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

1. Population Needs

1.1 National Context

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

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

Based on 2018/19 QOF data, Nottingham North & East has 6,997 patients registered with diabetes accounting for 4.94% of the population.

Evidence base

There will be a significant increase in the number of patients with type 2 diabetes who will 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 NNE practices will lead to:

- High quality personalised health care for diabetes patients
- Improved self-management by patients through the effective use of care plans
- Improved care closer to home
- Patients receiving support from appropriately qualified and competent healthcare professionals to work towards optimising their control
- Increased and improved management of patients living with diabetes 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 clinical standards N28 2015 and local guidelines when starting insulin therapy and prescribing
- Clinician's upskilled through on-going support, mentorship and education
- 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, 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, 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 for patients living with diabetes
- To educate patients in understanding their treatment, such as diet, lifestyle choices and use of medication
- Initiate care planning in partnerships with the patient for all identified and encourage active involvement when 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

3.2 Service Description/Care Pathway

The following should be adopted by primary care providers within Nottingham North and East who provide a level 1, 2 or 3 Insulin Initiation Diabetes Service.

Roles and responsibilities

Responsibilities of Nottingham and Nottinghamshire CCG:

- Commission and monitor the performance of primary care providers, in accordance with the service level agreement for the provision of a level 1, 2 or 3

diabetes services

- Ensure a system is in place for clinicians to receive urgent medical advice relating to people living with diabetes on their caseload
- Ensure all service providers meet quality standards with support from the Diabetes Specialist Nurse
- Ensure that all providers submit minimum data set to enable regular audit of the consortium's diabetes 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 service providers:

- Ensure all people living with Type 2 diabetes receive an equal or better service than that received in secondary care
- Ensure appropriate business continuity plan measures are in place for service delivery
- Lead responsibility for insulin initiation and management will be as follows (see Accreditation below):
    - Level 1 (Mild complexity) – insulin Initiation (as well as other non-insulin injectable therapies) and management for all patients led by the Diabetes Specialist Nurse (DSN) (employed by Local Partnerships); principally through joint clinics with practice staff
    - Level 2 (Moderate complexity) – insulin Initiation (as well as other non-insulin injectable therapies) and management for patients in the mild and moderate categories led by the practice, support from the DSN service focused upon patients in the severe category principally through support and joint clinics with practice staff
    - Level 3 (Severe complexity) – Insulin Initiation (as well as other non-insulin injectable therapies) and management led by the practice with support from the DSN service focused upon patients in the severe/complex category. Principally through support and mentorship via joint clinics with practice staff as deemed appropriate

Responsibilities of the patient's GP:

- To ensure that the service is provided by appropriately trained and qualified nurses and general practitioners
- Overall responsibility for the care of the patient continues to reside with the 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. At least 6 monthly if on newer oral therapies, non-insulin injectables and insulin
  Practices signing up to levels 1, 2 or 3 Insulin initiation will allow the DSN access to the patient's notes and allow the registered patients to be seen within the practice
- All participating practices will be required to nominate an appropriate diabetes lead/s who has completed appropriate training
- To ensure that the necessary administrative support is available to ensure the efficient running of the service
- To ensure quality management of the service and on-going evidence based practice, all service levels are expected to sign up to a Diabetes Practice Development Plan facilitated by the DSN

- Practices are required to attend three 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 implement a triage booking process to ensure the DSN clinics are used appropriately; failure to do so may result in the DSN service being withdrawn. It is advised the Practice Diabetes Lead Clinicians are solely responsible for the booking process of the clinics
- All practices are asked to inform the Primary Care Commissioning Team, 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

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. This will consist of the following:

- Practices are **required to attend three upskilling education sessions** each year, one of which must be represented by a GP in order to upskill clinicians with regards to diabetes and insulin initiations, this will also offer the opportunity for peer to peer support
- A **randomised audit of patients initiated and managed** under the service to ensure improved care and management of patients with diabetes
- Practices delivering **level 1 and 2 are required to engage in at least 10 joint clinics per annum** for mentorship with the DSN to facilitate enhanced learning and development in diabetes care
- Practices delivering **level 3 care will ensure that regular contact with the DSN is maintained** through ad hoc joint clinic / meetings or peer review
- All practices have a **named diabetes lead GP AND practice nurse** with the appropriate skills and experience required

Accreditation

Accreditation will be validated through practice supervision by the DSN to assess level of competency according to the complexity of patients and practice competency to manage.

Practice's level of accreditation

The practice is contracted to deliver care at the level agreed by the community DSN. The review/evaluation will be agreed on a quarterly basis through follow up between the commissioner lead and community DSN. It is therefore essential that engagement between the practice and DSN is continued to ensure levels of competency are monitored accordingly.

Complexity Level	Description
Level 3 (Severe)	Patients with Type 2 diabetes on insulin with: • significantly poor glycaemic control (HbA1C >100 mmol/mol) AND / OR • >x3 co-morbidities AND / OR • >x2 admissions/12 months as a result of diabetes AND / OR • >x2 episodes of symptomatic hypoglycaemia/12 months AND / OR • significant complications of prescribed therapy AND / OR significant end organ damage AND / OR • Significantly symptomatic secondary to hyperglycaemia (>10% weight loss, excessive symptoms and/or ketotic).
Level 2 (moderate)	Patients with Type II diabetes on insulin with: • moderate control (HbA1c 60-100 mmol/mol) AND / OR 1-3 co-morbidities AND / OR

	• one or less admissions/12 months as a result of diabetes AND / OR • one episode of hypoglycaemia/12 months AND / OR mild end organ damage AND / OR • mild symptoms secondary to hyperglycaemia (polydipsia, polyuria, stable weight and no ketones).
Level 1 (Mild)	Patients with Type II diabetes on insulin with: • reasonable control (HbA1c<60mmol/mol) • 1 or less co-morbidities • No recent admissions/12 month related to diabetes • No hypoglycaemic episodes/12 months no significant complications of prescribed therapy • No end organ damage and no symptoms related to hyperglycaemia

GLP-1

- Initiation 60 minutes
- Titration & Education 30 minutes
- Titration & Dose adjustment education 30 minutes
- Telephone Follow up 10 minutes

The following times <u>are examples</u> of the times required to initiate a patient on **GLP-1** therapy, these times may vary, to suit individual patients' needs:

- Initiation 45-60 minutes
- Support and education 15-30 minutes at 1month
- Support and monitoring 30 minutes at 3 month
- Support and monitoring 30 minutes at 6 month

Should the patient require further support or follow ups, appropriate appointments and follow ups should be arranged as required.

Once the patient is stable and able to manage their own insulin / GLP-1 regime the patient can resume their 6 monthly check-ups and on-going annual review. At each review the efficacy of treatment should be undertaken and altered or stopped if GLP-1 if no longer effective.

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 new service.

Days/hours of operation
The service will be accessible during core practice opening times.

Accessibility/acceptability
Insulin initiation will be accessible to all Nottingham North & East GP registered patients who have type 2 diabetes. All patients must be:

- Aged 18 years and over
- Have good cognitive function or a supportive carer
- Needs are appropriate to the service to be provided by the Diabetic Specialist Nursing Service
- Patients with uncontrolled diabetes despite all possible lifestyle measures and maximum oral hypoglycaemic agents (OHAs)
- HbA1c persistently above agreed target despite delivery of core measures
- Patients requiring newer medicines i.e. Amber 2/GLP-1

Referral criteria & sources
Referral route
Patients can be referred to the DSN following discussions with the DSN, using the referral form accessible on the intranet F12 by the:

- GP
- Practice Nurse
- Community Matron
- District Nurse
- Secondary Care (upon hospital discharge) Telephone or letter referral
- Dietetics Telephone or letter referral

Discharge criteria level 1 practice:

- Patients will be discharged from the Community Diabetes Specialist Nursing Service once the patients are stable and no longer require these specialist services
- Where appropriate, discharge planning should be discussed with the patient; discharge of the patient is managed within a controlled environment, discussing the patient's care with the GP, Practice nurse in the clinic setting or telephone or letter to other referring healthcare professional
- Appropriate care plans will be provided upon discharge to ensure on-going care and support is maintained
- It is expected that the DSN service works with the patient and other professionals to ensure that equivalent support is subsequently available to the patient
- As part of the discharge process, patients will be given the opportunity to comment about the service they have received to inform the provider's understanding of the patient's experience of the service. In turn, the commissioner will with to receive information to support understanding of patients' outcomes as a result

Discharge procedure (care transfer)
It is expected that disease progression or stabilisation may require that patients are transferred to other care providers. To avoid unnecessary referrals to secondary care, discussions with the DSN should take place in the first instance. Referral into secondary care will be done through the patient's registered practice following these discussions.

3.3 Population Covered
The service is accessible to all NNE GP registered patients who have type 2 diabetes requiring insulin/GLP-1 agonists and their management.

3.4 Any Acceptance and Exclusion Criteria and Thresholds
Patients who are not registered with a Nottingham North & East GP practice or who do not have a confirmed diagnosis of type 2 diabetes. 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:

- Type 1 diabetes
- 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
- Other Specialist Nurses
- Public Health Professionals
- Physiotherapist/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 (eg Royal Colleges)

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all 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.

- Nottinghamshire Diabetes Guidelines: https://www.nottsapc.nhs.uk/guidelines-formularies/
- Central Nottinghamshire Diabetes Network Adult Care Pathway for Diabetes Care

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.dh.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

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

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

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

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 North & East. 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 1st April 2020 to 30th September 2021. This contract will cease on 30 September 2021 as an outcome of the CCG wide review of diabetes services.

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

The practice is contracted to deliver care at the level agreed by the community DSN. The review/evaluation will be agreed on a quarterly basis through follow up between the commissioner lead and community DSN.

Remuneration and Outcome Measures
Practices will receive a proportion of their allocated funding based on the complexity level they are operating at, as follows:

	Level 1	Level 2	Level 3
Annual payment per patient on insulin (£8.34)	0%	50% payment	100% payment

Practices will be required to submit a quarterly claim form at the end of each quarter. Practices will claim for the total number of type 2 diabetic patients on insulin on their practice register on the last day of the quarter.

A quarterly per capita payment of 25% of the annual per capita payment for a patient on insulin will then be made against this claim figure:

For example, at the end of quarter 1, a practice delivering level 2 care with 100 type 2 diabetes patients on insulin would claim for 100 patients. The payment they receive for the quarter would be calculated as follows:

100 * £8.34 / 4 * 50% = £104.25

Where '100' is the register size on the last day of Q1, '£8.34 / 4' is the annual per capita payment value of £8.34 divided by 4 to give the quarterly per capita payment value, and '50%' is the level 2 multiplier.

Evidence must be submitted to the Primary Care Commissioning Team nnccg.primarycarenotts@nhs.net by 31 October 2021

- A **randomised audit of patients initiated and managed** under the service to ensure improved care and management of patients with diabetes

The Primary Care Commissioning Team will liaise with the DSNs to evidence the following (pro-rata for six months):

- Practices are **required to attend three upskilling education sessions** each year, one of which must be represented by a GP in order to upskill clinicians with regards to diabetes and insulin initiations, this will also offer the opportunity for peer to peer support
- Practices delivering **level 1 and 2 are required to engage in at least 10 joint clinics per annum** for mentorship with the DSN to facilitate enhanced learning and development in diabetes care
- Practices delivering **level 3 care will ensure that regular contact with the DSN is maintained** through ad hoc joint clinic / meetings or peer review