Fit for the Future
Working together to keep people well

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Diabetes Local Enhanced Service 2017/19

1. Purpose of Agreement

This Agreement outlines the service to be provided by the Provider, called Diabetes LES 2017/19.

2. Duration of Agreement

This agreement is for a period of two years, commencing **1st April 2017** and ending on **31st March 2019.**

3. Background

Prevalence of diabetes is increasing, in 2008/09 there were 31,000 people with a diagnosis of diabetes in Cambridgeshire and Peterborough. Latest QoF data (2015/16) shows numbers have now increased to 43,000 people with a diagnosis of diabetes. Based on current trends, this figure is expected to rise.

Diabetes is one of the STP priority areas, and review of the RightCare data shows the outcomes for people with diabetes are poor in comparison to other CCG areas. Cambridgeshire and Peterborough CCG is currently rated as “greatest need for improvement” for diabetes.

4. Aims

The aim of the Diabetes LES is to support primary care training and development, and to encourage more integrated working with the specialist diabetes teams in community and secondary care.

This will help to improve outcomes for patients by promoting attendance at structured education and supporting the achievement of NICE Recommended Treatment Targets: HbA1c, Blood Pressure and Cholesterol, which will help to prevent or delay the development of the long term complications of diabetes.

Additionally engagement in the LES will help to reduce the expected increase in the number of people developing type 2 diabetes. This will be achieved through proactively identifying and referring people who are at high risk of developing the disease (NICE Guidance PH38) to our local NHS Diabetes Prevention Programme.

5. Service Delivery

As part of the Diabetes LES Practices agree to:

Have a named Clinical Lead(s) for Diabetes*:
Named clinical leads should have, or be working towards agreed diabetes competencies; these are set out in the CDEP modules, and are covered as part of the Diabetes Study Days:

- Practice to provide name of their Diabetes Clinical Lead. Where the lead is a Practice Nurse not a GP, there should be a GP Champion who is able to provide support to the lead nurse.

- Engage in any training that supports maintenance and/ or development of diabetes competencies. This may include attendance at annual study days set up by the Diabetes Network, other Diabetes Training Events, or CDEP online training the Practice considers to be relevant:

    - Practice to provide the name of the clinician(s) and date of the diabetes training undertaken **OR**
    - Practice to confirm name(s) of staff members who have completed at least 2 modules of the Cambridge Diabetes Education Programme (CDEP) training during the year, and which modules completed. This is FREE to all NHS staff working within Cambridgeshire and Peterborough, and is accessed online https://www.cdep.org.uk/

**Practices may wish to provide this on a federated basis where such arrangements exist within their localities.*

- The CCG is exploring ways of obtaining more timely information regarding achievement of treatment targets, and the Practice commits to engage with the CCG (Primary Care Information Team) to determine how best this can be done. The CCG commits to working with the LMC to ensure IG requirements are met, and workload for Practices is kept to a minimum.

Practices will be commissioned to provide the following objectives. Practices must achieve all objectives to achieve full payment:

Objectives	**Measure and further details**
1. DELIVERING TREATMENT TARGETS: BLOOD PRESSURE CONTROL, HbA1C, CHOLESTEROL	
1.1 CASE FINDING & INTEGRATED WORKING	
Case finding and integrated working between primary, community and acute services: a) To identify undiagnosed people with diabetes (case finding) b) To proactively manage: - patients with diabetes ensuring that blood pressure, HbA1c and cholesterol are optimally controlled - patients at risk of developing diabetes	Practices should specify what work has been done to achieve this. Methods may include, but not be limited to: ▪ Electronic searches to identify high risk patients suitable for diagnostic testing such as previous gestational diabetes or pre-diabetes and proactive care ▪ Follow up from NHS Health Checks ▪ Designing and implementing systematic processes e.g. call and recall systems to enable the activities above to be regularly undertaken and consistently implemented ▪ Engagement and co-operative working with existing and new staff in the community diabetes team to optimise control of blood pressure, HbA1c and cholesterol ▪ Aim to improve on 2015/16 National Diabetes Audit baseline ▪ Refer eligible patients to the local NHS DPP programme where clinically appropriate.

1.2 INTEGRATED WORKING WITH COMMUNITY & SECONDARY CARE	
<u>Attend at least one Virtual Clinic(s):</u> Support the Clinical Diabetes Lead and others to attend the VCR clinics with the community diabetes team, and, subject to availability or where the practice has been prioritised for support, Consultant Diabetologist.	▪ Practice to confirm date of VCR booking(s). ▪ Work with clinical team on areas of need individual to surgery and caseload ▪ Focus on improving NICE recommended treatment targets, particularly optimising blood pressure ▪ Additional focus on discussing patients with more than 2 diabetes related admissions in the last year.
<u>Practice visit:</u> Arrange a one hour practice visit with the diabetes specialist nurse / diabetes technician and local GP lead, and, subject to availability or where the practice has been prioritised for support, consultant diabetologist.	▪ One visit per year expected. Practices may wish to arrange a joint visit with a nearby practices in their locality ▪ Visit discussion to be decided by practices and diabetes team in advance. Suggested areas practices may wish to focus on include discussion of practice National Diabetes Audit results, difficult cases, clinical guidelines and local challenges.
2. PATIENT EDUCATION	
<u>Self-Management:</u> Support Diabetic patients to be engaged in self-management of their condition, and make best use of psychological services where appropriate.	▪ Practice to refer 90% of all newly diagnosed diabetics to a Diabetes Education Programme and ensure accurate coding within the clinical system using the national guidance. ***(DESMOND is now available to those within first 2 years of diagnosis – part of bid).*** ▪ Practice to follow up patients who do not attend a Diabetes Structured Education Programme, with the aim of increasing the number of patients attending. ▪ Practice to provide numbers of patients who have been referred to the CPFT Psychological Wellbeing Service (formerly IAPT) where appropriate to encourage management of an underlying psychological problem and engagement with self-management of their long term condition(s).
Practice staff to engage in training on motivational interviewing and health coaching.	▪ Name and date(s) of staff attendance at health coaching training.
3. PATIENTS AT RISK OF DEVELOPING DIABETES	
NHS Diabetes Prevention Programme: Offer referral to all relevant patients where clinically appropriate.	▪ Practice to provide number of relevant patients who have been offered referral to local NHS DPP, how many have accepted; how many were referred following a Diabetes UK website self assessment (when available). ▪ Practice to undertake retrospective search for pre diabetic patients in line with CCG guidance, clinically check that patients are appropriate for referral to the NHS DPP, and provide the search results to ICS (local NHS DPP provider) to send invitation letters on

	behalf of the practice – Practices may decide to write to patients directly if they wish, or have the opportunity to implement an equivalent practice led process to achieve the same aim. ▪ Please give examples of reasons given for patients not wanting to participate in the programme.

COMPONENT	DRAFT PROPOSED FUNDING
1. Delivering integrated care & treatment targets	30p per head*
2. Patient Education	20p per head
3. Patients at risk of developing diabetes	10p per head

*****Per head of registered patients on the practice list at 1st April 2017.

6. Service outline

a) **The development and maintenance of a register**. Contractors should be able to produce an up to date register of all patients which includes patient ID reference number, date of birth, the indication for, and length of treatment

b) **Professional Links.** To work together with other professionals when appropriate. Any health professionals involved in the care of patients in the programme should be appropriately trained

c) **Referral Policies.** When appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist

d) **Patient Education.** To provide education to patients (and their carers and support staff when appropriate) in the management of their condition

e) **Call and Recall.** To ensure that a systemic call and recall of patients on this register is taking place either in a hospital or general practice setting

f) **Clinical Procedures.** To ensure that all clinical information related to the service is recorded in the patient's own GP held lifelong record

g) **Record-Keeping.** To maintain adequate records of the service provided

h) **Training.** Each practice must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so

i) **Review.** Providers must perform an annual review and make available to the Commissioner on request:
Evidence to demonstrate achievement of the objectives, collated through completion of the reporting template.

7. Accreditation

Those doctors who have previously provided services similar to this service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and

competence as is necessary to enable them to contract for the service shall be deemed professionally qualified to do so.

8. Untoward events

It is a condition of participation in this service that practitioners will give notification to the Commissioner clinical governance lead of all emergency admissions or deaths of any patient covered under this service, where such admission or death is or may be due to usage of the drug(s) in question or attributable to the relevant underlying medical condition. This must be reported within 72 hours of the information becoming known to the practitioner. This is in addition to a practitioner's statutory obligations.

9. Activity Reporting and Payment Arrangements

Reporting Arrangements
Practices are required to complete the Diabetes LES Reporting Template, to report the following information on and submit to sally.berry1@nhs.net on the following dates: 15th April 2018, 15th October 2018, and 15th April 2019.

Practices are required to demonstrate achievement against each of the objectives outlined in the table in Section 5.

If Practices require help or advice on clinical recording, coding and reporting, please contact The Primary Care Information team via the following email address: capccg.primarycareinformation@nhs.net.

Payment Arrangements
Practices will receive an aspirational payment of 30ppp based on list size as of 1st April 2017 upon sign up to this agreement, with a final balancing payment of 30ppp to be paid upon full achievement of the objectives for the year 2017/18 following submission of the final report. Any adjustments to be made at year end if necessary.

The same payment process will apply for 2018/19, and Practices will receive an aspirational payment of 30ppp based on list size as of 1st April 2018, with a final balancing payment of 30ppp to be paid upon full achievement of the objectives for the year 2018/19 following submission of the final report. Any adjustments to be made at year end if necessary.

10. Payment Verification

Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available and Practices are encouraged to utilise Practice computer systems to enable this condition to be met.

11. Performance

The CCG reserves the right to suspend the commissioning of this service where there are concerns around compliance and patient safety.

12. Safeguarding Adults

It is important that practices protect adults from avoidable harm (as defined in Safeguarding Adults guidelines) including safeguarding training, training on the Mental Capacity Act and Deprivation of Liberty. A Safeguarding lead should be identified in each practice.

13. Care Quality Commission (CQC)

The provider must meet CQC standards and where appropriate be registered with the Care Quality Commission (CQC). The standards and the relevant services are contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2014.

14. Termination

Should either party wish to terminate this agreement, a minimum period of 3 months notice must be provided in writing.

15. Signatories to the Agreement

Practices wishing to provide this service are required to complete and sign the application form, and return to the Commissioner for consideration.