Cambridgeshire and Peterborough
Clinical Commissioning Group

APPENDIX 7 – DIABETES

1. BACKGROUND

Cambridgeshire & Peterborough (C&P) CCG currently are "Requires Improvement" nationally as our achievement of the three NICE Treatment Targets (Blood Pressure (BP); Cholesterol/being on a Statin and HbA1c for our patients with diabetes is poor. Such poor management is associated with increased risk of complications and significant morbidity at younger age than expected.

The impact of social deprivation on the incidence and management of LTCs such as Diabetes is recognised in the local Health Inequality Strategy and this specification will reflect the need to invest healthcare resource equitably according to clinical need. Monies will be thus allocated according to the number of patients with Diabetes, with consideration of the local practice IMD score.

This specification is in line with C&P Outcomes to support people to achieve higher levels of health activation, with the knowledge, skills, and confidence to manage their health and to adopt healthy behaviours, have better clinical outcomes and less hospitalisation.

This includes having an "Ambition *for* Remission" for all patients with Non-Diabetic Hyperglycaemia (thus avoiding the development of Type 2 Diabetes); all patients with newly diagnosed Type 2 Diabetes and for those who have had the diagnosis of Type 2 Diabetes for the less than 10 years. This would therefore decrease the prevalence of Non-Diabetic Hyperglycaemia (NDH) and T2DM and avoid the possible future complications, and ensure our patients live happier healthier lives.

For those patients who have a diagnosis of Diabetes, C&P seeks to ensure appropriate monitoring and screening for co-morbidities and complications and thus seeks to ensure all patients with Diabetes or Diabetes in Remission have had all NICE recommended Nine Care Processes assessed each year (Eight Care Processes (8CPs) within Primary Care documentation and review).

For those patients who have a diagnosis of Diabetes, C&P seeks to ensure appropriate management of our patients, particularly the three NICE Treatment Targets (Blood Pressure (BP); Cholesterol/being on a Statin; HbA1c), (considered in line with drug volume/spend), and supporting patients adopt healthy behaviours, including maintaining a healthy Body Mass Index. Such lifestyle changes, including weight loss are demonstrably better to achieve 3 Treatment Targets (3TTs), as well as decrease risk of other co-morbidities (high BMI-related cancers; depression; MSK concerns etc).

2. AIM OF SERVICE

The aim of the service is to deliver consistent, high quality care, coordinated and person-centred care, beyond the requirements in QOF, for all adults diagnosed with Diabetes or at risk of developing Diabetes, across Cambridgeshire & Peterborough, which supports patients to achieve their treatment goals and reduce the risk of complications and other morbidities. The service will support tackling health inequalities with proportionate universalism in allocating resources according to need.

The improvements will be evident in greater achievement of the NICE 8 Care Processes for patients with Diabetes, and the delay or prevention of the onset of Diabetes for NDH patients, through improved monitoring, education and patient empowerment.

Updated November 2020

Recognising the current pressures on Primary Care, the requirements through this service specification until 31/03/2021 is for practices to work towards matching last year's achievement against the 8 care processes by the end of March 2021.

To help practices to understand their 2019-20 year end position and the gap to match this ambition, we aim to share practice specific information as part of this commissioning offer.

Eclipse is the recognised toolkit to support and evidence progress against this ambition and will also support the prioritisation of care to high-risk patients.

3. SERVICE DELIVERY

Across Practice Population:

Patients who are Overweight or Obese	1. If BMI recorded within the last 3 years and is raised (ethnic-specific) offer Very brief Intervention (VBI) via SMS: see Appendix A for suggesting wording 2. For those patients from a Black or Asian ethnicity – a BMI of 23+ = overweight; a BMI of 27+ = obese 3. For those patients from a White background: a BMI of 25+ = overweight; a BMI of 30+ = Obese 4. For those patients with no ethnicity recorded, practices should use the levels for patients of a white ethnicity (it should be noted that this will result in potential under reporting)
Eclipse	1. Practices are advised to use and update Eclipse on a **weekly basis** to support and facilitate the improvement of the care of their DM patients

Diagnosed Disease

Non-Diabetic Hyperglycaemia (NDH, or Pre-diabetes or borderline diabetes)	1. Send an SMS offering VBI to ALL patients who have had a raised HbA1c of 42-47mmol/mol (but who are not pregnant nor with a diagnosis of diabetes) in the last 24 months. See Appendix A for suggesting wording 2. Offer referral to National Diabetes Prevention Programme (NDPP) 3. Record when a patient has been invited/ attended / declined/non responder to complete NDPP structured education
Type 2 Diabetes	1. Send an SMS offering VBI: directing self-referral to Structured Education and lifestyle services. See Appendix A for suggesting wording 2. For those patients given a foot examination, please inform patient of their risk of foot disease and give patient embedded Clinical Support Tool (CST) (or equivalent) leaflets (via SMS or printed) 3. Use CCG-wide formulary once published (October 2020) 4. Using Eclipse work towards maintaining the 8 Care Processes (CP) level that was achieved last year 5. Using Eclipse to identify and prioritise care to those patients with 'Red' level indicators: BP >160/100 mmHg, HbA1c >86 mmol/mol, total cholesterol >7 mmol/l

	6. Record when a patient has been invited/ attended / declined/non responder to complete structured education 7. Use CST (or equivalent) embedded dietary sheets
Type 1 Diabetes	1. For those patients given a foot examination, please inform patient of their risk of foot disease and give patient embedded CST (or equivalent) leaflets (via SMS or printed) 2. Utilising Eclipse work towards maintaining the 8 Care Processes (CP) level that was achieved last year 3. Using Eclipse to identify and prioritise care to those patients with 'Red' level indicators: BP >160/100 mmHg, HbA1c>86mmol/l, total cholesterol > 7mmol/l 4. Record when a patient has been invited/ attended / declined/non responder to complete structured education.

Those practices with 8CP achievement of <20% last year, as recorded on Eclipse, will have a virtual 'visit' to discuss any specific challenges they are experiencing and the options of support available. These supportive visits are also available on request to all other practices. The intention is that these visits are scheduled as soon as practically possible.

Practice Structures

National Diabetes Audit	1. Continue practice participation
Practice or PCN Diabetes Lead	1. Depending on size of Diabetes population, practices may decide to have individual named practice leads and/or PCN Diabetes Lead 2. Practice or PCN Diabetes Lead to attend the 2-hour CCG-wide Diabetes meetings and cascade key messages to their respective Practice Diabetes Leads. Next meeting 5th Nov 2020, also available as a recording for those unable to attend 3. Practice or PCN Diabetes Lead is responsible for disseminating information from CCG to local clinicians 4. Practice or PCN Diabetes Lead to support staff to be competent to fulfil their particular role in Diabetes care and Management. 5. Practice or PCN Diabetes Lead will inform CCG of their Diabetes - accredited staff at year end.
Engage in Virtual Clinic Reviews with your named Endocrine Consultant	These are now **optional** and remain good opportunities to support the care and management of targeted patients. The aim is to bring a few patients, or themes, to discuss as an MDT with the Endocrinologist, Dietician & DSN – both for personal CPD and improved care of patients. Virtual Clinic Reviews - can be held at either Practice or PCN level depending on number of patients with diabetes. There should be practice representation at any PCN level meeting to ensure agreed clinical action is taken and learning disseminated.

4. PRICING

The total investment in Diabetes care is £600k which is divided between practices according to a formula from the Health Inequality Strategy which has been modified with the intention of staging these funding changes over several years.

Payment is based on £0.62 per patient x total actual list size on 1st April 2020. Individual Practices will receive a share based on the formula - 50% of funding allocated on IMD score + registered diabetic patient and 50% allocated on registered diabetic patients.

5. REPORTING

The following information will be monitored by the CCG:
Achievement for the majority of indicators will be monitored remotely via ECLIPSE, The following information will be extracted remotely by our Primary Care Information Team: 1. The number of patients on the Non-Diabetic Hyperglycaemia (NDH) register - very brief intervention (VBI) delivered- baseline & year end 2. The number of patients on the Obesity register & VBI delivered - baseline & year end