Service	Rushcliffe Diabetes Level 2 Monitoring Enhanced Service
Commissioner Lead	Rachael Harrold, Primary Care Commissioning Manager Nottingham & Nottinghamshire CCG
Provider Lead	GP Practices of Rushcliffe PCN
Period	1 April – 30 September 2021

1. Population Needs

1.1 National/local context and evidence base

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 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, Rushcliffe CCG has 5,894 diabetic patients registered across 12 practices. This accounts for 4.55% of Rushcliffe's registered population. However, Public Health estimates the total prevalence of people with diabetes in Rushcliffe, both diagnosed and undiagnosed, to be 8.0%, with the average in England being 8.8%.

Information provided by East Midlands Clinical Network indicates there has been a 13.3% increase (662) 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	
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	

2.2 Local defined outcomes

It is expected that the provision of this service within Rushcliffe GP 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 care
- Compliance with NICE Guidance NG28, Management of type 2 diabetes in adults when starting insulin therapy and prescribing
- Collaborative working with the Diabetic Specialist Nurses (DSN)
- 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
- Increased clinical engagement and innovation

3. Scope

3.1 Aims and objectives of service

The provision of a diabetes primary care led service that offers patient choice, where appropriate, for insulin initiation and management of adult type 2 diabetes.

The service is available to patients within their own registered general The provider. The service will also:

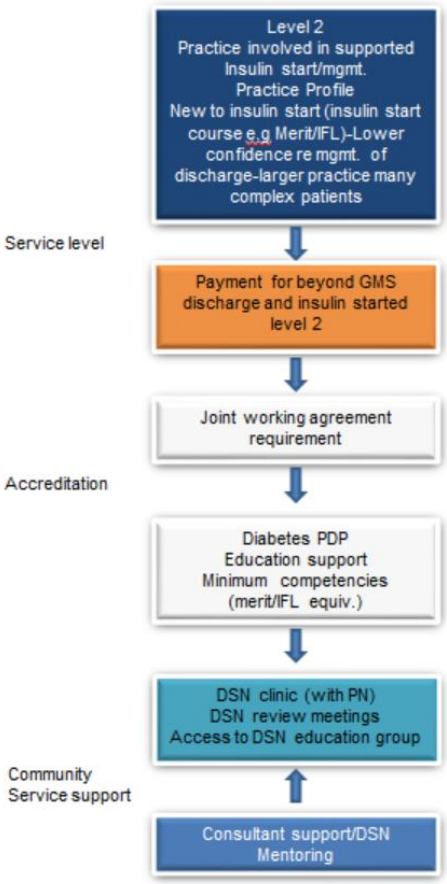
- The service will support the initiation of other injectable therapies
- Support the discharge of stable patients from secondary care back to primary care for management of diabetes and thereby reduce first to follow-up rates in secondary care
- Support data capture for audit purpose and contract management
- Receive clinical support from community Diabetes Specialist Nurse (DSN)
- The service will flex to meet the need of other patients with diabetes who otherwise may not be engaging with active management of their condition.

3.2 Service description/care pathway

There will be regular DSN availability to the Provider, a DSN telephone and email advice line and DSN led education sessions for staff which will help develop the skills of the provider nurses / lead GP. The DSN will also have a role in delivering patient education and be involved in reviews of the Dietetic, Podiatric and Retinopathy services. The DSN will also support the Provider's data capture for audit purposes and contract management.

The Provider will give the DSN access to clinical systems for data capture and for extracting data for defined audits.

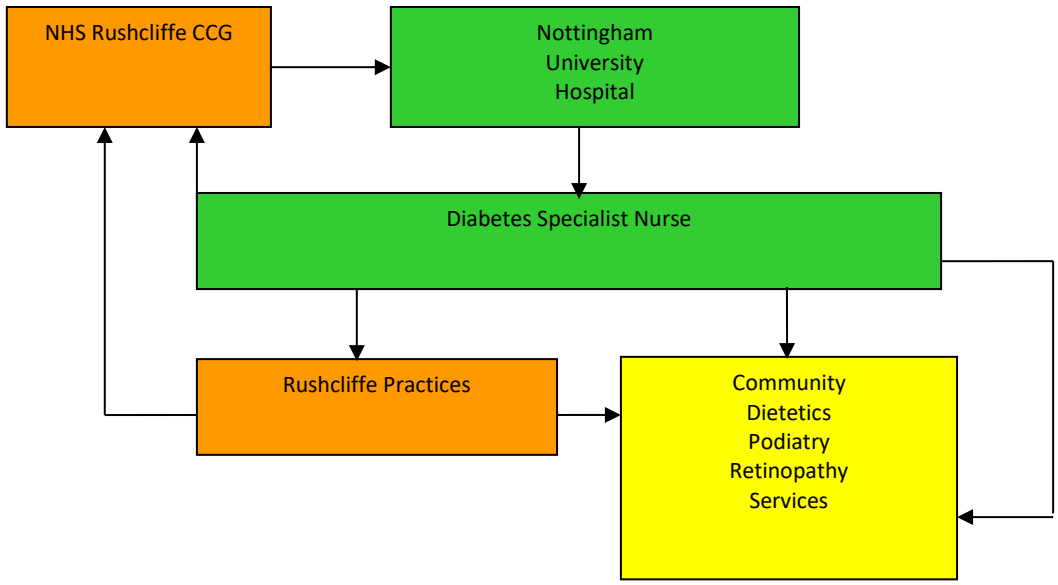
Service level description for general practice



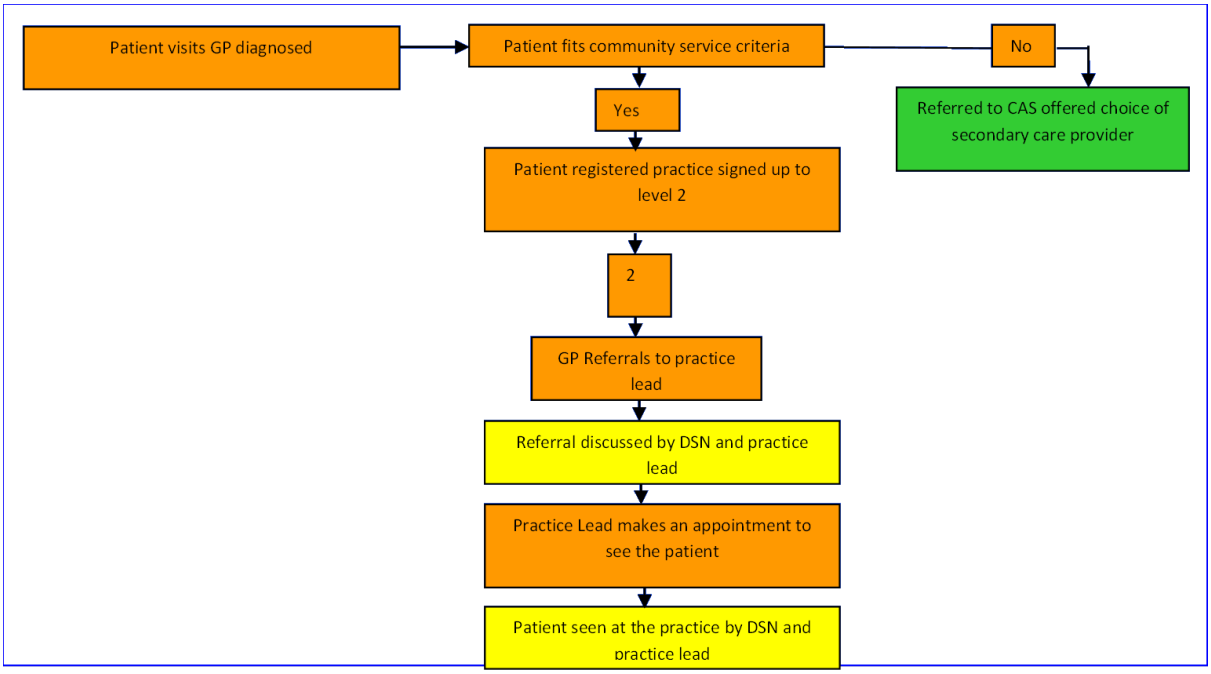
1) Facilitate new ways of working across professional boundaries
2) To continue to provide the same level of diabetes care or better in the community as is currently provided in secondary care
3) To work with DSN to facilitate discharge back to the provider from secondary care suitable patients
4) To deliver this in the patient's registered GP practice (exceptions outlined in section 4.1)
5) To ensure that the 18 week wait target does not come under threat with rising diabetes prevalence
6) To work with DSN to devise the provider development plans
7) To influence program of education developments

Expected Outcomes

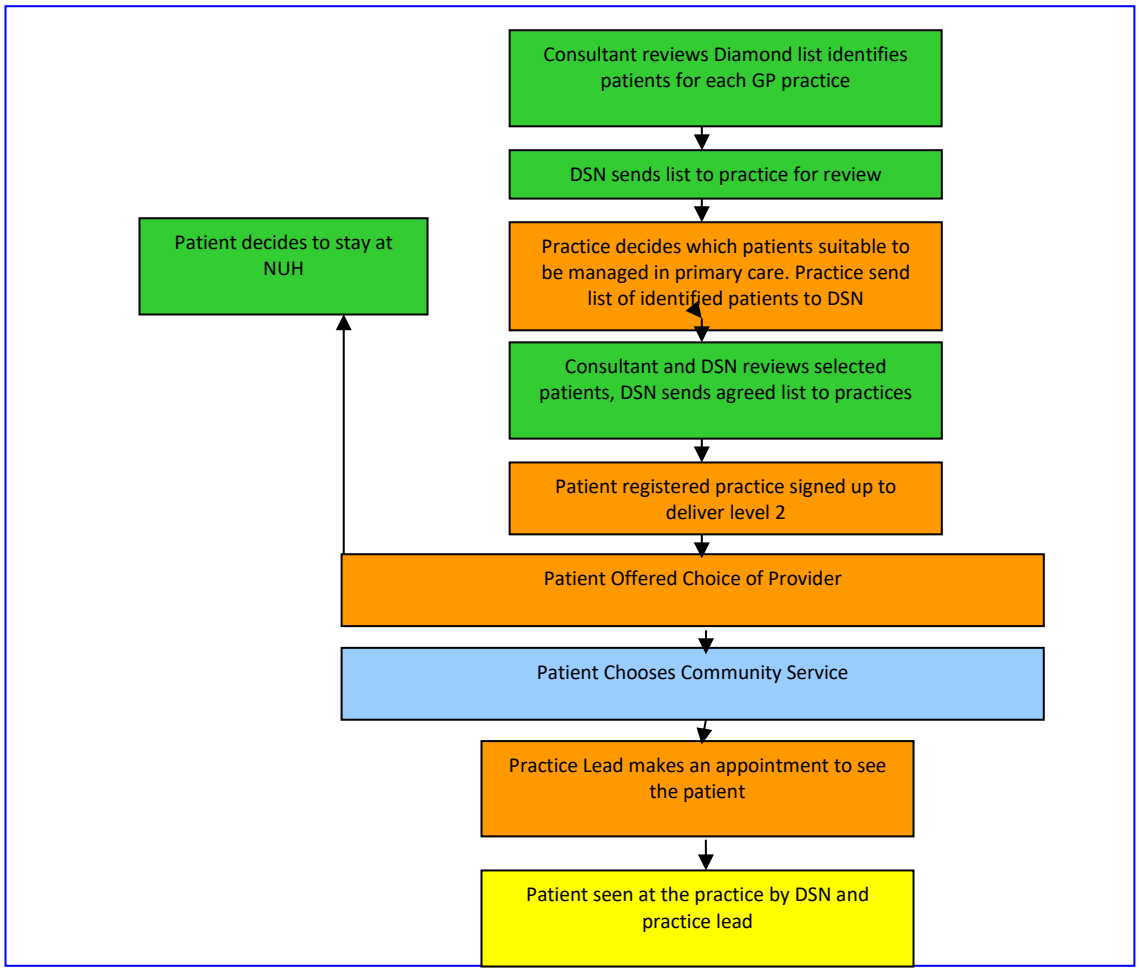
1) Greater patient satisfaction
2) Care in patient's own GP practice (exceptions outlined in section 4.1)
4) Less duplication
5) Maximisation of skills leading to staff satisfaction
6) Service responsive to the needs of staff
7) Integrated care pathway and fewer unplanned admissions



Care Pathways
Pathway Insulin Initiation



Management Pathway



3.3 Population covered

All patients =>20 and registered with a Rushcliffe GP practice

3.4 Any acceptance and exclusion criteria and thresholds

Geographic coverage/boundaries

The provider will offer the service for their registered population. The provider will have the flexibility to work with other providers within Rushcliffe and with the DSN to set up shared care services for their patients with diabetes. Patients however must not be adversely affected for example by extended waits or substantially increased journey times.

Referral criteria & sources

Referrals will be made into the service by the patient's registered GP. Patients will also be transferred into the service from secondary care, following agreement with the provider and the DSN.

Transfer requests and full referral criteria are outlined in the Rushcliffe Diabetes Service Standard Operating Procedure, revised 2013.

Referral route

Patients will be referred via their GP and be contacted by the provider by letter with an appointment date.

Patients suitable for transfer to the provider will be contacted by the provider and offered the

choice of remaining at NUH or transferring back to their provider.

The referral process, supporting paperwork and the provider responsibilities can be found in the Rushcliffe Diabetes Service Standard Operating Procedure (SOP).

Exclusion criteria
Patients with the following conditions must not be managed in primary care:

- Patients under the age of 20
- Pregnancy
- Rheumatology patients (on steroids)
- Renal failure (any cause)
- Haemochromatosis
- Mental Health issues: Eating disorders, severe Mental illness (particularly patients on antipsychotic
- People who need to be considered for insulin pump therapy
- Unstable *brittle* type 1 diabetics
- Women with diabetes who are contemplating pregnancy.
- Anyone with a diabetes problem that the provider and/or DSN does not feel they have the expertise to manage within a primary care setting

The criteria can also be found in the Rushcliffe CCG Diabetes Service Standard Operating Procedure (Appendix 1). It should be noted that there may be exemptions to the above criteria; these will be reviewed by the DSN and consultant mentor on a case by case basis.

Response time & detail and prioritisation

- New referrals will be seen within 4-6 weeks of a GP referral
- Patients transferring will be seen at their usual follow-up interval

Discharge Criteria & Planning
It is not envisaged that patients will be discharged from the service unless care transfers to secondary care or the patient registers with another provider.

Self-Care and Patient and Carer Information
All patients will receive a personal care plan on their first visit to the service; examples are in the Rushcliffe Diabetes Service Standard Operating Procedure. Patients will also receive supporting literature.

3.5 Interdependence with other services/providers

Establish key working relationships and interdependencies with:

- Community nursing and therapy staff
- Nottingham University Hospital
- Medicines Management Team
- Adult Health and Social Care
- Local Authority
- Out of Hours Providers
- East Midlands Ambulance Service
- Care Quality Commission
- Continuing Care
- Public Health
- Nottinghamshire Health Care Trust

4. Applicable Service Standards

4.1 Applicable national standards (eg 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.

- NICE
- National Service Framework for Diabetes (2002/03)
- National Diabetes Workforce Strategy (2007)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Diabetes UK

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 Area Prescribing Committee (APC) Diabetes management guidelines
- Notts/Derby Area Team Incident Reporting for Independent Contractors

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

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 Rushcliffe 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 1st April 2020 to 30 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.

Remuneration and Outcome Measures
Providers will receive quarterly payments in arrears on production of the quarterly data set for monitoring purposes:

- Indicator A – Number of Type 2 patients on practice QOF register initiated onto insulin or other drug therapy - £140 per patient initiated
- Indicator B – Number of patients on practice QOF with 'Insulin treated Type 2 diabetes mellitus' - £36 per patient per annum (Read code X40J6)

Appendix 1

Appendix 1
Rushcliffe Diabetes S(