC ‘Care Planning annual appointments /</td><td></td><td>Record of the status of all implementation tasks. This should be provided in one email by financial year end to: occg.plannedcare@nhs.net</td></tr>
</table>

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<tr><th>Section</th><th>Practice Requirement</th><th>Payment</th><th>Information reporting</th></tr>
<tr><td></td><td>Goals & Action planning' template) or the 8CS Agreement of care plan code
c) Assign a named clinical champion for YoC in the practice. This YoC champion will:
○ Lead implementation
○ Have YoC as a standing item on practice meeting agenda
○ Disseminate YoC learning, ethos and delivery processes to whole practice team
○ Engage with OCCG YoC Coordinator once a year
○ Offer assistance to OCCG YoC Coordinator with YoC auditing or patient survey requests (Further details to follow).
d) Ensure use of the YoC self-assessment tool* for staff to check level of understanding/skills and identify further support or training needs to refresh or develop consultation skills in line with a personalised C&SP approach to care.

*The Year of Care Practice Checklist and Self-evaluation Tools for clinicians are available in the YOC packs or by request from: occg.yoc@nhs.net</td><td></td><td></td></tr>
<tr><td>3.5 Other essential items</td><td>Each practice will also:

a) Ensure the accurate recording of ethnicity for individuals living with diabetes within GP systems.
b) Apply complete coding for all diabetes structured education activity using nationally standardised codes[3]. This is to include referral, declines, attendance, non-attendance and completion of structured education. This should include coding of education for both Type 1 and Type 2 patients.</td><td></td><td>Structured Education - Continuation of coding of referral to structured education and outcome of structured education with the following standard[4] Snomed codes for EMIS and Vision.

<table><tr><th>Outcome of referral to diabetes structured education</th><th>Snomed Code</th></tr></table></td></tr>
</table>

[3] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-structured-education-data
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<tr><th>Section</th><th>Practice Requirement</th><th>Payment</th><th>Information reporting</th></tr>
<tr>
<td></td>
<td>c) Apply complete diabetes eye screening coding.
d) Make their data available for the Oxfordshire Diabetes Dashboard.
e) Ensure a lead GP and lead Practice Nurse for Diabetes are nominated as main points of contact for the CCG, with contact details provided. It is understood that not all diabetes care will be undertaken by just one Practice Nurse and GP in all practices.
f) Ensure full submission to the National Diabetes Audit.
g) Completion of the Training Needs Assessment survey. This will be sent out separately by the YoC team.</td>
<td></td>
<td>
<table>
<tr><td>Diabetes structured education declined</td><td>306591000000103</td></tr>
<tr><td>Did not attend diabetes structured education</td><td>306861000000107</td></tr>
<tr><td>Attended* diabetes structured education</td><td>413597006</td></tr>
<tr><td>Diabetes structured education completed</td><td>755491000000100</td></tr>
</table>

*Where a structured education course consists of more than one session, and the patient only attends some of the sessions then, enter a Read Code of attended. If the patient attends all the sessions and completes the course enter a Read Code of completed.

Coding will be monitored through the Diabetes Dashboard.

Diabetic Retinopathy Screening - Coding will be monitored through the Diabetes Dashboard. Read Code for Diabetic Retinopathy Screening is: 134395001 ‘Diabetic retinopathy screening’.

Diabetes Dashboard - Relevant data made available for pull into diabetes dashboard on a monthly basis.</td>
</tr>
</table>

APPENDIX A: SCHEDULE OF PAYMENTS BY LCS SECTION AND PRACTICE

Practice Code	Practice Name	No. Type 2 Adult Diabetes Patients (incl. others) - end May 2021 Oxfordshire Diabetes Dashboard	Diabetes MDTs (x 3 meetings in 2020-21)	Insulin Initiation (approx 2 per practice - to be confirmed through coding)	Reviews of individuals with Diabetes	Total Payment
K84054	Abingdon Surgery	540	£884	£244	£4519.8	£5,648
K84613	Alchester Medical Group	728	£884	£244	£6093.36	£7,221
K84010	Bampton Surgery	432	£884	£244	£3615.84	£4,744
K84028	Banbury Cross	1769	£884	£244	£14806.53	£15,935
K84021	Banbury Road (172)	166	£884	£244	£1389.42	£2,517
K84032	Bartlemas Surgery	530	£884	£244	£4436.1	£5,564
K84016	Beaumont St (19)	265	£884	£244	£2218.05	£3,346
K84049	Beaumont St (27)	144	£884	£244	£1205.28	£2,333
K84080	Beaumont St (28)	140	£884	£244	£1171.8	£2,300
K84035	Bell Surgery	318	£884	£244	£2661.66	£3,790
K84023	Berinsfield Health Centre	332	£884	£244	£2778.84	£3,907
K84052	Bicester Health Centre	684	£884	£244	£5725.08	£6,853
K84058	Bloxham Surgery	293	£884	£244	£2452.41	£3,580
K84025	Botley Medical Centre	599	£884	£244	£5013.63	£6,142
K84075	Broadshires Health Centre	465	£884	£244	£3892.05	£5,020
K84047	Burford Surgery	327	£884	£244	£2736.99	£3,865
K84610	Charlbury Surgery	217	£884	£244	£1816.29	£2,944
K84030	Chipping Norton Health Centre	672	£884	£244	£5624.64	£6,753
K84033	Church Street Practice	724	£884	£244	£6059.88	£7,188
K84034	Clifton Hampden Surgery	143	£884	£244	£1196.91	£2,325
K84618	Cogges Surgery	258	£884	£244	£2159.46	£3,287
K84063	Cowley Road Medical Practice	261	£884	£244	£2184.57	£3,313
K84056	Cropredy Surgery	194	£884	£244	£1623.78	£2,752
K84055	Deddington Health Centre	453	£884	£244	£3791.61	£4,920
K84002	Didcot Health Centre	816	£884	£244	£6829.92	£7,958

K84004	Donnington HC	678	£884	£244	£5674.86	£6,803
K84006	Eynsham Medical Centre	660	£884	£244	£5524.2	£6,652
K84071	Goring & Woodcote Health Centre	376	£884	£244	£3147.12	£4,275
K84045	Gosford Hill Medical Centre	406	£884	£244	£3398.22	£4,526
K84001	Hart Surgery	331	£884	£244	£2770.47	£3,898
K84009	Hedena Health	816	£884	£244	£6829.92	£7,958
K84059	Hightown Surgery	590	£884	£244	£4938.3	£6,066
K84048	Hollow Way Medical Centre	403	£884	£244	£3373.11	£4,501
K84003	Islip Surgery	219	£884	£244	£1833.03	£2,961
K84078	Jericho Health Centre (Leaver)	88	£884	£244	£736.56	£1,865
K84605	King Edward Street	45	£884	£244	£376.65	£1,505
K84079	Long Furlong MC	297	£884	£244	£2485.89	£3,614
K84066	Luther Street Medical Centre	17	£884	£244	£142.29	£1,270
K84027	Malthouse Surgery	860	£884	£244	£7198.2	£8,326
K84044	Manor Surgery Headington	687	£884	£244	£5750.19	£6,878
K84041	Marcham Road Health Centre	537	£884	£244	£4494.69	£5,623
K84036	Mill Stream Surgery	217	£884	£244	£1816.29	£2,944
K84038	Montgomery House Surgery	739	£884	£244	£6185.43	£7,313
K84014	Morland House Surgery	457	£884	£244	£3825.09	£4,953
K84015	Nettlebed Surgery	147	£884	£244	£1230.39	£2,358
K84019	Newbury Street Practice	633	£884	£244	£5298.21	£6,426
K84072	Nuffield Health Centre	625	£884	£244	£5231.25	£6,359
K84624	Oak Tree Health Centre	329	£884	£244	£2753.73	£3,882
K84026	Observatory Medical Practice	276	£884	£244	£2310.12	£3,438
K84065	Sibford Gower Surgery	94	£884	£244	£786.78	£1,915
K84020	Sonning Common Health Centre	362	£884	£244	£3029.94	£4,158
K84013	St Bartholomews MC	509	£884	£244	£4260.33	£5,388
K84060	St Clements Surgery	195	£884	£244	£1632.15	£2,760
K84011	Summertown Health Centre	370	£884	£244	£3096.9	£4,225

K84007	Temple Cowley Health Centre	435	£884	£244	£3640.95	£4,769
K84082	The Key Medical Practice	625	£884	£244	£5231.25	£6,359
K84031	The Leys Health Centre	615	£884	£244	£5147.55	£6,276
K84050	The Rycote Practice	497	£884	£244	£4159.89	£5,288
K84037	Wallingford Medical Centre	703	£884	£244	£5884.11	£7,012
K84008	Watlington & Chalgrove Surgery	325	£884	£244	£2720.25	£3,848
K84051	White Horse Practice	749	£884	£244	£6269.13	£7,397
K84017	Windrush Health Centre	858	£884	£244	£7181.46	£8,309
K84024	Windrush Surgery (Banbury)	387	£884	£244	£3239.19	£4,367
K84043	Woodlands Medical Centre	694	£884	£244	£5808.78	£6,937
K84062	Woodlands Surgery	379	£884	£244	£3172.23	£4,300
K84042	Woodstock Surgery	330	£884	£244	£2762.1	£3,890
K84046	Wychwood Surgery	270	£884	£244	£2259.9	£3,388

APPENDIX B: Insulin initiation service specification

A. Definition of patients to be treated

Primary Care patients:

- People over the age of 18 with diabetes
- Age: 40 + (under this age and with complications d/w Secondary Care)
- Ethnic origin: all (use of interpreters if required)

The inclusion criteria for the client group of Type 2 patients will include:

- HbA1c ≥ 59mmol/mol (7.5%) for at least 3 months
- Intolerance of or inadequate response to maximised oral medication
- Intercurrent illness / steroids therapy exacerbating hyperglycaemia

The exclusion criteria will be:

- Renal patients with chronic kidney disease including those undergoing CAPD
- Patient currently reviewed by Secondary Care & Community DSN service (unless otherwise discussed)
- Patients with complex complications (usually Secondary Care patient)
- Pregnancy (GDM and T2DM requiring insulin conversion during pregnancy)

B. Insulin Initiation - Over-arching Requirements

Identification of those patients who meet the insulin conversion therapy criteria as specified in the guidance document available on NHS Oxfordshire CCG intranet at:

- Promote full understanding of the need for insulin to both patients and carers
- Provision of a safe and supportive environment in normal daily surroundings
- Initiation of insulin and stabilisation as per the specified local guidelines as above
- Referral to the multi-disciplinary team as required

C. Insulin Initiation - Service Outline

Patients are to have a regular appointment with a GP or Practice Nurse to discuss the need to be converted to insulin therapy. Referral to a GP or Practice Nurse (PN) for an appointment to discuss Insulin Therapy as per Local Insulin Conversion Guidelines (see link below):

The Practice Nurse will review the patient and discuss:

- Current situation and reasons for Insulin Conversion.
- Social and psychological issues addressed.
- Issues relating to commencement of insulin eg. diet, hypo's and driving
- Blood glucose monitoring
- Insulin type and regime (first line use is NPH insulin if HbA1c < 75mmol/mol (9%) but should be either a basal-bolus regimen or twice daily biphasic regimen if HBa1C ≥ 75mmol/mol (9%)) as per guidance available on NHS Oxfordshire CCG internet at: http://www.oxfordshireccg.nhs.uk/clinical-guidelines/insulin-initiation-and-adjustment-in-type-2-diabetes/32324
- Insulin pen device
- Agree time scale to commence the treatment
- Appropriate visits* with the GP/PN, monitoring and follow-up as necessary for individual patients
- Agreed written educational material will be used within the service.

- All staff to work within updated local clinical guidelines.

Close links with the Community Diabetes Nurse Specialists to provide support and guidance throughout the process.

*Appropriate visits – recommend weekly titration reviews for at least one month and 2-4 weekly until target achieved. Some reviews could be by telephone.

D. Accreditation and competencies

The contractor will identify a GP or Practice Nurse who is the lead for insulin initiation for the practice. A named doctor or nurse, with insulin management knowledge, will be accessible within working hours to patients.

GPs and Practice Nurses should be able to demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on their competency level and take part in necessary supportive educational activities. They should have a responsibility for ensuring that their skills are regularly updated.

The GP and/or Practice Nurse lead for initiating insulin must attend one of the following and provide evidence of attendance before initiating patients on insulin:

- Local insulin initiation course within the last 3 years
- Warwick courses in insulin initiation
- Intensive management in type 2 diabetes MSc in Diabetes Theory and Practice of Insulin Initiation
- Alternatively they may demonstrate equivalent competencies and experience to undertake insulin initiation safely.

Regular educational updates such as local insulin management & intensification courses should be undertaken as recommended and the practice may be assessed annually for Competency using the competency assessment (Knowledge and Skills framework August 2004; HA11, HA12 HD3 & Trend Competency Framework) to include:

- Demonstrate an understanding of the physiological aspects of diabetes.
- Demonstrate an understanding the role of insulin during everyday life.
- Demonstrate competency in managing insulin therapy and to maintain their skills by regular clinical involvement.
- Demonstrate knowledge of all insulin devices and types of insulin

E. Equipment – minimum requirement

- Insulin/pen device/pen needles/sharps box/safeclip/hypostop
- Blood testing strips - all on prescription
- Blood glucose meter/ finger pricking device provided by the patient

APPENDIX C: Sign Up Form

Diabetes Locally Commissioned Service 2021-22

Confirmation of intention to participate

Name of practice: **Practice Code:**

The practice confirms its agreement to implement Year of Care Planning and to carry out all other elements of the Diabetes Locally Commissioned Service as set out in the Service Specification and summarised below. ***(This form only needs to be completed if you have not signed up via the Primary Care LCS scheme)***

Activity	Payment
Diabetes MDTs at Primary Care Network level: By end of the year, the practice will have prepared for and attended 3 Diabetes MDTs.	**£884**
Insulin Initiation: Practice will provide initiation of insulin for all Type 2 Diabetes patients requiring conversion in line with the specification set out in Appendix B.	**£122.15 per patient initiated on insulin**
Reviews of individuals with diabetes: By the end of the year Practices will aim to achieve 60% of individuals with type 2 diabetes completing all 8 Care Processes.	**See Schedule of Payments by Practice**

Diabetes Leads	**Name**	**Contact Details**
YoC Leads	**Name**	**Contact Details**

Name: **Position in practice:**

Signed: **Date:**

This form is to be completed and sent to occg.plannedcare@nhs.net to confirm practice agreement to participate in the Diabetes LCS