NHS
Lancashire and South Cumbria
Integrated Care Board

Local Enhanced Service Specification:

Enhanced Diabetes Care

Service Specification No.	
Service	Enhanced Diabetes Care
Commissioner Lead	Lancashire and South Cumbria ICB
Provider	GP Practices in Lancashire and South Cumbria
Period	1st April 2026 to 31st March 2027
Date of Review	To be reviewed annually

1. Population Needs

NHS Lancashire and South Cumbria ICB covers 195 GP Practices and has a total weighted population of 1,988,701 (as of Jan 2026) patients.

The scope of this specification will cover all the 195 practices and registered patients and temporary residents (where appropriate) that live within the geographical area of Lancashire and South Cumbria.

The ambition of the commissioner is to secure the highest quality and most responsive services for local people that are clinically effective and safe but also importantly are consistent and equitable to the population that we serve.

1.1 National/local context and evidence base

Diabetes is a national, regional, and local clinical priority. It is associated with significant morbidity and early mortality, with associated complications including cardiovascular disease, stroke, blindness, renal failure, and lower limb amputation. Diabetes is a major chronic disease which has significant impact on mortality, morbidity, and health costs in the UK.

Diabetes is one of the common endocrine diseases affecting all age groups with approximately 3.5 million people in the England having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetes, particularly type 2 diabetes, is undertaken by the GP and members of the primary care team.

Diabetes is a growing problem for our health services. Over 90% of people with diabetes have type 2 diabetes which can result in severe complications, affecting the eyes, the nervous system, and the kidneys.

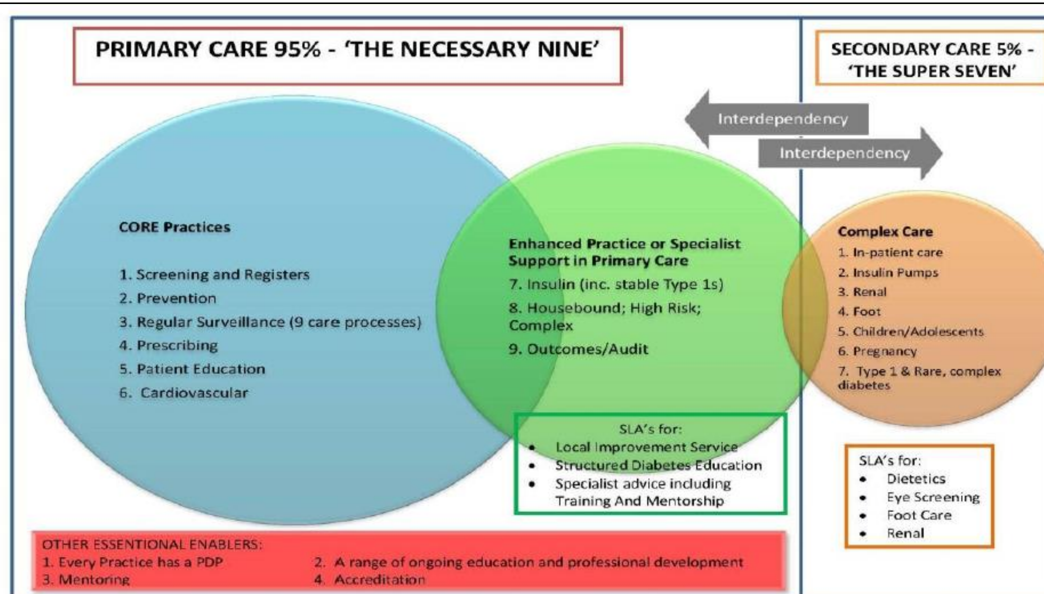
The number of practices referring their patients for support under the care of hospital-based services is increasing, as more patients require additional or intensive treatment to achieve optimal glycaemic control. Developing the capacity for primary care to undertake additional, more specialised services will reduce the need for referral significantly, reduce waiting times, facilitate specialist care to concentrate and improve its service for the more complex diabetes patients and provide a more easily accessible service for patients closer to home.

ICB Vision
To strengthen, integrate, and coordinate all sectors to improve quality of life and health outcomes and reduce the social and economic impact of diabetes in Lancashire and South Cumbria.

Principles
1. Facilitation of person-centred care and self-management throughout life
2. Reduction of health inequities
3. Collaboration and cooperation to improve quality, patient experience, and health outcomes
4. Coordination and integration of diabetes care across services, settings, technology, and sectors
5. Measurement of health behaviours and outcomes

Goals
1. Reduce the burden of diabetes and its complications and improve quality of life.
2. Reduce the impact of pre-existing diabetes and gestational diabetes in pregnancy.
3. Strengthen prevention and care through research, evidence, and data.

Key diabetes objectives for enhanced care (insulin management) providers include:
- improving management of diabetes in Primary Care
- ensuring patients have easy access to treatments and high quality of care
- ensuring patients have better quality of life, improved outcomes, and positive patient experience
- enabling Secondary Care to focus complex patients that require specialist support
- reducing clinical variation in diabetes care, processes, and outcomes
- ensuring the Primary Care workforce are trained and competent to deliver enhanced care
- management of stable patients on insulin therapy, including initiation, monitoring, and dose titration of patients with diabetes as appropriate



All practices are contracted to provide essential core services to all their patients. This service specification outlines enhanced level diabetes care to be provided which is beyond essential core requirements. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Resilience and business continuity
The Provider is to ensure they can continue to deliver this enhanced diabetes service, core diabetes service and associated services in the face of disruption caused by loss of staff for example recruitment issues or staff sickness.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	ü
Domain 2	Enhancing quality of life for people with long-term conditions	ü
Domain 3	Helping people to recover from episodes of ill-health following injury	
Domain 4	Ensuring people have a positive experience of care	ü
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	ü

2.2 Local defined outcomes

Clinical and quality outcomes from the service include:

- Insulin start-ups, dose titration and ongoing monitoring
- prescribing in line with NICE clinical guidelines and local health economy joint formulary
- reduced admissions and outpatient appointments to Secondary Care
- reduce percentage of exception coding and provide clear explanation for non-attendance of appointments and strategies used to encourage attendance
- initiation, monitoring and on-going review for patients meeting the criteria for CGM devices

- transfer of patients on insulin from secondary care to primary care, when stable and appropriate care can be delivered in general practice
- evidence of insulin initiations, monitoring and dose titrations
- for patients on CGM devices, monitoring must take place 2 weeks after initiation and every 3 months thereafter. See links below:
- assessment of improved patient outcomes from baseline
- reduction in hospital admissions and outpatient appointments
- reduction in exception coding and evidence of a multi-systems approach to engaging patients

3. Scope

3.1 Population covered

NHS Lancashire and South Cumbria ICB covers 195 GP Practices and has a total weighted population of 1,988,701 (as of Jan 2026) patients.

The scope of this specification will cover all of the 195 practices and registered patients and temporary residents (where appropriate) that live within the geographical area of Lancashire and South Cumbria.

This specification is intended to cover injectable GLP-1 analogues and insulin that are primary care initiated only. Secondary care will be expected to manage initiation for patients under their care. The specification is intended to cover individuals aged 17 and over.

3.2 Interdependencies with other services

Secondary care services, including, the Diabetologists, GPs with specialist interest (GPwSI) and Diabetes Specialist Nurses (DSNs) and where necessary the referring GP practice.

Where the provider is delivering the service on behalf of other practices data sharing agreements should be in place to enable full access to patients' notes.

Patients who are considered as unstable/poorly controlled should be referred to or advice sought on management from the appropriate specialist team.

The on-going development of an Integrated Model of Care for Diabetes will continually work towards a model that supports both patients and clinicians to deliver high quality diabetes care in the community with the support of specialist clinical leadership.

3.3 Aims and objectives of service

The aim of the service is to deliver a universal enhanced offer to patients in Lancashire and South Cumbria, setting out a range of services that General Practice are expected to deliver to their registered along with temporary registered patients.

Furthermore, the aim of the offer is to ensure an equitable and consistent service to all patients across Lancashire and South Cumbria and to deliver care closer to home.
The overall aim of this service is to commission a comprehensive diabetes service to improve health outcomes for those people with diabetes. This will be achieved by:

- supporting the provision of enhanced general practice-based management of diabetes for appropriately placed patients based on a practice or subcontracting model, offering a comprehensive service with fully integrated access to patient notes via data sharing agreements.
- ensuring that specialist diabetes services are available in a timely manner and closer to patients' homes.
- empowering patients to actively participate in care and control of their diabetes.
- providing a resource to clinicians, in the sharing of knowledge and skills and to improve patient care and outcomes through collaborative working.
- reducing the demand on outpatient and inpatient specialist diabetes activity
- engage with specialist services either face to face or virtually to ensure provision of continued support, development and upskilling for improved patient outcomes.

3.4 Service Outline

The service provider will provide enhanced diabetes care management as detailed in the Enhanced Primary Care diabetes section in the table below:

Diabetes prevention/targetted screening

- general health education, including healthy schools, obesity strategies and public health.
- enable self-care
- NHS health checks

Core primary care diabetes

- screening of patients at risk of diabetes
- management of prediabetes
- long term conditions register and record maintenance and review
- annual review to include the 8 key care processes, BP, BMI, height and weight, ACR, foot assessment, HbA1c, renal function, smoking status, cholesterol management
- ensure patients are referred for retinal screening and encourage uptake
- follow up of uncomplicated type 2 patients as per NICE guidelines
- personalised care plan in collaboration with the patient to support self management
- comprehensive cardiovascular risk assessment and management
- annual medication review
- supporting patient education and referral to support services
- providing lifestyle advice and support

Enhanced primary care diabetes (includes all elements of 'core' above)

- support and follow up for patients with more complex needs that cannot be met in core primary care
- initiation and support for injectable GLP1 patient initiation
- initiation and follow up of patients requiring basal insulin or BD mixed insulin regimes
- routine supportive management and monitoring of patients with well controlled type 1 diabetes and type 2 diabetes on injectable treatments (insulin or complex regimens)

- early follow up and advice following hospital admission for diabetes related illness/complications

3.5 Service requirements

GLP-1 Analogues Initiation
Provide the assessment and initiation of injectable GLP-1 analogues to those patients (not under secondary care) with inadequate diabetes control on oral hypoglycaemic agents (as NICE Guidance) who meet the criteria as set out by LSCMMG.
http://www.lancashireandsouthcumbriaformulary.nhs.uk/

Practice requirements for this service are:
To complete a comprehensive assessment of the suitability of the patient for initiation of GLP-1 analogues which will include:

- concordance with current treatments and discussion around any reasons for non-concordance.
- confirmation of sub-optimal glycaemic control despite maximum tolerated doses of oral hypoglycaemic agents
- confirmation that the patient desires to lose weight
- review of other options available, including emphasis on lifestyle modification
- discussion of the likely side-effects from GLP-1 analogues
- capacity of the patient and/or carer to manage the therapy
- wishes of the patient
- check renal function prior to commencing on GLP-1
- ability to use the pen device
- agreement to regularly self-blood glucose monitor if indicated
- assessment for diabetic complications or symptoms

A decision regarding the continuation (or dose reduction) of oral hypoglycaemic agents alongside GLP-1 analogues therapy should be made.

To provide the following education at the initiation of injectable GLP-1 analogues appointment, and provide an information pack for patients and carers which will include individual information on:

- when to test blood glucose
- dosage
- when where and how to inject
- Hypoglycaemia (for those taking Sulphonylureas)
- diet and exercise
- encourage patients to attend the DESMOND education programme
- treatment leaflet
- pen device booklet
- driving

- managing intercurrent illness
- follow up arrangements

To contact the patient by telephone where appropriate two weeks after initiation of the GLP-1 analogues to check there are no problems with injections and offer support as necessary. Some patients may require support and supervision from the district nurse team until confident.

A follow up appointment, four weeks after GLP-1 analogues initiation should be arranged for the patient. The dose should be increased providing good concordance; minimal side effects; stable or improved glycaemia and stable or slight weight loss. Individual information should be given on:

- when to test blood glucose
- any amendments to oral hypoglycaemic agents
- to provide telephone support/supervision of the patient until stable glycaemic control is achieved.
- to arrange a full clinic review three months following GLP-1 analogues initiation (approximately half hour consultation) some weight loss should be apparent at this appointment.
- to adhere to the agreed guidelines for the initiation of GLP-1 analogues in primary care and relevant care pathways.
- to arrange a 6-month review to assess if there is a reduction in weight and HbA1c (as per NICE guidelines) and as to whether the treatment should be discontinued or not.
- for patients who are house-bound or living in residential, or nursing homes should be offered the same standard of care by the practice as those who are living in their own homes and must include an annual needs assessment and management plan. It is expected that practices arrange a home visit for non-ambulatory patients, but it would be reasonable to expect all ambulant patients to attend the surgery for diabetes care.
- for housebound patients requiring GLP-1 analogues initiation, liaison with the district nurse team/ community matron may be necessary for follow-up support and/or supervision, however, provision of education and information as above should be given.

Insulin initiation

This service is in addition to the core essential contract requirements. It will provide the assessment and initiation of insulin to those patients (not under secondary care) with inadequate diabetes control on oral hypoglycaemic agents as per NICE guidance. It will also provide re-assessment of stable patients.

Provider requirements for this service are:

To complete a comprehensive assessment of the suitability of the patient for transfer to insulin this will include:

- concordance with current treatments and discussion around any reasons for non-concordance

- review of other options available, including lifestyle changes and due consideration to effects of likely weight gain with insulin
- capacity of the patient and/or carer to manage insulin treatment
- consideration of implications to employment and/or social activities
- wishes of the patient
- confirmation of sub-optimal glycaemic control despite maximum tolerated doses of oral hypoglycaemic agents
- agreement to regularly self-blood glucose monitor
- assessment for diabetic complications or symptoms

To ensure the patient makes an informed treatment choice. When the decision has been made to commence insulin treatment, the following should be considered:

- an assessment of dietary pattern
- lifestyle (including periods of activity and exercise)
- driving
- employment/work patterns
- ability to self-care
- the choice of different insulin pen devices

To provide the following education at the first appointment and subsequent reviews:

- when to test blood glucose
- access and initiation of CGM testing and ongoing monitoring where appropriate
- adjustment to Insulin doses
- when where and how to inject
- Hypoglycaemia management
- driving and insulin/hypoglycaemia, DVLA guidelines
- lifestyle advice including, diet and exercise, alcohol etc
- Insulin pen device booklet
- Insulin Passport
- follow-up date with contact name and number for urgent queries

To contact the patient following insulin initiation to check that there are no problems and offer support, as necessary, to be agreed at the initiation appointment. Follow up for dose titration will be required and should be agreed as part of the care plan with the patient.

Suitable patients should be able to self-increase their insulin doses following guidance.

To arrange a follow-up appointment usually four weeks after insulin initiation; the patient should be given education and an information pack which should include:

Information on:

- travel
- fasting
- sick Day Rules

Individual information on:

- when to test blood glucose
- Insulin dose self-adjustment
- contact name and number
- follow-up date

Telephone support/supervision of the patient to continue until stable glycaemic control is achieved.

To arrange a full clinic review for three months following insulin initiation, including blood tests as appropriate.

To ensure prompt referral to specialist diabetes services when required:

- If the HbA1C remains above 58mmol/mol after six months of insulin treatment and where the dose has already been optimised, further advice from the diabetes specialist nurse should be considered.
- Should the patient remain symptomatic and show very little response to insulin treatment, despite regular dose titrations, a discussion with the diabetologist resulting in referral to specialist care may be necessary, advice and guidance may be appropriate in this situation.

To provide the same service as above for housebound patients:

- For housebound patients requiring insulin initiation, liaison with the district nurse team/ community matron may be necessary for follow up support and /or supervision, however, provision of education and information as above should be given.

Patients that meet the criteria for CGM devices must be reviewed at 2 weeks and followed up every 3 months thereafter. Clinicians are expected to follow the SOPs below which include initiation, interpretation of results and ongoing monitoring using suitable available technologies including Libre View and Clarity.

Ongoing monitoring for patients on insulin therapy who are NOT under secondary care follow up, for both Type 1 and Type 2 diabetes patients.

To undertake an enhanced level of review above that required for ‘routine QOF level care’ for those patients on insulin therapy and not having their care monitored by secondary care.

Review to be completed at least 6 monthly, ensuring all 9 key care processes are completed annually.

To provide the following education at each review, personalised to the needs of the patient:

- when to test blood glucose
- access and initiation of CGM testing and ongoing monitoring where appropriate
- adjustment to Insulin doses
- when where and how to inject

- Hypoglycaemia management
- driving and insulin/hypoglycaemia, DVLA guidelines
- lifestyle advice including, diet and exercise, alcohol etc
- Insulin pen device booklet
- Insulin Passport
- follow-up date with contact name and number for urgent queries

3.6 Education, Training and Support

3.6.1 All Providers delivering this service should be competent to do so.

3.6.2 A designated senior clinician in the practice will have overall responsibility for the service. A GP must take overall responsibility for the service even if the lead clinician is the practice nurse.

3.6.3 All staff that are involved in insulin initiation must complete the NHS e-learning module on the safe use of insulin on annual basis or have completed and maintained their competency through other similar training.

3.6.4 Clinical training for CGM should be undertaken and refreshed to ensure that both the processes and interpretation of results are managed effectively.

3.7 Information and Data Collection Requirements

The practice should ensure:

- Maintenance of accurate records, including informed consent, record of interventions, reviews, and outcomes
- Recording of procedure
- Maintenance of an accurate diabetes register (see appendix 2)
- SNOMED coding referrals to; stop smoking, weight management, exercise programmes, and secondary care.
- Commitment to support the specialist primary care clinics audit as part of the diabetes service redesign.

The practice must complete the National Diabetes Audit annually.

3.8 Service Review

This specification is for the financial year detailed at the beginning of the specification. The service and the outcomes will be reviewed on an annual basis, to take account of any relevant changes to QOF, relevant guidance and to ensure that health inequalities are addressed within the service.

3.9 Variation

The service may be varied if the Provider and the ICB agree this in writing.

4. Applicable Service Standards

4.1 Applicable national standards (e.g., NICE)

4.1.1 Infection Prevention

The service provider is required to adhere to all current infection prevention guidance including the Health and Social Care Act 2012 and NICE Guidance CG139 or relevant guidance which supersedes these detailed.

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- National Service Framework for Diabetes 2001 (Gov.uk)
- The National Service Framework for Diabetes 2008 (Diabetes.org.uk)

4.3 Applicable local standards

n/a

5. Location of Provider Premises

Service delivery must be from the premises identified within the providers NHS Contract or where the service has been sub-contracted, the premises must be in suitable premises for delivery of the services set out in the specification.

6. Finance and Activity

Finance

Payment to be claimed by practices:

Initiation of insulin £279.80
Initiation of injectable GLP1 £55
Ongoing care for patients on insulin therapy not under secondary care £85.30

The above prices are per patient per year, although initiation prices are for the year in which the drug is initiated only and not an ongoing price. The above prices include all clinical and administration time and include all appropriate consumables for delivering this service.

The overarching Local Enhanced Service (LES) claims process, timescales, and parameters for practices to submit claims for LES activity is within a 3 month period after the activity has been completed and to ensure that this is included within contractual agreements.

The provider must email lscicb.localenhancedservices@nhs.net by the 10th of every month. Forms must be submitted within 3 months of the activity taking place. Please note that claims submitted to the Enhanced Service Contract Team after the 3 month period will not be approved for payment.

If you have any questions, please contact the Contract Team lscicb.localenhancedservices@nhs.net or your local primary care team

Fraud Policy

In the event of suspected fraud or other illegality being uncovered at any stage the ICB will implement the ICB Fraud Policy and will investigate.

Information supporting reported activity and monitoring information must be made available to the ICB or its representatives upon request. Failure to provide this information, or the provision of incomplete or inaccurate information, may result in suspension of payments or clawback, as well as further investigation by the ICB and its representatives.

7. Monitoring

The provider will need to submit monthly claims stating the number of patients:

- On the diabetic register
- Initiated on insulin in line with the specification
- Initiated on GLP1 in line with the specification
- Monitored for insulin management in line with the specification

These should be recorded using the appropriate SNOMED codes and an appropriate Data Quality Template will be supplied by the commissioner to support automated extraction, where possible.

All details regarding data quality (codes, guides, searches, templates and data extraction) can be found in the Data Guide in Appendix 1. Any changes to data or coding throughout the contractual year will be shared with practices via the Data Quality Team and the GP intranet.

APPENDIX 1 – DIABETES LES DATA QUALITY GUIDANCE

CLAIM CODES

Search named: 1. Initiation of Insulin

Code (Concept IDs)	Description
345041000000101	Insulin treatment initiated **or**
344641000000106	Insulin initiation enhanced services administration

Search named: 2. Initiation of Injectable GLP1

Code (Concept IDs)	Description
702542006	Incretin mimetic therapy started
And include Patients with Medication Issues	
416859008	Exenatide
444828003	Liraglutide
714080005	Dulaglutide
708808004	Lixisenatide
764283003	Semaglutide
1351584008	Tirzepatide

Search named: 3. Ongoing care for patients on Insulin Therapy

Code (Concept IDs)	Description
166221000000105	Enhanced service administration **AND**
170747006	Diabetic on Insulin

GUIDES AVAILABLE

Guides for the following can be found on the GP Intranet/Learning Academy/DQ Specialist:

ML DQ Diabetes LES Guide

For activating the template launcher: **LSC ICB LES Protocol Guide**

TEMPLATES

The page for the Diabetes LES is available as part of the **ML ICB Local Enhanced Services** template and is available through your shared folder in Resource Publisher. Emails will be sent whenever the template is updated. Please ensure that you keep Resource Publisher refreshed to ensure that you are using the most up to date template

A template picker is also available to support the selection of the appropriate template. Instructions on how to enable these protocols are provided in the guide referenced above.

SEARCHES

All searches for the Diabetes LES are available through Enterprise Searches & Reports, the CCG tab at the bottom of Population Reporting. Searches are managed by the Data Quality Team and emails will be sent from the Data Quality Team regarding the location, also when any searches have been updated. Any updated searches will be available in the same place. Searches need to be copied and pasted into your practices folder to be able to use them.

DATA EXTRACTS

All data is extracted based on left/deceased patients and the code above being added to the patients record once within the specified timeframe.

CONSULTATION TYPES

All searches are based on face to face consultation, home visit note, telephone or Enterprise consultation type.

All other consultation types will appear in the ACTION searches as CHECK consultation type, and these should be reviewed. If you find any activity in the Action/Check Consultation Type searches that should count towards claims, add a new consultation to the patient's record (on the same date as the excluded one) using an acceptable consultation type and the correct claim code(s). This keeps the original consultation unchanged and ensures the patient appears in the claim searches.

DATA QUALITY CONTACT DETAILS

All requests for support or query resolution should be logged on the Self-Service Portal at: https://sunrise-saas.com/mlcsu/SContacts/

For any urgent queries please ring: **0300 555 0212**