NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Diabetes Local Enhanced Service 2019/20
(October 2019 – March 2020)

1. Purpose of Agreement

This Agreement outlines the service to be provided by the Provider, called Diabetes LES 2019/20.

2. Duration of Agreement

This agreement is for a period of six months, commencing **1st October 2019 and ending on 31st March 2020.**

3. Background

Prevalence of diabetes is increasing, in 2008/09 there were 31,000 people with a diagnosis of diabetes in Cambridgeshire and Peterborough. Latest QoF data (17/18) shows the numbers have now increased to 46,000 people aged 17 years or older with a diagnosis of diabetes.

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

4. Aims

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

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

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

5. Service Delivery

As part of the Diabetes LES Practices agree to undertake the following:

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

Objectives	Measure and further details
1. Identify Clinical Lead and Attend Educational Events	
a) Each Practice to nominate a Practice Diabetes Clinical Lead who will attend at least **2 of 3 leads' meetings** Sept 2019 - March 2020. ❑ *These meetings would allow the Diabetes Clinical Community to utilise the clinical skills and experience of the DM Clinical Leads to ensure that such pathways are both manageable and sustainable, to identify skill gaps and resource/asset requirements etc* ❑ *'Leads' meetings will last two hours and be held in Huntingdon on rotating Tuesdays, Wednesdays and Thursdays.*	**Autumn Meeting (Oct 2019):** ▪ To be informed of the agreed 'vision' of the new Diabetes with Obesity Strategy, including **education of 'Ambition for Remission'**. ▪ **To participate, create and agree** the new standardised Primary Care pathway for Pre-Diabetes, T2DM and DM Footcare (as part of the Pathway Re-Design of D&O Strategy Delivery Plan) **(Process-Mapping Exercise).** ▪ **To peer-review performance data** (3TT / Structured Education/NDPP) and learn and develop new ways of working to improve these. **Winter Meeting (11 Dec 2019):** ▪ **Solely an Educational meeting** – External speakers – Prof Shumone Ray (NNEd Pro); GPwSI Low Carb diets; Endocrine Cons; New Diabetic CCG Formulary and Flowchart. **Spring Meeting (March 2020):** ▪ **To learn & be informed** of Pilot site results and Learning Pointers ▪ To **Peer-Review Performance data** and establish different or better ways of working. ▪ **To consider** how to deliver optimal Diabetes care in different Integrated Neighbourhood Models (**table-top /reflective exercise**)
2. Annual Audit	**Audit Requirements**
Each Practice to undertake an **annual audit** (under the supervision of Practice Diabetes Clinical Lead). The audit and subsequent action plan will focus on two areas – see next column for Audit Requirements: Practices can choose to utilise Eclipse Software to assist with the audits. The audit concerns the achievements of the practice against the KPIs (these include 3TT, referrals to Structured Education and NDPP, completion of 8 Care Processes), and identifies training requirements for the coming year.	▪ The key performance indicators - HbA1c, Cholesterol, BP and referral for Structured Education on diagnosis and ensuring all patients receive the 8 care processes each year. ▪ Managing a wider range of patients in primary care. In-house accreditations and clinical skills including initiating and adjusting insulin and GLP-1 in type 2 DM, use of new agents and management of uncomplicated type 1 DM *Note the data will be prepared for practices by ECLIPSE automatically so it requires only interpretation and action*. For those Practices which choose not to use ECLIPSE, they will need to use their own search & audit tools as part of their particular IT system.*
3. Community Diabetes Services	
Each Practice is asked to work alongside our **Community Diabetes Services,** and to request further support if the Practice is	Support could include requesting additional visits or clinics by the Diabetes Specialist Team, including Virtual Consultant Reviews

struggling to deliver the key performance indicators.	

**Per head of registered patients on the practice list at 1st April 2019.*

6. Service outline

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

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

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

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

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

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

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

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

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

7. Accreditation

Those doctors who have previously provided services similar to this service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the service shall be deemed professionally qualified to do so.

8. Untoward events

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

9. Activity Reporting and Payment Arrangements

Reporting Arrangements

Practices are required to complete the Diabetes LES Reporting Template, Appendix 1, and submit to emma.sheldon@nhs.net by 30th April 2020.

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

Payment Arrangements

Practices will receive a payment of £0.20 per patient, based on list size as of 1st April 2019 for undertaking the requirements as outlined in Section 5 of this agreement.

10. Payment Verification

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

11. Performance

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

12. Safeguarding Adults

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

13. Care Quality Commission (CQC*)*

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

14. Termination

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

15. Signatories to the Agreement

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