Service	Diabetes Local Enhanced Service (Revised Version, January 2025)
Commissioner Lead	[redacted]
Provider Lead	GP Practices of Nottingham and Nottinghamshire ICB
Period	1st April 2025 to 31st March 2026

1. Population Needs

1.1 National/local context and evidence base

Diabetes mellitus is a chronic complex metabolic disorder characterised by high levels of blood glucose and caused by defects in insulin secretion and/or action. It is estimated that more than 5.8 million people in the UK are living with diabetes. Diabetes UK data shows that almost 4.3 million people in the UK live with a diabetes diagnosis. Additionally, nearly 1.3 million people could be living with Type 2 diabetes who are yet to be diagnosed. These registration figures for 2023-24 are up by 185,034 from 2022-23.

According to the National Diabetes Audit 2023/24 there are 76,510 people in Nottingham and Nottinghamshire with diabetes (6.8% prevalence), of which >90% have Type 2 diabetes. It is further estimated that between 15% and 39% of people with Type 2 Diabetes have not been diagnosed in Nottingham and Nottinghamshire. Type 1 diabetes affects 8% of people, with 5,945 people in Nottingham and Nottinghamshire diagnosed (0.6% prevalence). National Diabetes Audit data suggests that since March 2015, the local diabetes population has increased by 19.6%.

People with Type 2 diabetes are 50% more likely to die prematurely than those without diabetes. A common complication of diabetes that can lead to early death is heart disease. People with Type 2 diabetes are two-and-a-half times more likely to experience heart failure and twice more likely to have a heart attack compared to people without diabetes.

The NICE recommended care processes and three treatment targets (blood glucose, blood pressure and cholesterol) are important markers of improved long-term care and management of patients with diabetes. To implement the care quality indicators and improve and sustain optimal care management; access to education, support planning and on-going care should be made available to all individuals with diabetes.

Based on 2023/24 National Diabetes Audit data, Nottingham and Nottinghamshire achievement of these indicators is as follows:

Three Treatment Targets	**8 Care Processes**
Type 1 – 27.6% (Eng – 24.7%)	Type 1 – 40.1% (Eng- 44.3%)
Type 2 – 35% (Eng – 36%)	Type 2 – 59 % (Eng - 62%)

The NHS Long Term Plan states that we will enable more people to achieve the recommended diabetes treatment targets and drive down variation between GP Practices to minimise the risk of future complications.

The landscape of diabetes is changing; with its growing prevalence, interest in Type 2 diabetes remission, shift of management from glucose-centric to reducing disease burden, evolving technology and greater treatment repertoire. Furthermore, the needs of people with diabetes are changing to include a younger population, requiring earlier intensive management, including support with self-management, and allowing people with diabetes to flow through the different areas of the NHS dependent on their needs at the point of access to healthcare. The need for improving glycemic control and changing the way diabetes care is delivered has been

highlighted not only by the number of recent cardiovascular outcome trials but also the events of the COVID-19 pandemic; with diabetes being an independent risk factor for mortality related to COVID-19.

This diabetes local enhanced service provides an opportunity to share good practice, upskill and develop the capacity of colleagues in Primary Care directly to ensure high-quality, cost-effective care that, when delivered collectively, should improve the effectiveness, safety, and experience of care for adults with diabetes.

Developing the skills of primary care in diabetes management will enable more autonomy in prescribing, titrating, and stopping medication as well as increasing confidence with supporting and managing people with the condition.

This enhanced service is based on a tiered approach that enables GP Practices to identify their own strengths and weaknesses in diabetes management and helps set goals and action plans to facilitate competency development.

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 and Nottinghamshire practices will lead to:

- High quality personalised health care for patients with diabetes.
- Improved quality of life for patients with diabetes.
- Improved self-management by patients through the effective use of care plans and education on treatment, diet and lifestyle.
- Improved care closer to home in the community.
- Improvement in health outcomes and a reduction in unwarranted variation of care for patients with diabetes e.g. 3TTs and 8 Care Processes for patients with diabetes.
- Reduction in complications arising from diabetes.
- Patients receiving appropriate support and education to work towards optimised glycaemic control.
- Increased and improved management of diabetes patients in primary/intermediate care with fewer urgent/non-urgent admissions into secondary care.
- Compliance with APC Guidance in the Management of Type 2 diabetes in adults when prescribing.
- A provision of a parity of esteem between mental and physical ill health with the promotion of psychological therapies to those patients with comorbid depression and diabetes.
- Clinicians being upskilled through on-going support, mentorship and education.

- Collaborative working with Community Diabetes Specialist Nurses (CDSN).
- Increased clinical engagement and innovation.

3. Scope

3.1 Aims and objectives of service

The overarching aim of the diabetes enhanced service in Nottingham and Nottinghamshire is to establish a diabetes service which focuses on the needs of the whole person, empowering people with diabetes to live healthy lives, and which provides timely support when issues arise.

The service will enable people living with diabetes to receive specialised treatment, care and ongoing management of their diabetes care within the Primary Care setting.

All practices are expected to provide core diabetes services and those additional services they are contracted to provide to all 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 core diabetes services.

The objectives of the service are:

- To provide standardised and clinically effective diabetes care to patients.
- To actively identify patients with Type 2 diabetes who are appropriate for the initiation of insulin by the practice.
- To actively identify and refer patients with diabetes to structured education.
- To initiate insulin for suitable patients in line with NICE recommendation, local APC guidelines or when clinically necessary to do so.
- To actively identify patients with Type 2 diabetes who are appropriate for the Type 2 Path to Remission (also known as Low Calorie Diet).
- To actively identify eligible patients with Type 2 diabetes who are appropriate for the initiation of Continuous Glucose Monitoring.
- To fully optimise use of medications to ensure cost effective and appropriate choices are made, maximising therapy and de prescribing fewer effective agents prior to adding in or switching to other more costly choices, in adherence to local APC guidelines.
- To educate patients in understanding their treatment, such as diet, lifestyle choices and use of medication.
- Initiate care planning in partnership 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.
- To improve achievement of the 3TTs and 8 Care Processes for people with diabetes.
- To improve confidence levels among health care professionals when treating patients and supporting them with their diabetes management.

3.2 Service description/care pathway

This diabetes local enhanced service is made up of 3 levels of care.

To be eligible to provide this enhanced service GP Practices must meet all the criteria of the level of care they choose to sign up to deliver.

GP Practices are expected to decide which level of care to sign up to via a joint discussion with the CDSN.

Named diabetes clinical leads may include GP, Practice Nurse, or other appropriately trained clinical individual, but must be a prescribing role.

This enhanced service is designed to enable practices to identify their own strengths and weaknesses in diabetes management, help set goals and develop action plans to facilitate progression through the levels of care. However, it is not a mandatory requirement to progress through the levels of care.

Please note: GP Practices may choose to deliver aspects of the enhanced service at PCN level to maximise capacity, resilience and reduce duplication. Where choosing to work at PCN level GP Practices should seek to provide the same enhanced level of care for their registered diabetes patients.

Enhanced Level of Care

Level of Care	**Practice Requirements and Responsibilities**
Essential	Each Practice at this level must: ➢ Identify an appropriate clinical lead (s). ➢ Lead clinicians are expected to engage in dedicated training, education and mentorship with the CDSN service that supports maintenance and/ or development in line with national diabetes competency frameworks. ➢ Deliver joint face to face diabetes clinics, at least monthly, with the CDSN as required and subject to capacity of the CDSN service. ➢ Insulin initiation (as well as other non-insulin injectable therapies) and management for patients will be led by the CDSN principally through the joint clinics (in line with APC guidance), support and mentorship with practice staff.
Intermediate	Each Practice at this level must: ➢ Identify an appropriate clinical lead(s). ➢ Lead clinicians are expected to engage in dedicated training, education and mentorship with CDSN service that supports maintenance and/ or development in line with national diabetes competency frameworks. ➢ Deliver joint face to face and virtual diabetes clinics, at least monthly, with the CDSN as required and subject to capacity of the CDSN service. ➢ GP or PN will triage the more complex patients suitable to attend the joint clinic. ➢ GP Practice will have a GP and/or Practice Nurse competent in insulin initiation and management via completion of a relevant accredited course (e.g.

	MERIT, Warwick, PITOM) or equivalent experience. ➢ Insulin initiation (as well as other non-insulin injectable therapies) and management for patients with mild to moderate needs will be led by the practice (in line with APC guidance), with support from the CDSN service focused upon complex patients principally through the joint clinics, support and mentorship with practice staff.
Complex	Each Practice at this level must: ➢ Identify an appropriate clinical lead(s). ➢ Lead clinicians are expected to engage in dedicated training, education and mentorship with CDSN service that supports maintenance and/ or development in line with national diabetes competency frameworks. ➢ Deliver joint face to face and virtual diabetes clinics with CDSN as required and subject to capacity of the CDSN service. ➢ GP or PN will triage the more complex patients suitable to attend the joint clinic. ➢ GP Practice will have a GP and Practice Nurse competent with insulin initiation and management, via completion of a relevant accredited course (e.g. MERIT, Warwick, PITOM) or equivalent experience. ➢ Insulin initiation (as well as other non-insulin injectable therapies) and management will be led by the practice, (in line with APC guidance), with support from the CDSN service focused upon patients in the severe/complex category, principally through the joint clinics, support and mentorship with practice staff as deemed appropriate. ➢ Actively develop the skills of the broader practice team in diabetes management (succession planning).

3.3 Roles and responsibilities:

Responsibilities of Commissioner:

- Commission and monitor the performance of primary care providers, in accordance with the outlined criteria for the provision of essential, intermediate or complex levels of diabetes service.
- Ensure all service providers meet quality standards with support from the CDSNs.
- 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 the patient's registered GP Practice

Please note the following responsibilities form a continuing part of the core GMS contract and are not responsibilities solely under this LES.

- 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 QOF, ensuring all patients receive appropriate monitoring including:
    - Maintenance of diabetes registers.
    - Identification of patients with non-diabetic hyperglycaemia, specifically including pre-diabetes and gestational diabetes and providing appropriate education, support, referral to NHS Diabetes Prevention Programme.
    - Referral for weight management e.g., NHS Digital Weight Management Programme.
    - Referral for structured education e.g., DESMOND (T2DM), DAFNE (T1DM), KAREN (T1DM), X-PERT (T2DM), Healthy Living (T2DM).
    - To proactively identify and support people living with Type 2 diabetes to achieve remission through referral to NHS Type 2 Path to Remission (formerly Low-Calorie Diet).
    - Provision of preconception advice.
    - To actively identify patients with comorbid depression and anxiety and to provide information of available psychological therapies.
    - Ensure patients are receiving at least 6 monthly blood testing (interim HBA1c or annual bloods) and an annual review.
    - Ensure monitoring of QOF indicators.
    - Offers treatment options following local APC guidelines.
    - Ensure that all diabetes 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.

- Being aware of appropriate advice and guidelines for diabetes care.
- 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).
- Arranging referral to secondary care and community teams if required and in accordance with the local referral criteria.
- Issuing prescriptions for Diabetes medication including insulin and non-insulin injectable therapies and monitoring appropriately.

Responsibilities of Diabetes Enhanced Service Providers

- To ensure that all staff involved in service delivery are appropriately trained and qualified to deliver the enhanced aspects of care e.g. insulin initiation and non-insulin injectable therapy and management.
- GP Practices are encouraged to work collaboratively with the CDSN in allowing them access to the patient's notes and allowing the registered patients to be seen within the GP practice.
- To collaborate with CDSNs to provide joint face to face clinics within the practice and additional virtual clinics and tabletop exercises where appropriate and subject to capacity of the CDSN service.
- To ensure that the necessary administrative support is available to ensure the efficient running of the service.

- All participating GP Practices will be required to nominate an appropriate diabetes lead/s.
- GP Practices are encouraged to attend locally commissioned education sessions each year to upskill clinicians with regards to diabetes care as appropriate, this will also offer the opportunity for peer support.
- Ensure appropriate business continuity plan measures are in place for service delivery.
- All GP Practices are asked to inform the commissioner of any changes to the clinicians delivering this service, as it is a requirement that all clinicians meet the required accreditation standards.

Aims of the Community Diabetes Specialist Nursing Service

It is not the responsibility of the CDSN service to deliver this LES and this specification confers to no additional request upon them. The aims of the CDSN service are summarised below and the collaborative working encouraged within this LES should help facilitate the delivery of those aims.

- CDSNs will support optimisation of medication treatment including up titrating to maximum appropriate doses, de prescribing where targets are not achieved and reviewing and streamlining inappropriate poly pharmacy ahead of any step up to the next level of the treatment pathway.
- CDSNs will support GP Practices to upskill in insulin initiation and management.
- CDSNs will support a holistic review of the patient looking at meeting all QOF requirements via joint clinic reviews, timings of which will be agreed with each practice and delivered either face to face or virtual as required.
- CDSNs will signpost or offer education and support.
- CDSNs will provide regular mentorship to GP Practices.
- CDSNs will access regular clinical mentorship from a specialist consultant to support the service.
- CDSNs will support practice diabetes leads to achieve national diabetes competency framework standards.
- CDSNs will support GP Practices to develop improvement plans.
- CDSNs will maintain awareness and adherence to local and national guidelines.

Please note the above responsibilities are subject to the capacity of the CDSN service. GP Practices will not be held to account for the capacity of the CDSN service and where it is impractical for the CDSNs to help deliver any of the above this will not affect the payments to the practices under this LES.

Training/Education/Review

The responsible GP Practice must ensure that all staff involved in providing any aspect of care under the scheme have the necessary training and skills, liaising with the CDSN where necessary.

This will consist of the following:

- All GP Practices must identify a named diabetes lead – this may include a GP and/or Practice Nurse or other appropriately trained clinical individual involved in the management of diabetes care.
- GP Practices are required to engage in joint clinics to facilitate enhanced learning and development in diabetes care.
- GP Practices are encouraged to participate in tabletop exercises/complex case review sessions with the CDSN as required by the practice and subject to capacity of the CDSN service.
- Lead clinicians involved in the delivery of diabetes care will work towards an approved competency framework with support from the CDSN.
- Lead clinicians are encouraged to attend locally delivered diabetes education sessions, to address gaps in knowledge and skills in diabetes care, as well as ensure understanding and adherence to latest clinical guidelines.
- GP Practices are also encouraged to support the training and development of the wider GP Practice workforce (clinical and non-clinical) by promoting uptake to and completion of e-learning modules via the Cambridge Diabetes Education Programme (CDEP). This e-learning platform has been locally commissioned to provide free access to accredited diabetes training for all healthcare professionals across the system. (See appendix 1 for more details).

Practice's Level of Accreditation

Accreditation will be validated through practice supervision with the CDSN to assess level of competency according to the complexity of patients, practice competency to manage and in line with national diabetes competency frameworks.

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

Should a GP Practice wish to move up or down a tier this must be evidenced through engagement in the process above.

GP Practices must then inform the Primary Medical Services Commissioning Team via nnicb-nn.primarycarenotts@nhs.net prior to any change in level of service delivery. Payments will be adjusted accordingly.

3.4 Any acceptance and exclusion criteria and thresholds

All patients identified on the practice Type 2 diabetes register who are aged 17 and over.

Patients who are not registered with a Nottingham or Nottinghamshire 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:

- All children and young people aged < 25 years with Type 1 or Type 2 diabetes should be referred to Secondary Care Diabetes Team.
- Type 1 diabetes.
- Insulin pumps, hybrid closed loops and those who need continuous blood glucose monitoring.
- Ante and post-natal care for women with diabetes.
- Gestational diabetes.

- Long term complications:
  - Renal – CKD Stage 4 or 5
  - Vascular – where vascular complication requires referral to secondary care i.e., foot disease, difficult Hypertension, and Ischaemic Heart Disease etc.

3.5 Interdependence with other services/providers

Establish key working relationships and interdependencies with:

- Consultants/clinical lead
- General Practitioners
- Practice Nurses
- Podiatrists/Community Foot Protection Team – 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
- Mental health and wellbeing services
- Social Prescribing services
- Lifestyle services i.e. health and wellbeing coaches, weight management, smoking cessation, alcohol support
- Other statutory agencies involved in the care of people with diabetes
- Third/voluntary sector organisations associated with diabetes care and advice

3.6 Assessment of Patient Satisfaction of Diabetes Care

GP Practices should seek to use validated tools to assess treatment satisfaction and evaluation of service provision. A survey template is available on request.

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.

NICE Guidance:

- Type 2 diabetes in adults: management, NICE guidelines [NG28] Published date: December 2015, updated June 2022.
- Diabetic foot problems: prevention and management, NICE guidelines [NG19] Published date: August 2015, updated October 2019.
- Type 2 diabetes: prevention in people at high-risk NICE guidelines [PH38] Published date: July 2012, updated September 2017.
- Cardiovascular disease: risk assessment and reduction, including lipid modification NICE guidelines [NG238] Published date: December 2023.
- Hypertension in adults: diagnosis and management [NG136] Published date: November 2023.

NICE Quality Standards:
Diabetes in Adults, NICE quality standard [QS6] Published date: March 2011(updated august 2016).

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.

- An Integrated Career and Competency Framework for Pharmacists in Diabetes, May 2018
- An Integrated Career and Competency Framework for Diabetes Nursing (TREND UK)
- Diabetes Foot Screening Competencies
- The Cambridge Diabetes Education Programme (CDEP)
- Best Practice in the Delivery of Diabetes Care in the Primary Care Network

Language Matters in Diabetes and Obesity
GP Practices need to be aware of the impact the words used have on people living with diabetes and/or obesity. Two documents have been produced: Language Matters in Diabetes and Language Matters in Obesity. These documents should be used as reference tools to ensure that consultations, literature, and education build a trusting and valued relationship with those who are managing diabetes every day.

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 Regulations for Service Providers and Managers met (https://www.cqc.org.uk/guidance-providers/regulations). Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

Local guidelines include:

- Type 2 Diabetes Guidelines - https://www.nottsapc.nhs.uk/media/ytxnci0d/type-2-diabetes-guideline.pdf
- Blood Glucose and Ketone Meter Formulary - ccg-bgt-meters-formulary.pdf
- Continuous Glucose Monitoring - https://www.nottsapc.nhs.uk/media/tcibva3n/cgm-commissioning-policy-for-nottingham-and-nottinghamshire.pdf
- Chronic Kidney Disease Management in Adults guidelines-for-management-of-chronic-kidney-disease-ckd-for-adults-1.pdf

Serious Incidents (SI's) and Patient Safety Incidents (PSI's)
It is a condition of participation in this service that providers will report all incidents where a patient has experienced harm to the ICB, in line with the Patient Safety Incident Response Framework (PSIRF). 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 ICB 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
- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the ICB 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 and vaccination.
- 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/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069

Looked After children Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing (rcn.org.uk)

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 and Nottinghamshire GP Practices. 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 2025 to 31st March 2026.

The notice period is three months under General Condition 17.2.

GP Practices must inform the Primary Care Commissioning Team by email nnicb-nn.primarycarenotts@nhs.net in advance of any change in level of care they will be delivering in the following quarter for payment purposes.

Final agreement of payment will be made by Primary Medical Services and Diabetes Commissioning Leads.

If GP Practices do not meet any part of the criteria in the applicable quarter payment will not be made.
All practices should have processes and alerts in place to ensure LES requirements are met.

Providers will be required to:

- Comply with requests from Nottingham & Nottinghamshire ICB to provide information as it may reasonably request for the purposes of monitoring the providers' performance of its obligations under this service.
- Participate in an audit relating to this service as requested by Nottingham & Nottinghamshire ICB, as required.

Remuneration and Outcome Measures

Payments for the enhanced level of care will be paid pro-rata, quarterly in arrears and automatically to the GP Practice based on the level of care signed up to.

Level of care	Payment	Timescale of payment
Essential	[redacted] per registered diabetes patient per annum	Paid pro-rata, quarterly in arrears
Intermediate	[redacted] per registered diabetes patient per annum	Paid pro-rata, quarterly in arrears
Complex	[redacted] per registered diabetes patient per annum	Paid pro-rata, quarterly in arrears

Diabetes Population
The funding awarded to participating practices will be based on each GP Practices total diabetes population. This will be the practices diabetes population as of 1st April 2025 and annually thereafter and will be determined by eHealthScope.

There are no in-year adjustments where payment is made based on the practice's weighted population on 1 April, with the exception of a practice receiving significant numbers of additional patients as an immediate result of a contractual change (e.g., practice closure or merger leading to increase of patients).

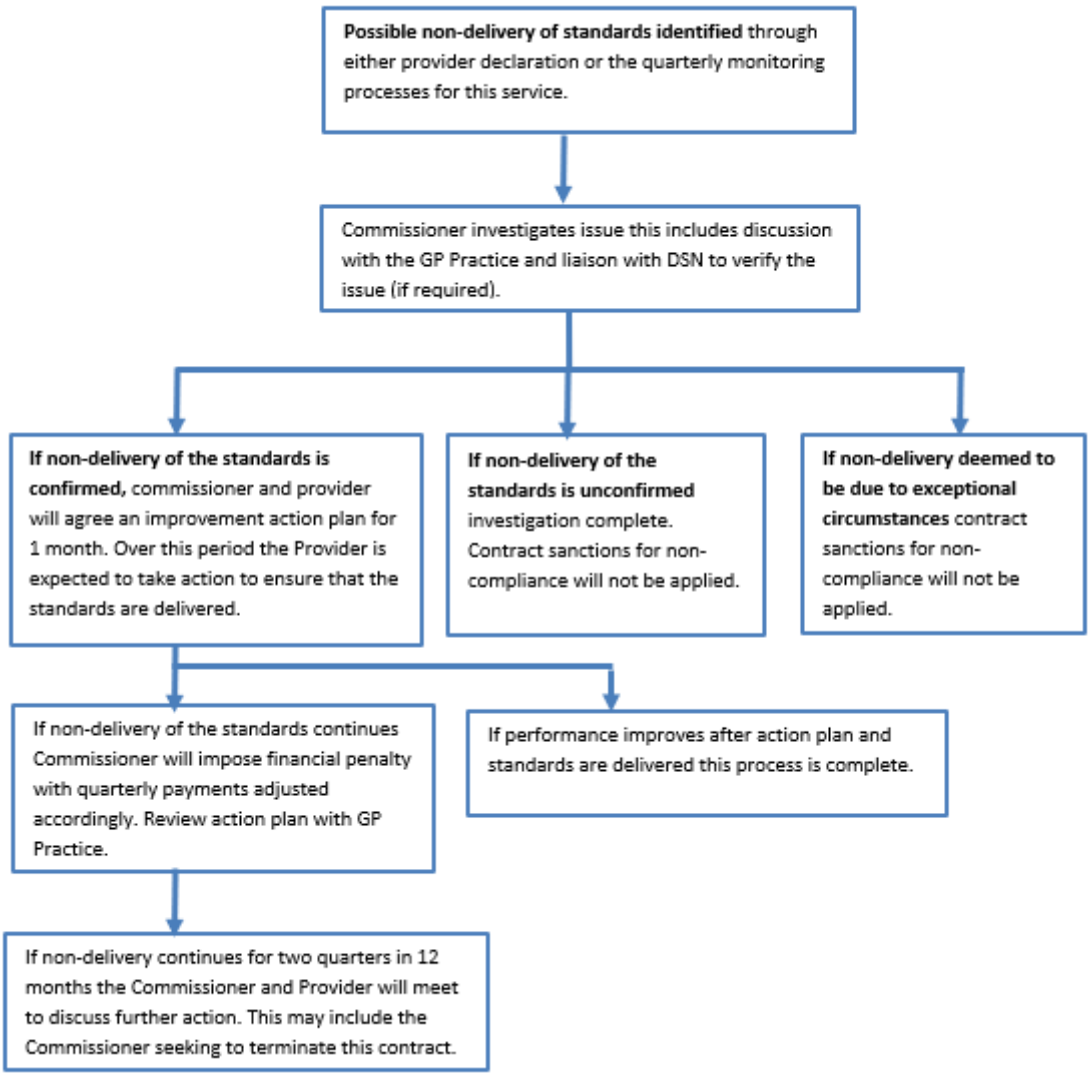
Management of Non-Compliance
Providers are required to meet all the criteria of the enhanced level of care they choose to sign up to deliver, as specified in this contract, to receive the contract values as referenced above.

Where it is identified that a provider is not delivering the standards as per this specification the contract management process outlined in the figure below.

It is acknowledged that there may at times be exceptional circumstances where a provider is unable to deliver the standards and / or reporting requirements as detailed within this

specification. The GP practice is responsible for notifying the commissioner immediately as soon as they become aware, and these will be reviewed on an individual basis.

Figure 1.



Appendix 1 – Cambridge Diabetes Education Programme

Cambridge Diabetes Education Programme

How to register:

1. Go to CDEP's website at www.cdep.org.uk
2. Click on the link in the top right corner: SIGN IN/REGISTER
3. Under NEW CANDIDATE REGISTRATION, enter your EMAIL address and click CREATE ACCOUNT.
4. Complete the rest of the registration form and you are all set to start CDEP!

For FREE access, please don't forget to enter the REGISTRATION KEY CODE: NOTTSCCGCDEP

*If this code is not entered, you will be automatically passed to CDEP's payment page.
If this does occur, please contact CDEP for support.

How long will it take me to complete a topic?

Each topic has a different number of competencies (depending on the topic and your chosen CDEP level). So the length of time differs from 15 mins (Hospital Hypos) to 3½ hours (Nutrition & Physical Activity), but most topics take around 1-2 hours to complete.

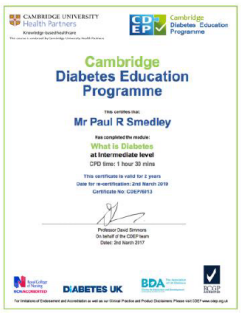
Where should I start?

CDEP currently offers a variety of topics. People may start wherever they choose as there is no particular order that needs to be followed.

If in doubt …. start at the top with one of your essential topics!

Do I have to complete all the topics to generate a certificate of diabetes competency?

No, once you finish a topic you can generate a certificate of competency for that specific topic.


Cambridge Diabetes Education Programme

Mr Paul R Smedley

What is Diabetes

at Intermediate level

What CDEP level should I register at?

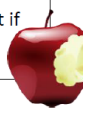
CDEP has 5 levels (as per the UK diabetes competency framework)…

- Core – *the minimum level for staff who have any contact with people living with diabetes*. Ideal for HCAs, receptionists, students, psychologists, care workers, etc.
- Intermediate – perfect for *registered staff who are not primarily responsible for supporting people manage their diabetes, but their role may impact on care* e.g. practice nurses, GPs, paramedics, ward/care home/mental health/prison staff, HCAs trained to deliver enhanced diabetes care, podiatrists (not working in diabetes foot clinics), physiotherapists, midwives, pharmacists, etc.
- Diabetes Specialist – ideal for *staff responsible for delivering the majority of diabetes care in their setting or for staff starting to specialise in supporting complex diabetes care* e.g. practice nurse, GPs, dietitians, junior DSNs, diabetes link nurses, diabetes podiatrists / midwives / pharmacists, etc.
- Diabetes Expert – this level is for *staff delivering intensive care to complex diabetes cases or delivering diabetes specialist support to other staff*.
- Diabetes Consultant - Suitable for *staff delivering complex specialist diabetes care as well as responsible for workforce / business planning and diabetes clinical strategy in their region*.

Once you have chosen a level, CDEP offers you all the topics and competencies that are appropriate for that level. *Don't worry if you choose the wrong level, you can easily change your level in the 'my account' section on the website.*

CDEP is designed to be done in 'bite-sized chunks'

Just log in when and where you can and do a few competencies within a topic – one can take as little a minute to do. Once a competency is finished, it will automatically be saved, so none of your work will be lost if you dip in and out!



CDEP Topics:

- Coronavirus and diabetes
- Ramadan and diabetes
- Structured diabetes education
- Promoting self-care
- Mental health and diabetes
- Safe use of insulin in hospital or the community
- Driving with diabetes
- Physical activity in people with type 1 diabetes
- Physical activity in people with pre-diabetes, gestational or type 2 diabetes
- What is diabetes
- Hypoglycaemia
- Hyperglycaemia
- Oral Therapies
- Injectable Therapies
- Diabetic Foot care, Screening and Risk Assessment
- Care of the Diabetic foot in a residential setting
- Nutrition
- Blood glucose and ketone monitoring
- Pre-conception care
- Screening, prevention & early detection of type 2 diabetes
- Nutrition & Physical Activity (intermediate level & above)
- Managing diabetes in hospital
- Hospital Hypos / Hypos at Home
- Managing diabetes in residential or nursing home care
- Carbohydrate counting and insulin injection dose adjustment (diabetes specialist level and above)

Clinical Practice Feedback…

Ever wondered what your patients, their carers or your peers thought about your diabetes knowledge?

You can invite feedback on your diabetes clinical practice in specific areas that match the CDEP topics via our secure clinical practice feedback portal.
Look out for the link when your next sign into CDEP…

CREATE A CLINICAL PRACTICE FEEDBACK REQUEST

All you have to do is ask their permission to share their email address with CDEP.

Reflection…

Completing CDEP 's evaluation after finishing a topic, automatically generates a reflection document for you to submit as part of evidence for **revalidation**.

So have a careful think about the impact of the topic when answering the questions as you can not go back later to change your answers. Like the certificate, the reflection form can be emailed or printed from your CDEP account.

CPD accredited / endorsed by:

BAPO

BDA The Association of UK Dietitians
Centre for Education and Development

CAMBRIDGE UNIVERSITY Health Partners
Knowledge-based healthcare

DIABETES UK

RCM ACCREDITED

Royal College of Nursing
RCN ACCREDITED

The COLLEGE of PODIATRY

Help *is always on hand…*

Learning resources are available which can be assessed before, during or after the topic competencies.
For more support, please contact: candice.ward@addenbrookes.nhs.uk

CDEP will send you monthly emails helping you make the most of the CDEP. Inactive CDEP accounts (ie accounts registered, but no learning undertaken) will be archived after 6 months and free access to CDEP removed at that time. Archived accounts can be re-activated by undertaking learning.

Appendix 2 – Frequently Asked Questions

Who can be the named Diabetes Clinical Lead?	Named diabetes clinical lead may include a GP and/or Practice Nurse or other appropriately trained clinical individual involved in the management of diabetes care. Whilst it would be desirable to have two nominated leads it is recognised that this is not always possible.
Expectation of Joint Clinics	It is expected that GP Practices will work with their CDSN to determine the frequency and duration of joint clinics to meet the needs of registered diabetes patients. Joint clinics should be delivered face to face, however additional clinics may be provided virtually where appropriate. Joint clinics will focus on providing a holistic approach to diabetes care to ensure management and treatment choices are tailored to the individual. Working in collaboration with the CDSN, joint clinics will aim to improve knowledge, skills and confidence in both GP Practice and patients. In the event of unforeseen circumstances like sickness or emergency leave (either PN or CDSN), clinics should continue to go ahead to avoid cancelling patient appointments. The GP Practice will not be penalised financially for this. Similarly, if joint clinics cannot be accommodated one month due to annual leave of either the PN or CDSN, the GP Practice will not be penalised financially. Where long term absence occurs business continuity plans should be enacted.
What are the expectations around education?	Lead clinicians are encouraged to attend locally delivered diabetes education sessions, to address gaps in knowledge and skills in diabetes care, as well as ensure understanding and adherence to latest clinical guidelines. Practices are also encouraged to support the training and development of the wider GP Practice workforce (clinical and non-clinical) by promoting uptake to and completion of e-learning modules via the Cambridge Diabetes Education Programme (CDEP). Training/competencies could be achieved through any of the existing locally provided routes mentioned below, for example: ➢ Attendance at locally commissioned events such as Diabetes Foundation Courses, Continuous Glucose Monitoring, 3TT, Foot Care, Frailty, CKD, Type 2 in the Young sessions. ➢ Protected Learning Time events – specific to Diabetes and lifestyle management (where available). ➢ Local DSN led Diabetes forum events (where available) ➢ In house sessions delivered by local diabetes teams.

	➢ Diabetes specific webinars. ➢ Lunch and Learns e.g., NHS DPP, Type 2 Path to Remission. ➢ Practice case study sessions. Training and education may also be sought through other routes. There is no mandatory requirement around the number of sessions to be attended.
Will GP Practices receive extra funding to attend off-site training?	No, GP Practices will not be reimbursed for sending clinicians to off-site training. The ICB will aim to provide training in a variety of formats to support attendance. Through conversation with your local CDSN, GP Practices should identify any training needs and the possibility to deliver onsite sessions / local forums as appropriate.
What is the Cambridge Diabetes Education Programme (CDEP)?	CDEP is an online diabetes education platform providing a number of bite size diabetes related modules appropriate to different levels of competencies. It is free for HCPs to access in Nottingham and Nottinghamshire. CDEP can be accessed via www.cdep.org.uk . Each user needs to set up an account. Please enter registration code **NOTTSCCGCDEP** for free access. It is recommended that members of the clinical team routinely involved in diabetes care such as named diabetes lead, GP, Practice Nurse, HCAs, Pharmacist complete modules accordingly. CDEP is also appropriate for non-clinical members of the team to access to enhance their knowledge and understanding. There is no expectation that all modules are completed. This is a recommendation in the LES not mandatory.
Insulin initiation and management training	To sign up to deliver intermediate or complex levels it is expected that a minimum of a GP and/or Practice Nurse must be skilled and competent in insulin initiation and management. However, the number of appropriately trained clinicians may vary dependent on practice size and diabetes population. GP Practices should also link in with other appropriately trained clinicians (e.g., Pharmacists) to ensure coverage during annual leave/sickness absence. All of whom will have completed an accredited course (e.g. MERIT, Warwick, PITOM, PITSTOP) or equivalent experience, as well as accessed mentorship and training from the CDSN.

What happens if GP Practice does not do any new insulin starts in a quarter?	Nothing, the number of insulin starts are expected to vary each quarter. GP Practices should seek to fully optimise and review oral medication therapy ahead of initiation of insulin for suitable patients in line with NICE recommendations or when clinically necessary to do so.
Practice List Size	The funding awarded to participating practices in 2024/26 will be based on each GP Practices total diabetes population as of 1st April 2025 based on eHealthScope data. This will remain the same throughout the year with the exception of a practice receiving significant numbers of additional patients as an immediate result of a contractual change (e.g., practice closure or merger leading to increase of patients). Changes like this would then be accurately reflected and adjusted at the next possible quarter.
What happens if a GP Practice does not submit the quarterly claim form and required evidence?	If GP Practices do not meet any part of the criteria in the applicable quarter or fail to produce the required evidence, within applicable timeframes, payment will not be made.
PCN solutions	This is a GP Practice LES. However, that does not prevent GP Practices working together to provide capacity and resilience by delivering aspects of the LES at PCN level if they wish to do so.
What happens if a GP Practice chooses not to sign up to the LES?	GP Practices should continue to provide core diabetes care as part of the medical contract and QOF. The assigned DSN will work directly with GP Practices to define the support offer available from the DSN service and to minimise impact on Secondary Care. GP Practices may still access local education support offers and CDEP.
Can a GP Practice move up and down the tiers within the year?	Yes, this LES aims to facilitate practice progression through the tiered approach. Should a GP Practice wish to move up a tier, this must be evidenced through engagement in the competency framework process and signed off by the CDSN. Should a GP Practice wish to move down a tier because of changes to the clinicians delivering this service, this must be evidenced through engagement in the competency framework and signed off by the CDSN. GP Practices must inform the Primary Medical Services Commissioning Team nnicb-nn.primarycarenotts@nhs.net prior to any change in level of service delivery. Payments will be adjusted accordingly.

Can a GP Practice stay at the same tier?	Yes, whilst this LES is designed to facilitate progression, we also recognise that for a variety of reasons/challenges a GP Practice may not wish to progress to the next tier. There is no time restriction on progression and nor is there a penalty for not moving up to the next tier of care.
How can we monitor 8 Care Processes achievement?	Data can be accessed on e-ehealthscope > under Community Wide KPIs > Diabetes – Type 2 – Care Processes Financial Year. It is strongly recommended this workflow is used to monitor progress throughout the year.
Patient Satisfaction Survey	A template is available for GP Practices to use on request from nnicb-nn.diabeteseducation@nhs.net. However, you may choose to use your own template if preferred. GP Practices may complete the survey at any point throughout the year. This element is not linked to payment in 2024/26 but should be completed to inform service delivery and patient experience of care. There is no requirement to submit this as evidence to the ICB.
Who has been involved in the development of this specification?	The development of this service specification has been led by local diabetes clinical experts and commissioning leads from across the ICB, including CDA Diabetes GP Clinical Lead, CDSNs, GPwSI, Meds Management. This development has been informed by the ICS Diabetes Clinical Services Strategy. Feedback on the LES was gathered via a number of stakeholders including LMC, CDA, Primary Care Commissioning Leads, APC leads, Locality Teams, Patient representatives and Diabetes UK.
Are housebound patients included in the LES?	Practices should be maintaining the annual diabetes reviews for their housebound patients, as with other LTCs. CDSNs will work closely with District Nursing teams / Community Matrons to support with more complex patients and if a home visit is needed, this will be carried out. Ideally this should be joint with a Community Nurse / Practice Nurse during joint clinic time. These patients should also be discussed during joint clinic time to prevent unnecessary visits.