Service	Nottingham West Diabetes Enhanced Service
Commissioner Lead	Rachael Harrold, Primary Care Commissioning Manager Nottingham & Nottinghamshire CCG
Provider Lead	GP Practices of Nottingham West PCN
Period	1 April 2021 – 30 September 2021
Date of Review	December 2020

1. Population Needs

1.1 National/local context and evidence base

According to new figures released in February 2019 (Diabetes UK) the number of people living with diabetes in the UK has risen to over 4.7million (one in 15 people). There is an increasing trend in the number of adults diagnosed at 3.8 million and almost 1 million people with undiagnosed Type 2 diabetes. By 2030 the total number of patients with diabetes in the UK is expected to rise to 5.5 million.

As the number of people living with the condition continues to rise, there is increasing pressure on the NHS to improve upon the quality of care received by patients as more than 24,000 people a year die prematurely from diabetes.

Type 2 diabetes prevalence in particular has been growing at a particularly high rate and is now one of the world's most common long term health conditions.

Local Context

Based on 2018/19 Quality and Outcome Frameworks (QOF) data, Nottingham West has 6,271 diabetic patients registered across 12 practices. This accounts for 5.89% of Nottingham West's registered population. However, Public Health estimates the total prevalence of people with diabetes in Nottingham West, both diagnosed and undiagnosed, to be 8.4%, with the average in England being 8.8%.
Information provided by East Midlands Clinical Network indicates there has been a 32.3% increase (1,494) in the CCG's diabetic population from March 2014 to March 2019.

Evidence Base and General Overview

There will be a significant increase in the number of patients with diabetes and many type 2 diabetics who will need to be converted to insulin therapy. Traditionally insulin initiation has been managed in secondary care, however this document sets out standardised and effective processes for the care of patients receiving insulin initiation and diabetes management in primary care, whilst minimising the associated risks.

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 following injury	x

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

2.2 Local defined outcomes

It is expected that the provision of this service within Nottingham West PCN practices will lead to:

- High quality personalised health care for diabetic patients
- Improved quality of life for patients
- Improved self-management by patients through the effective use of care plans and education
- Improved care closer to home in the community
- Patients receiving appropriate support and education to work towards optimised control
- Increased and improved management of diabetic patients in primary/intermediate care with fewer urgent/non-urgent admissions into secondary care
- Reduction in the out-patient new/follow up ratio for diabetic episodes of care through earlier discharge into primary/intermediate care
- Compliance with NICE Guidance NG28, Management of type 2 diabetes in adults when starting insulin therapy and prescribing
- A provision of a parity of esteem between mental and physical ill health with the promotion of psychological therapies to those patient with comorbid depression and diabetes
- Clinicians being upskilled through on-going support and education
- Ensure the 18 week wait target does not come under threat with the rising diabetes prevalence
- Collaborative working with the Diabetic Specialist Nurses (DSN)
- Increased clinical engagement and innovation

3. Scope

3.1 Aims and objectives of service

The aim of this service is to implement a comprehensive care model, which will span the gap between primary care and secondary care. The service will enable the specialised care of people with diabetes to be managed within primary care, rather than looking to secondary care for all of the specialised on-going management of the condition.

All practices are expected to provide essential services and those additional services they are contracted to provide to all of their registered patients. The specification for this service is designed to cover the enhanced aspects of clinical care of the patient only, all of which are beyond the scope of essential services.

The objectives of the service are:

- To provide standardised and clinically effective insulin initiation and management to patients
- To actively identify patients with type 2 diabetes who are appropriate for the initiation of insulin by the practice
- To identify patients with type 2 diabetes and offer transfer of care from hospital to primary care clinics for appropriate patients in accordance with need
- To initiate insulin for suitable patients in line with NICE recommendations or when clinically necessary to do so
- To produce optimum management of diabetic patients and provide support to

patients with suboptimal control
- To educate patients in understanding their treatment, such as diet, lifestyle and medication
- Initiate care planning for all identified patients and encourage active involvement of the patients in deciding, agreeing and owning how their diabetes will be managed
- To optimise care to patients receiving insulin in terms of accessibility, continuity and waiting times
- To actively identify patients with comorbid depression and anxiety and to provide information of available psychological therapies
- To support data capture for audit purpose
- To provide a minimum of 4 clinics per annum

3.2 Service description/care pathway

The following should be adopted by all primary care providers within Nottingham West.

3.3 Roles and responsibilities:

Responsibilities of Nottingham and Nottinghamshire CCG:

- Commission and monitor the performance of primary care providers, in accordance with the outlined criteria of the Nottingham West Diabetes Enhanced Service
- Ensure all service providers meet quality standards with support from the DSNs
- Ensure that all providers submit minimum data set to enable regular audit of the diabetes enhanced service
- Make appropriate payments to the relevant providers on receiving the full evidence that the specified and agreed thresholds have been met

Responsibilities of Diabetes Enhanced Service Providers:

- Ensure a system is in place for clinicians to receive urgent medical advice relating to diabetic patients on their caseload
- Ensure patients receive equal or better service than that received in secondary care
- Develop and maintain a register of all patients who are receiving insulin therapy
- Ensure patients are receiving at least 6 monthly blood testing (interim HBA1c or annual bloods) and an annual review
- Ensure that all staff involved in providing any aspect of care under this service has the necessary training and skills to do so
- Refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist, when appropriate to do so (for example IAPT services)
- To ensure that the service is provided by appropriately trained and qualified practice nurses and general practitioners
- Ensure that all newly diagnosed patients (and/or their carer and support staff when appropriate) receive appropriate education on the management of, and prevention of, secondary complications of their diabetes in line with NICE guidance
- Practices are encouraged to work collaboratively with the Diabetic Specialist Nurses (DSN) in Nottingham West allowing them access to the patient's notes and allow the registered patients to be seen within the practice
- To ensure that 4 pro-active clinics are provided per year within the practice
- All participating practices will be required to nominate an appropriate diabetes lead/s
- To ensure that the necessary administrative support is available to ensure the efficient running of the service
- Practices are required to attend two upskilling education sessions each year in order to upskill clinicians with regards to diabetes and insulin initiations, this will also offer the opportunity for peer to peer support
- Practices are required to circulate a satisfaction survey to a random sample of the entire practice population – this is to be submitted annually in an agreed format, see

overview of diabetes enhanced service for more information

- All practices are asked to inform Nottingham & Nottinghamshire CCG of any changes to the clinicians delivering this service, as it is a requirement that all clinicians meet the required accreditation standards

Responsibilities of the patient's Registered GP Practice:

- Overall responsibility for the care of the patient continues to reside with the patient's registered GP
- Continue to provide core diabetes care, as part of the medical contract and ensure that all patients receive appropriate monitoring
- Being aware of appropriate advice and guidelines for diabetes care
- Arranging referral to secondary care if required in accordance with the referral criteria
- Issuing insulin prescriptions and appropriate monitoring of injectable consumables
- Ensure that all patients receive appropriate monitoring

Training/review:

The responsible practice must ensure that all staff involved in providing any aspect of care under the scheme has the necessary training and skills, liaising with the DSN where necessary. This will consist of the following:

- Practices are required to attend two upskilling education sessions each year, in order to upskill clinicians with regards to diabetes and insulin initiations, this will also offer the opportunity for peer to peer support
- Practices are required to engage four clinics per annum to facilitate enhanced learning and development in diabetes care
- All practices have a named diabetes lead GP and practice nurse with appropriate skills and experience
- All practices distribute an agreed satisfaction survey and provide a minimum of 10 returns and with a maximum of 5% of the entire practice diabetics population response to Nottingham West in an agreed format on an annual basis – this will inform the CCG on the service and provide qualitative information
- Practices works towards an approved set of skills for all Practice Nurses/Health Care Assistants delivering diabetes care; DSN and Clinical lead to agree skill set.

Overview of Diabetes Enhanced Service: 1 April to 30 September 2021

The Nottingham West Diabetes Enhanced Service is made up of two indicators, Indicator C having been removed as a requirement for the period 1 April to 30 September 2021

To be eligible to provide this service practices must meet the requirements of Indicator A and Indicator B as set out below

Appendix 1 provides a breakdown of funding.

Indicator A

Indicator	Definition	Measure
Diabetes Education	Each practice must be represented at the twice yearly education session unless otherwise agreed by the Diabetes Clinical lead	At least one member of the clinical team attends the education session (occurs twice a year)
Satisfaction	The satisfaction survey is extended to a random sample of the entire practice diabetic population (minimum 10 returns and with a maximum of 5% of the diabetic population).	Satisfaction survey data to be submitted as evidence in Q2
Diabetes Lead	All practices have a named Diabetes Lead, and that all practices have a suitably trained Diabetes nurse – this is to be review annually. For practices who do not have a suitably trained diabetes nurse, practices are to formulate an action plan and training schedule for their nurse to be approved by the clinical lead/DSN	Clinical lead identified. This can be a diabetes nurse or other individual.

Indicator B

Indicator	Definition	Measure
Insulin Initiating practices *(Both practice staff and DSNs able to initiate insulin)*	Appropriately trained practice team performing enhanced role of insulin starts and insulin dose adjustment. Practice to arrange 4 joint clinics with the DSNs, (1 per quarter).	**Evidence required:** Q1-Q2: One detailed case study to be submitted per quarter
or		
Non-insulin initiating practices *(Insulin initiated by*	Practice to arrange a minimum of 4 joint clinics with DSNs, 1 per quarter, with a focus on patients with suboptimal control or difficult issues where active management	**Evidence required:** Q1-Q2: Three detailed case studies to be submitted per quarter

DSNs <u>only</u> and not by practice staff)	is deemed to be beneficial. It is expected that each clinic is populated with a minimum of 5 patients, filled and run by the practice, with expectation of; a) Improving patient care e.g. control/BP etc. b) Looking for a system which could be improved in the practice e.g. suboptimal lipid control due to simvastatin - search all diabetics on simvastatin - move to appropriate dose atorvastatin. c) Looking for odd drug combination - ensuring there is a practice protocol for GP's which they all follow d) Identifying patients who are suitable for the IAPT service	Q1: Learning outcomes to be submitted with one area of audit identified for the coming year Q2: Audit outcome to be submitted

Management of previously discharged insulin initiated patients in primary care
All previously discharged patients from secondary care should continue to receive their annual review under the service.

3.4 Any acceptance and exclusion criteria and thresholds

All patients identified on the practice Diabetes register who are aged 17 and over.

Patients who are not registered with a Nottingham West GP practice or who do not have a confirmed diagnosis of diabetes are not eligible for the Diabetes enhanced service. Any patients being excluded from the service must be discussed and agreed with the relevant GP.

The service will run alongside existing secondary care services which cater for those with more specialised care needs and experience the following conditions:

- Insulin pumps and those who need continuous blood glucose monitoring
- Ante and post natal care for women with diabetes
- Gestational diabetes
- Long term complications:
  - Renal – unstable eGFR <30 or declining renal function
  - Vascular – where vascular complication requires referral to secondary care i.e. foot disease, difficult Hypertension and Ischaemic Heart Disease etc.
  - Children and young people – who will be referred to a Consultant Paediatrician

3.5 Interdependence with other services/providers

Establish key working relationships and interdependencies with:

- Consultants/clinical lead
- General Practitioners
- Practice Nurses
- Podiatrists – particularly in relation to diabetic foot care

- Pharmacists
- Ophthalmologists – particularly associated with Diabetic retinopathy
- Diabetes Specialist Nurse
- Other Specialist Nurses
- Public Health professionals
- Physiotherapists/Occupational Therapists/Pharmacists
- Community Matrons
- District Nurses
- Other statutory agencies involved in the care of people with diabetes
- Third/voluntary sector organisations associated with diabetes care and advice

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)
The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
The provider must ensure they are aware of, compliant with and provide evidence if required to demonstrate compliance with any relevant standards.

4.3 Applicable local standards
The provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all local policies, procedures and guidance. CQC registration is completed and the essential 16 standards achieved. Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

Serious Incidents (SI's) and Patient Safety Incidents (PSI's)
It is a condition of participation in this service that providers will report all Serious Incidents that relate to primary care services to the appropriate CCG, in line with NHS England's Serious Incident Framework, March 2015 (new Patient Safety Incident Response Framework (PSIRF) in development, anticipated roll out Autumn 2022). If it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. If deemed to be a Serious Incident the incident will be logged by the CCG on the current serious incident management system STEIS (the Strategic Executive Information System) or any other data base as directed by national guidance.

Safety Alerts
Providers must ensure that they are aware of and have a process in place for managing any safety alerts from the following sources that apply to any equipment or patient safety concerns associated with this enhanced service and that these are acted upon:

- Medicines and Healthcare products Regulatory Agency (MHRA) http://www.mhra.gov.uk/#page=DynamicListMedicines
- Central Alerting System (CAS) https://www.cas.mhra.gov.uk/Home.aspx
- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the CCG within the designated timescale.

4.3.1 Infection Prevention and Control

Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone (The Health Act 2008) Registered providers should meet the requirements of The Health and Social Care Act 2008. The provider should:

- Have systems in place to manage and monitor the prevention of infection, including regular audit and training. Infection prevention and control training for all staff every 2 years and hand hygiene yearly for all clinicians
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections and meets national estates guidance and local IPC guidance
- Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely manner
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others
- Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide adequate isolation facilities
- Secure adequate access to laboratory support
- Have and adhere to infection prevention and control policies that are based on national and local guidance
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
- Have robust systems and processes in place to manage pandemics at a practice level including the management and reporting of staff outbreaks

Safeguarding

All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance: -

Children: https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies

Looked After children:
https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge_skills_and_competence_of_healthcare_staff.pdf

Adults: https://www.rcn.org.uk/professional-development/publications/pub-007069

All staff will comply with Nottingham and Nottinghamshire safeguarding children and adult procedures which can be accessed via these links: -

Safeguarding Children Procedures City & County: -
https://nottinghamshirescb.proceduresonline.com/

Safeguarding Adult Procedures Nottinghamshire : -
https://nsab.nottinghamshire.gov.uk/procedures/

Safeguarding Adult Procedures Nottingham City: - https://www.nottinghamcity.gov.uk/information-for-residents/health-and-social-care/adult-social-care/adult-safeguarding

On the request of the commissioner, the provider will provide evidence to give assurance of compliance with safeguarding standards.

5. Applicable Quality Requirements and CQUIN Goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN Goals (See Schedule 4 Part E)
To be agreed by commissioner

6. Location of Provider Premises

The Provider's Premises
The Service will be provided within the boundaries of Nottingham West PCN. Providers must have adequate mechanisms and facilities including premises and equipment as are necessary to enable the proper provision of this service.

Location(s) of Service Delivery
The Provider is required to carry out the service within a recognised primary care setting registered for the purpose of healthcare.

Days/Hours of operation
As a minimum the service will operate Monday to Friday 8am to 6.30pm, GP core opening hours. The service will be expected to provide a variety of clinic times providing choice for the patient and will vary from provider to provider.

7. Contract

The contract will run from 1 April 2020 to 30 September 2021. As an outcome of the CCG wide review of diabetes services, this service will cease on 30 September 2021

The notice period is three months for termination under General Condition 17.2.

Practices must confirm in writing to the Primary Care Commissioning Team if they will be participating for the remaining period of the service (Q1 & Q2) and confirm if they are an insulin initiating or non-insulin initiating practice.

Practices will be eligible for payments on a quarterly basis paid in arrears on production of the quarterly data set and evidence required for monitoring purposes.

Appendix 1 provides a breakdown of funding.

Evidence must be submitted to the Primary Care Commissioning Team nnccg.primarycarenotts@nhs.net within the month following the completed quarter:

- Q1 (April - June) evidence must be submitted by 31 July
- Q2 (July – Sept) evidence must be submitted by 31 October

If practices do not meet any part of the criteria in the applicable quarter or fail to produce the required evidence, payment will not be made.

Remuneration and Outcome Measures: April to September 2021/22

Indicator A: all practices that provide the diabetes enhanced service are required to deliver Indicator A. Funding will be split evenly between the 12 practices.

Indicator B: all practices that provide the diabetes enhanced service are required to deliver one aspect of Indicator B dependent on whether they initiate insulin or do not. Funding, equivalent to £3.25 per patient, will be paid based on the number of registered diabetic patients as at 1 April 2021

Diabetic Population
The funding awarded to participating practices will be weighted on each of the 12 practice's diabetic population. This will be the practices diabetic population as of 1 April 2021 (those on register aged 17 and over), and will be determined by QOF or eHealthScope.

Appendix 1: Nottingham West Payments 2021/22 (1 April to 30 September)

Indicator A

Practice Name	Practice Code	Type	Q1	Q2	Total Payment
Abbey Medical Centre	C84065	GMS	£600	£600	£ 1,200
Bramcote Surgery	C84112	GMS	£600	£600	£ 1,200
Hama Medical Centre	C84624	PMS	£600	£600	£ 1,200
Saxon Cross	C84042	PMS	£600	£600	£ 1,200
The Linden Medical Group	C84107	GMS	£600	£600	£ 1,200
Eastwood Primary Care Centre	C84032	GMS	£600	£600	£ 1,200
The Manor Surgery	C84080	PMS	£600	£600	£ 1,200
The Oaks Medical Centre	C84030	GMS	£600	£600	£ 1,200
Hickings Lane Medical Centre	C84705	PMS	£600	£600	£ 1,200
Chilwell Valley & Meadows	C84120	GMS	£600	£600	£ 1,200
Giltbrook Surgery	C84667	PMS	£600	£600	£ 1,200
Newthorpe Medical Centre	C84131	PMS	£600	£600	£ 1,200
				TOTAL	**£14,400**

Indicator B - number of registered diabetic patients by practice as of 23 July 2020 (data source eHealthScope)

Payments for 2021/22 equivalent to £3.25 per patient will be based on the number of registered diabetic patients as at 1 April 2021 (table to be updated and circulated to practices once data is available).

Practice Name	Practice Code	Type	No. of Diabetic Patients in Practice	Q1	Q2	Total Payment
Abbey Medical Centre	C84065	GMS	305	£496	£496	£991
Bramcote Surgery	C84112	GMS	199	£323	£323	£647
Hama Medical Centre	C84624	PMS	273	£444	£444	£887
Saxon Cross	C84042	PMS	445	£723	£723	£1,446
The Linden Medical Group	C84107	GMS	487	£791	£791	£1,583
Eastwood Primary Care Centre	C84032	GMS	1,462	£2,376	£2,376	£4,752
The Manor Surgery	C84080	PMS	766	£1,245	£1,245	£2,490
The Oaks Medical Centre	C84030	GMS	500	£813	£813	£1,625
Hickings Lane Medical Centre	C84705	PMS	374	£608	£608	£1,216
Chilwell Valley & Meadows	C84120	GMS	788	£1,281	£1,281	£2,561
Giltbrook Surgery	C84667	PMS	296	£481	£481	£962
Newthorpe Medical Centre	C84131	PMS	473	£769	£769	£1,537
		TOTAL	6,368		**TOTAL**	**£ 20,696**