DIABETES UK
CARE. CONNECT. CAMPAIGN.

SERVICE REDESIGN

CASE STUDY 2: AUGUST 2015

Prime contracting in North East Essex: Commissioning a GP federation to deliver a vertically integrated care pathway

SUMMARY

In many areas, primary care is entering the next stage of its evolution. The NHS Five Year Forward View in England sets out the need for future models to expand the leadership and role of primary care in delivering services in fundamentally different ways.

In 2013, NHS North East Essex CCG commissioned Suffolk GP Federation as prime contractor/lead provider of a pioneering model of care for adults with diabetes. A UK first in diabetes care for a GP federation, Suffolk GP Federation has a single, five year contract with the CCG to both provide care – including secondary care services and a new community based diabetes specialist team – and organise other providers across the care pathway through subcontracting arrangements.

One year on from the launch of the North East Essex Diabetes Service (NEEDS), the Federation has significantly increased the number of people receiving all eight care processes from 40.1% to 60.3%, improved cholesterol and blood pressure outcomes and decreased hospital readmissions due to diabetic ketoacidosis (DKA) and hypo/hyperglycaemia by 31.6%

The case for change

The number of people living with diabetes in North East Essex is rising. Over **18,400** people are living with the condition and a further **5,700** are estimated to have undiagnosed diabetes. At **7.3%** of the total population, prevalence is currently higher than the national average of 6.2%.

In 2009/10, North East Essex was in the lowest quarter of Primary Care Trusts (PCTs) for the number of people receiving all eight care processes and in the second lowest quarter of PCTs for achieving HbA1c, cholesterol and blood pressure targets.[1] In a system where a number of providers were contracted separately to deliver a range of diabetes services, care was often fragmented, episodic and frequently led to variation in patient experience and outcomes.

With the majority of treatment also provided by hospital based specialists, communication and integration with generalists in the community were limited and patients would often have to travel long distances to attend hospital appointments.

To address these issues, in November 2011 North East Essex PCT (now NHS North East Essex CCG) initiated a service redesign project to develop a new integrated model of care.

Developing the model of care

Timeline

1 As recommended by the National Institute for Health and Care Excellence (NICE).

How the change was achieved

A number of methods were used by the CCG to ensure the successful commissioning of the new model. These included:

- Using stakeholder analysis to identify the key individuals and groups who were likely to affect or be affected by the redesign.[2]
- Setting a compelling patient focused vision to communicate a clear future for everyone to work towards.[3]
- Providing dedicated time (over five months) for patients, healthcare professionals, managers and academics to meaningfully input into the design of the new model. This included interactive workshops and providing feedback on how their input had contributed to the design.
- Hosting two market engagement events for potential prime contractors and subcontractors to network and develop new alliances for joint bids.
- Engaging local voluntary sector organisations, such as Diabetes UK, to identify good practice from other areas and facilitate the involvement of patients to ensure their voices and ideas were heard.
- Identifying key dependencies on other teams within the CCG and Commissioning Support Unit (HR, IT, finance) and involving them from the start to prevent any delays to the procurement process.

Suffolk GP Federation was awarded the contract as prime contractor/lead provider in October 2013. After a six month mobilisation period, the North East Essex Diabetes Service (NEEDS) was launched in April 2014.

FOCUS POINT

Who are Suffolk GP Federation?

Suffolk GP Federation is a community interest company (CIC)[4] owned by 61 independent GP practice members from across Suffolk. Formed in 2013, the Federation covers a population of 580,000 patients and is governed by an elected board of GPs, practice managers and a chief executive officer.

The Federation delivers a range of services to patients (diabetes, ultrasound, lymphoedema, cardiology, pain) and services to practices (care home nursing, support with back office functions, dementia and COPD case finding).

The Federation's main role is to facilitate primary care 'working at scale'. This means providing a wider range of services (for example by shifting secondary care services into primary care), reducing variations in care and improving outcomes on a population basis.

More information about why the Federation was set up and how it is structured and financed is available at: **www.suffolkfed.org.uk/pages/files/business_plan_exec_summary.pdf**

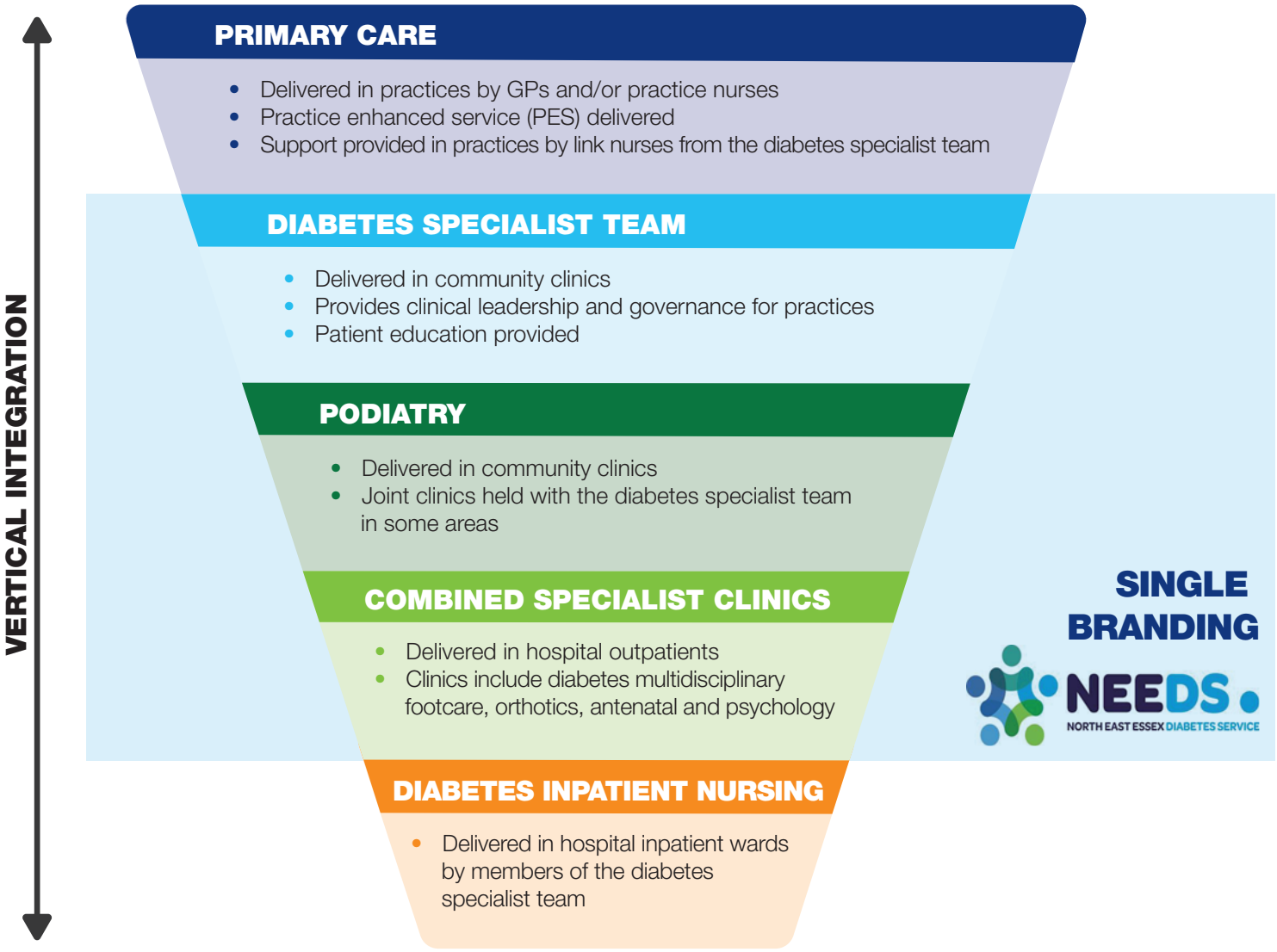
2 Stakeholder analysis is one of the first steps in any change project. More information is available at: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/stakeholder_analysis.html

3 For more information about using visions to improve alignment between providers and translating visions into leadership actions, see the report *Leadership and Leadership Development in Health Care: The Evidence Base* (2015), available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

4 A CIC is a special type of limited company which exists to benefit the community rather than private shareholders. As a CIC, members of the Federation have limited liability in the organisation. More information about social enterprises and comprehensive guidance for setting up a CIC is available at: https://www.gov.uk/set-up-a-social-enterprise

The model of care

Summary of the care pathway



The North East Essex model of care is based on learning from Bexley's GP led model of care developed in 2010/11.[5] The model aims to improve outcomes for adults with diabetes by providing a single point of access to, and continuity of care across, an integrated care pathway.

To achieve this aim, the North East Essex model is based on four 'cornerstones'.

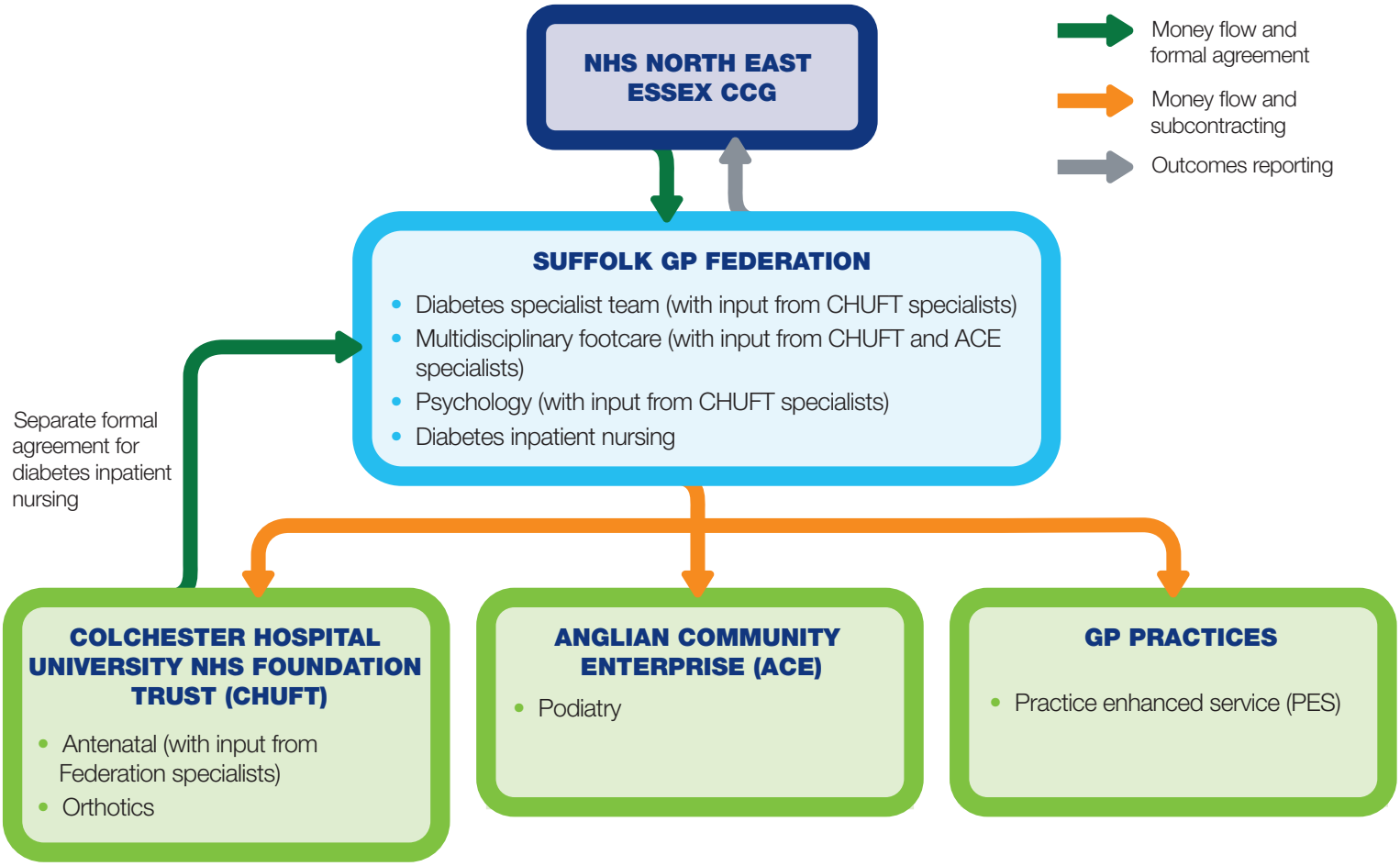
5 More information available at: http://www.rightcare.nhs.uk/downloads/RC_Casebook_Bexley_Diabetes_Care_final.pdf

The four cornerstones are:

1. **Prime contracting and vertical integration**
2. **Specialists working in the community**
3. **Building primary care capacity and skills**
4. **Patient involvement and education**

1 Prime contracting and vertical integration

As prime contractor/lead provider,[6] the Federation has a single contract with the CCG to both provide diabetes care and organise other providers across the care pathway through various subcontracting arrangements:



6 For an overview of different contracting approaches, see the report *Contracting for Outcomes* (2014), available at: http://outcomesbasedhealthcare.com/Contracting_for_Outcomes.pdf

The Federation is responsible for managing the performance and development of all services and reporting outcomes to the CCG. This is overseen by the Diabetes Services Board, which has representation from all providers and is chaired by a consultant diabetologist.

To provide a 'seamless' experience for patients across the care pathway, all of the above services (with the exception of the practice enhanced service and diabetes inpatient nursing) use the NEEDS branding. Only services which require input from other specialists or specialist equipment remain in secondary care.

The contract with the CCG is a five year agreement with an optional two year extension. 75% of the total budget is fixed and 25% is linked to performance against key outcomes.[7] The total value is £10m over five years, front loaded with £2.5m in year one and £1.8m thereafter to reflect initial service start up and training costs.

NEEDS is vertically integrated in that it brings together diabetes services from different levels of the care pathway (ie across primary, community and secondary care).[8] Where providers were previously contracted separately, NEEDS integrates the majority of diabetes care from across the care pathway under the umbrella of one service.

FOCUS POINT

Continuity of care across the pathway

Vertical integration can improve continuity of care for patients, especially for those admitted to hospital. In North East Essex, members of the community based diabetes specialist team (see cornerstone 2 below) also provide the diabetes inpatient service at Colchester University Hospital.

Where a patient is treated by a diabetes specialist nurse (DSN) at the hospital, they will often be seen by the same DSN if discharged into the care of the diabetes specialist team in the community. This provides a better experience for patients by having a continuous relationship with an identified healthcare professional and their care coordinated by a single team.[9]

7 The contract uses a 'sliding scale' of payments if outcomes are not achieved.

8 Alternatively, horizontal integration is where integration takes place between services or providers at the same level of the care pathway.

9 Guildford, M et al. (2008). *What is continuity of care?*

2 Specialists working in the community

At the heart of NEEDS is a new community based, multidisciplinary diabetes specialist team. The team includes community consultant diabetologists, DSNs, dieticians and a specialist midwife, supported by administrators.[10]

The main purpose of the team is to enable the safe and effective management of patients in practices by providing clinical leadership and governance. Dedicated DSN link nurses from the team provide advice and support in practices and telephone support from the consultant is available when needed.

Where specialist input or an emergency referral is required, an on call DSN, available 9am–5pm, Monday to Friday, triages referrals to the team. (Practices contact their link nurse prior to making a referral).

Once referred, patients are typically seen two-four times in their nearest community clinic over a period of three months (three consultant led clinics are held weekly). Patients are then reintegrated back into their practices. Insulin pump clinics are also provided by the team in practices.

QUICK FACTS

Diabetes specialist team referral criteria

- Insulin or GLP-1 initiation (training is provided to enable practices to initiate these regimes, see cornerstone 3 below)
- Poor glycaemic control (on insulin)
- Recurrent hypoglycaemia
- Admission prevention
- Complex needs/comorbidities
- Psychological support
- Pregnancy/planning pregnancy
- Podiatry/MDT footcare
- Dietetics
- Orthotics
- Patient education

Over the course of the contract the aim is to reduce consultant input from 2.5 days per week in year one to one day per week in year four. This is to reflect the increasing skills of practices in managing a wider range of patients and needs in the longer term.

10 For more information about community based, multidisciplinary specialist teams, including recommended referral criteria, assessment and clinical activities, see NHS England's *Diabetes Sample Service Specification*, available at: http://www.diabetes.org.uk/integrated-diabetes-care

3 Building primary care capacity and skills

Moving care closer to home by shifting hospital care into the community is central to the North East Essex model of care. To enable practices to safely manage a wider range of patients and needs (for example those with Type 1 diabetes),[11] the Federation launched an innovative practice enhanced service (PES) to coincide with the launch of NEEDS in April 2014.

FOCUS POINT

The Practice Enhanced Service (PES)

Funding for the PES is included in the Federation's single contract with the CCG. To date, the PES has been subcontracted to 39 of 42 practices. Practices receive £0.88 per listed patient in 2014/15, rising to £1.70 in 2018/19. 50% is paid monthly on non performance elements (attendance at meetings, annual audit) and 50% is paid at the end of the year on achievement of key performance indicators (KPIs).[12] In 2015/16, 100% of payment will be based on KPIs.

Key features of the PES require each practice:

- **To have an accredited GP and nurse** who will attend quarterly meetings and additional training sessions.
- **To follow NICE guidance for all patients,** (including those exception coded) with an HbA1c > 64 mmol/mol (including initiating insulin or GLP-1s) and for all patients with a cholesterol of > 5 mmol/mol by considering the use of a statin.
- **To standardise annual reviews by implementing care planning for all patients,** including those exception coded under the Quality Outcomes Framework (QOF).
- **To undertake an annual audit of diabetes care,** discuss this with the diabetes specialist team and implement an action plan.
- **To undertake an annual case finding exercise in Q1** to identify patients with a history of impaired glucose regulation (IGR).
- **To formally record, using read codes, confirmation of the eight care processes** provided to patients each year and referral to an education service for newly diagnosed patients.
- **To agree for CCG approved data extraction software**[13] to be installed on practice systems to enable automated downloads of non patient identifiable data to the Federation.

To support the delivery of the PES, Year of Care[14] training for care planning has been rolled out to 90% of all practices free of charge. **Advanced Diabetes Management** training, a course accredited by the University of Essex,[15] has also been provided to GPs and practice nurses to increase the number of Advanced Practitioners and enable more practices to initiate and optimise therapies including insulin and GLP-1 regimes.

11 In general, support for adults with Type 1 should be coordinated by a multidisciplinary diabetes specialist team, based either in a hospital or in a community setting. However, it may be possible for adults with Type 1 to have their ongoing care and support managed outside of the diabetes specialist team provided the person with diabetes chooses this and there is effective integration between those delivering care and the diabetes specialist team. More information available at: https://www.diabetes.org.uk/About_us/What-we-say/Specialist-care-for-children-and-adults-and-complications/Adults-with-type-1-diabetes/

12 The PES uses a 'sliding scale' of payments if targets are not achieved.

13 Supplied by Health Intelligence. The software produces performance dashboards at the practice and CCG area level. The CCG area dashboard is provided to the CCG on a quarterly basis.

14 More information available at: http://www.yearofcare.co.uk/

15 The course was developed in partnership with the diabetes specialist team and includes seven taught sessions and an additional three observational days. Healthcare professionals are supervised in practices by link nurses from the diabetes specialist team and successful candidates are awarded 30 credits at undergraduate Level 6/post graduate Level 7.

FOCUS POINT

Patient case reviews and data sharing in primary care

The Federation hosts quarterly meetings for all practices that have signed up to the PES. At each event, GP and nurse leads from each practice are mixed up to encourage sharing of good practice. Reviews of anonymised patient case studies, led by the consultant diabetologist, allow leads to learn from common clinical issues and discuss treatment approaches.

Referral case studies are also presented to reinforce who should be referred to the diabetes specialist team and individual practice performance data is shared at each meeting to encourage benchmarking.

4 Patient involvement and education

The Federation has invested significantly in engagement events, peer support groups and social media to involve patients in the ongoing development of NEEDS.

Two months before the launch of the service, the Federation provided a 'jargon free' leaflet to all patients outlining the changes they could expect to their care. Three engagement events were also held across North East Essex for 150+ patients to meet the team and voice their ideas for the new service. In February 2015, the Federation ran five further events and three more are planned for 2015/16.

A quarterly newsletter is published to keep patients up to date with the latest developments and demonstrate how their feedback has helped shaped the service (see right). Patients are also involved in the Diabetes Services Board to have their say in how the service is being run.

Two existing patient forums previously hosted by the CCG have been brought under the umbrella of NEEDS, with venue and refreshments paid for by the service. Two local peer support groups, supported by members of the diabetes specialist team, have been setup for patients and their families to meet and share their experiences. Patients can also share their questions and feedback via twitter and facebook and a new website providing information and resources has been launched: **www.diabetesneeds.org.uk**

NEEDS
NORTH EAST ESSEX DIABETES SERVICE

NHS

NEWS FROM NEEDS

WINTER 2014/15

A patient engagement event in Colchester in February 2014

YOU SAY, WE DO! Patient engagement events 2015

- See how we acted on patients' feedback in 2014
- Give your ideas for improving NEEDS for Type 1 and Type 2 patients
- Meet the Patient Forum and local support group members
- Learn about the choices for education and getting involved

Clacton
- Thursday 5th February 6pm-8pm CVS Tendring, CO15 1NZ
- Saturday 28th February 10am-12noon Clacton Leisure Centre, CO15 6DB

Colchester
- Saturday 14th February 10am-12noon St Johns Church Community Centre, CO4 0HP
- Wednesday 25th February 2pm-4pm Greenstead Community Centre, CO4 3QE

Harwich
- Wednesday 11th February 10am-12noon Dovercourt Central Church, CO12 3PH

Jaywick
- Thursday 19th February 10am-12noon Jaywick Methodist Church, CO15 2NA

Walton-on-Naze
- Wednesday 4th March 10am-12noon St Georges Community Centre, CO14 8HN

To book your place at one of the events or for more information, please call **0845 241 3313** or **01473 344930** or you can email **info@diabetesneeds.org.uk**

FOCUS POINT

Improving access to patient education

Patient education is delivered by the diabetes specialist team. A number of flexible options are provided to improve access to structured education and ongoing learning. For patients with Type 1 diabetes this includes **DAFNE** (five days in one week or five days over five weeks), **a locally developed carbohydrate counting course** for those wanting to improve their skills or who are unable to commit to DAFNE (three hours) and **insulin pump workshops.**

For patients with Type 2 diabetes this includes **Conversation Maps** (two hours), **DESMOND** (one day), **X-PERT** (two and a half hours weekly over six weeks), **Living with Diabetes** (modular online course provided by EduCare) and **a locally developed carbohydrate awareness course** for those on insulin (three hours).

Patients are able to self refer onto all courses. In 2015/16, carbohydrate counting courses will be integrated into patient events (during lunch) and other refresher courses provided to improve access to ongoing learning. 100+ patients are expected to attend each event.

DISCUSSION POINT

Why federate in primary care?

The concept of a federation in primary care was first set out by the Royal College of General Practitioners (RCGP) in 2007.[16] A national survey of members of the RCGP revealed that practices may choose to federate:

- To strengthen clinical governance and improve the quality and safety of services.
- To make efficiency savings/economies of scale, for example in back office functions or the procurement of practice services.
- To strengthen the capacity of practices to develop and tender for new services.
- To improve local service integration across practices and other providers.
- To develop training and education capacity.

More recently, the NHS Five Year Forward View in England has recognised that in many areas, primary care is entering the next stage of its evolution. Primary care of the future will build on the traditional strengths of 'expert generalists' and offer care in fundamentally different ways – making it possible for extended groups of practices to form, either as federations, networks or single organisations.

These 'Multispecialty Community Providers' (MCPs) would become the focal point for a far wider range of care that may include employing consultants, shifting outpatient consultations and ambulatory care outside of hospital settings and in time, taking on delegated responsibility for managing the health service budget for their registered patients.[17]

To enable practices to fulfil these ambitions, the RCGP has developed a toolkit providing advice and support to those who are thinking about, or have embarked upon, developing a federation. More information available at:
www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/19A1F84B41A04DFE8AAAF2F65FD3D757.ashx

The British Medical Association (BMA) has also developed a step by step guide to setting up GP networks.[18] More information available at:
www.bma.org.uk/practical-support-at-work/gp-practices/gp-networks/setting-up-a-gp-network

16 Royal College of General Practitioners. (2007). *The future direction of general practice. A roadmap.*

17 NHS. (2014). *Five Year Forward View.*

18 The BMA uses the term 'network' to describe a variety of arrangements where multiple practices come together for a common goal. These arrangements may include, among others, federations, networks, collaborations, joint ventures and alliances.

Lessons learned

1. **Prime contracting is complex** – but it can provide the 'leverage' for aligning providers around the needs of people with diabetes. By controlling a single budget and organising providers across the care pathway, the Federation ensures providers work together to coordinate care and share responsibility for improving outcomes. Although prime contracting carries significant financial risk for the Federation, it has provided an effective mechanism for shifting hospital services into the community.
2. **GP federations are well placed to deliver vertically integrated care pathways for diabetes.** With strong roots in primary care, the Federation has been able to draw on its members' extensive experience of planning and developing services in community settings. By directly employing specialists, the Federation has also been able to expand its capabilities into other levels of the care pathway – delivering a community based diabetes specialist team and services in secondary care.
3. **Shifting hospital services into the community requires early 'open book' conversations with secondary care.** Shifting diabetes activity and staff from secondary care can have significant impact on the ability of hospitals to deliver remaining services. Local systems can better plan for change where commissioners communicate their plans as early as possible and risk analysis and workforce planning are undertaken jointly by commissioning and secondary care leads.
4. **Investment is needed in primary care to enable practices to safely manage a wider range of patients and needs.** Upfront investment in care planning and advanced diabetes management training can help practices to build their capacity and skills. Longer term investment, delivered through innovative contractual mechanisms such as prime contractor led practice enhanced services, can also support practices to deliver higher quality care for patients (eg through incentivising annual audits, case finding, data sharing).
5. **Clinical governance can be improved where consultants are empowered to become 'leaders of the system.'** Access to support and advice from a specialist consultant is essential in building primary care capacity and skills. By embedding community consultant diabetologists at the heart of the system within the diabetes specialist team, the Federation is improving the quality and consistency of clinical leadership and governance at all levels of the care pathway (ie across primary, secondary and community care).
6. **Link nurses can play an important role in nurturing relationships between the diabetes specialist team and practices.** Although the diabetes specialist team continues to see a significant number of patients (including those with more complex needs), by providing clinical leadership and governance in practices, the link nurses are reducing the incidence of inappropriate referrals to the specialist team. Regular 'non clinical' visits have also helped to engage practices, build trust and improve clinical coding.

> "I feel honoured to be part of such an honest and trustworthy team. Yes there have been problems, but the Diabetes Services Board has always been open about sharing and working through them together. As a person with Type 1 diabetes, I was very anxious about the changes to my care. Personally, I have seen a great improvement in care in a short space of time…most of the patients I have spoken to since the changeover are very happy with the care they are now receiving in the community."
>
> **Patient representative, Diabetes Services Board**

7. **Budgeting for insulin pumps requires detailed cost modelling.** Expenditure on insulin pumps exceeded the planned budget for the first year of the service. Costs were underestimated despite an increase in pump funding from the CCG for the new service and due diligence by the Federation. Commissioners and providers should work together to implement NICE guidance for insulin pumps – this includes undertaking detailed cost modelling, based on estimated prevalence data and pump uptake, to forecast expenditure for the duration of the contract.[19]

8. **Scaling up activity and improving outcomes takes time.** Commissioners and prime contractors should work together to agree realistic trajectories, based on accurate baselines, for scaling up activity and improving outcomes. Even with the best data management systems, data flows from subcontractors to the prime contractor can also take significant time to embed (up to six months). Information governance arrangements should be agreed as early as possible during the mobilisation period to prevent delays in reporting.

FOCUS POINT

Reflections from the frontline

"When I was told that the CCG were tendering out the whole diabetes service, except for inpatient care, I had mixed feelings.

On the one hand, I was excited about how the new model would work, developing stronger links with my primary care colleagues and the benefits of vertical integration (which we had failed to achieve for the usual reasons).

On the other hand, I had been clinical lead for diabetes in North East Essex for 18 years and felt some personal and professional resentment at the perception 'my service' was a failure. Although we had achieved some success over the previous two years through informal integration with the then community DSN team, there was significant anxiety about how the service would be transitioned into the community while at the same time keeping our patients safe and our staff supported.

I knew this was what our patients needed. Working with the Federation would provide a more joined up service for our patients and a better working environment for our staff. It was up to us to engage with the change and overcome any resentment we felt.

We developed good working relations with the Federation. They were (and still are) listening to our views and recommendations as clinicians. Forming those relations was straightforward – once we decided to smile and not frown.

I would strongly encourage anyone who may be faced with a similar situation, and there will be many, to take an active and positive role in working with colleagues across the whole system. We can achieve so much more when we work together."

Consultant diabetologist

19 NICE has developed tools to help put the guidance into practice. This includes a costing tool to help commissioners calculate the local costs associated with implementing the guidance and a clinical audit tool to support providers to determine how well they meet NICE recommendations. More information available at: http://www.nice.org.uk/guidance/ta151/resources

Outcomes

The following outcomes were achieved during the first year of NEEDS from April 2014 to March 2015. The outcomes are based on data collected locally by the Federation and GP practices:

- **A 5.3% increase in the diagnosed population** (from 17,470 in 2013/14 to 18,400 in 2014/15).
- **66% of outpatients previously under the care of the acute hospital were discharged and are now being treated in primary care.** (44% of people with Type 1 diabetes and 83% of people with Type 2 diabetes). The remaining 34% are treated by the diabetes specialist team in community clinics.
- **An increase in the percentage of people receiving all eight care processes** (from 40.1% in April 2014 to 60.3% in March 2015).
- **A decrease in the percentage of people with an HbA1c < 64 mmol/mol** (from 66.9% in April 2014 to 65.8% in March 2015). The decrease is likely to have been caused by a combination of factors. These may include, among others, a significant increase in the diagnosed population and an increase in the number of hard to reach patients now receiving routine checks (including those usually exception coded under QOF).
- **An increase in the percentage of people with a cholesterol < 5 mmol/mol** (from 71% in April 2014 to 74.2% in March 2015).
- **An increase in the percentage of people with a blood pressure < 140/80** (from 67.4% in April 2014 to 70.3% in March 2015).
- **31.6% decrease in readmissions for patients with diabetic ketoacidosis (DKA) or hypo/ hyperglycaemia** (from 98 readmissions in 2013/14 to 67 readmissions in 2014/15).
- **95% of patients newly diagnosed with Type 1 diabetes and 96% of patients newly diagnosed with Type 2 diabetes were offered structured education** (within 24 months and 12 months respectively). Of the 1,607 people offered, 588 (37%) booked and 462 (29%) completed.
- **96% of patients stated they were 'likely' or 'extremely likely' to recommend the service to friends or family** (of 85 patients surveyed in September 2014, December 2014 and March 2015).

Future plans

Based on Diabetes UK's recommendations for diabetes care for older people resident in care homes,[20] the CCG has developed a Commissioning for Quality and Innovation (CQUIN)[21] specification for NEEDS. The CQUIN will ensure that people with diabetes resident in care homes are identified, placed on a register held in primary care and receive an annual review (including the eight care processes). The CQUIN will also ensure that a 'link carer' is identified in each care home and training and education resources are provided to all link carers.

The Federation has also initiated discussions with the local Improving Access to Psychological Therapies (IAPT) service to explore the integration of psychological support provided by NEEDS with existing IAPT treatments. A review of the diabetes footcare pathway is also planned for 2015/16 to identify foot complications earlier and reduce amputation rates.

20 More information available at: https://www.diabetes.org.uk/About_us/What-we-say/Diagnosis-ongoing-management-monitoring/Diabetes-care-for-older-people-resident-in-care-homes/

21 Launched in 2009/10, the CQUIN payment framework in England enables commissioners to reward excellence by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

Acknowledgements

Diabetes UK would like to thank Julie Smith, David Pannell, Clare McInerney, Dr. Charles Bodmer, Dr. Vithian Karunakaran, Chris Chaplin and all members of the Diabetes Services Board for their generous time and support in developing this case study.

Further information

For more information about this case study please email **sharedpractice@diabetes.org.uk**

The following documents are available on request:

- NEEDS service specification.
- PES service specification and contract.
- NEEDS CQUIN specification.
- Diabetes specialist team referral form.
- NEEDS patient leaflet and newsletter.

Disclaimer

The information in this case study was obtained from NHS North East Essex CCG, Suffolk GP Federation and other sources. The views and opinions expressed in this case study do not necessarily reflect the views of Diabetes UK.

Author

Ben Ellis, Shared Practice and Innovation Manager, Diabetes UK.

Has this case study helped you to improve diabetes care? Want to share your work with others?
Get in touch by emailing **sharedpractice@diabetes.org.uk**