OCCG Primary Care Contract 2017-18

Oxfordshire Diabetes Locally Commissioned Service (LCS)

Commencement date: 1 April 2017
End date: 31 March 2018

1. Responsibility of GP practice

The provision of care to diabetic patients will be the responsibility of the individual practice, with the support and advice of the Diabetes Specialist Teams (Community Diabetes Specialist Nurses and OCDEM) as jointly agreed with them. The Community Diabetes Specialist Nursing Team's primary role is to offer support and advice via email and phone. Referrals to their service should be in line with their service specification (supporting information available).

The provision of generalist diabetes care by primary care healthcare teams under the GMS contract incorporate the following:

- Opportunistic screening and diagnosis of people with Type 2 Diabetes
- Referral for structured education and retinal screening for people with Type 2 Diabetes
- Generalist management of glycaemia in people with Type 2 Diabetes
- Management of cardiovascular risk in people with Type 2 Diabetes
- Initial generalist management of complications of diabetes with referral to specialist service when either not effective or not tolerated
- Diagnosis of Type 1 Diabetes and urgent referral to specialised diabetes service
- Offer of referral to specialist diabetes care to all patients with Type 1 Diabetes
- Ongoing generalist insulin management

There is the potential for this service to be delivered through clusters of practices working together; the CCG is potentially supportive of this approach however it requires forward planning and consultation with the CCG before any commencement of clustered working.

2. Enhanced Diabetes Care Delivery

Practices participating in this locally commissioned service agree to deliver all elements of enhanced diabetes care.

2.1. Insulin Initiation	Each practice will provide initiation of insulin for all Type 2 Diabetes patients requiring conversion. Detailed criteria for the insulin initiation service are included in **Appendix A**. All patients with Type 1 Diabetes are to be either seen at OCDEM or stable patients discussed with an OCDEM consultant twice a year and actions implemented.
2.2. Training in Year of Care Planning	Evidence (supporting information available) has shown that Year of Care Planning improves outcomes for diabetes patients; therefore implementation for diabetes patients across Oxfordshire is a key element of the CCG strategy to deliver patient centred care. By the end of the year, under this contract each practice will: • Ensure one diabetes lead GP and one practice nurse has completed the

	Year of Care Planning 1.5 day training session or confirmed completion of the training within the last two years. • Provide feedback to the practice about the Year of Care approach following training. • Provide a signed agreement that the practice is willing to implement Year of Care Planning. Practices are encouraged but not expected to have implemented Year of Care Planning by year end. • Download the Year of Care Planning templates into the practice system (or have equivalent templates in place).
2.3. Locality Diabetes Review Meetings	The purpose of Locality Diabetes Review meetings is to support population health improvement for diabetes. Each locality will hold a Locality Diabetes Review meeting twice a year. Each meeting will be two hours in duration and include Diabetes Specialist Team representation. The meetings are to enable practices to; • Review their Diabetes Dashboard • Identify where improvements to diabetes care can be made • Share best practice • Develop strategies to ensure the best health outcomes for their diabetes population, which could include improved clustered working. Under this contract, each practice will ensure at least one GP and one Practice Nurse attend both Locality Diabetes Review meetings within the year and ensure implementation of any actions identified for individual practices from those meetings.
2.4. Other essential items	Under this contract, each practice will: • Make their data available for the Oxfordshire Diabetes Dashboard (information sharing agreement to be signed by 1st May 2017). • Ensure a lead GP and lead Practice Nurse for Diabetes are nominated as main points of contact for the CCG. It is understood that not all diabetes care will be undertaken by just one Practice Nurse and GP in all practices. • Ensure submission to the National Diabetes Audit – pending outcome of GMS contract negotiations.

3. Outcomes

Under this contract the practice is expected to achieve all of the outcomes set out in sections 3.1 and 3.2 below. Each practice should review their performance against these expected outcomes over the first half of the year to assess whether they will achieve all targets. If a practice judges that they will not achieve all the outcomes, they should produce a plan of improvement through an MDT involving the Diabetes Specialist Teams. The plan should set out; an assessment of performance and any progress to date, barriers to achievement, how challenges will be overcome and targets achieved. The plan should include timescales and any implementation progress at point of submission. The plan should be submitted to the CCG by 1st December 2017.

3.1. Eight Care Processes	Completion of all 8 care processes across Oxfordshire is currently at 51.6% of Type 2 diabetes patients. By the end of the year, under this contract each practice must have delivered all 8 care processes to **60%** of Type 2 diabetes patients. The care processes are outlined in

	Appendix B.
3.2. NICE Treatment Targets	The national average for achievement of all three NICE treatment targets (HbA1c <59, BP <140/80, Cholesterol <5) is 40.4% of Type 2 diabetes patients. In Oxfordshire the average is 40.2% of Type 2 diabetes patients meeting all three treatment targets; there is wide variation in achievement across practices (28% - 60%). By the end of the year each practice must achieve the Oxfordshire average of **40.2%** of Type 2 diabetes patients meeting this triple target.

4. Payments

The following payments require the practice to agree to deliver all activities and outcomes set out in this contract under sections 2 and 3.

4.1. Insulin initiation payment

Insulin initiation payment will be paid on a per patient basis according to the following payment structure in Table 1. The amount practices are paid in total for insulin initiation will therefore vary according to the number of patients initiating insulin in the year. For every 1,000 diabetes patients approximately 20 Type 2 diabetes patients will convert to insulin in a year. Practices must use read code **66Ap** to be paid for insulin initiation under this contract and payment will be based on quarterly activity reported through a MiQuest search. As numbers are anticipated to be relatively low (not more than 20 per practice), payment for insulin initiation will be made as part of the final reconciliation process for locally commissioned services at the year end.

Table 1

Activity	**Payment**
Per patient payment for insulin initiation	*£122.15*

4.2. Fixed payments per practice

The payments set out in Table 2 are fixed for each practice, irrespective of practice size or diabetes register. The Year of Care training is provided free of charge by Health Education England. The payment for the training course covers the cost of backfill for the practice, which includes time on the training course and feedback time, as well as administrative time in downloading the templates. The payment for the Locality Diabetes Review meetings covers the cost of backfill for the practice and includes the meeting time and one hour for both GP and practice to implement agreed actions. These fixed payments will be paid at the start of the year on receipt of the **Sign up Form** attached at **Appendix C**.

Table 2

Activity	**Payment**
Year of Care Planning	£1,276
Locality Diabetes Review Meetings	£589
Total	*£1,865*

4.3. Incentive payment

The incentive payment for taking part in the enhanced service and achieving the outcomes as specified above will be £1,178 for a practice with an average sized diabetic population *(see Table 3 below)*. The total payment is calculated according to the total number of diabetes patients (including

Type 1 and Type 2) registered within the practice and is therefore variable by practice. Payment for this element will be made after the year end on receipt of the ***End of Year Claim Form*** attached at ***Appendix D***. Please refer to ***Appendix E*** for the anticipated values for each individual practice.

Table 3

Activity	**Payment**
Example: Total payment for an average practice of 415 diabetes patients achieving all outcomes or submitting an improvement plan	*£1,178*

The payment set out in Table 3 is for the practice achieving all outcome targets set out in section 3 and delivering all essential items in section 2.4 by the end of the year. If the practice does not achieve all outcomes by the end of the year but has submitted an improvement plan by 1st December 2017, the practice will receive the payment.

5. Information reporting requirements

Insulin initiation	Read coding of all patients initiated on insulin. The read code to be used to ensure payment is: **66Ap**. Email verification of attendance at insulin initiation training to: **occg.primarycarecontracting@nhs.net**
Year of Care Training	Record of training completion and implementation planning, including who, when and where. This should be provided in one email by year end to: **occg.primarycarecontracting@nhs.net**
Locality Diabetes Review Meetings	Minutes and attendance recorded at each meeting and emailed on a per locality basis to: **occg.primarycarecontracting@nhs.net**
Diabetes Dashboard	Relevant data made available for pull into diabetes dashboard on a monthly basis.
Outcomes	End of year MiQuest search to determine achievement of outcomes outlined in section 3.

APPENDIX A: Insulin initiation service specification

A. Definition of patients to be treated

Primary Care patients:

- People over the age of 18 with diabetes
- Age: 40 + (under this age and with complications d/w Secondary Care)
- Ethnic origin: all (use of interpreters if required)

The inclusion criteria for the client group of Type 2 patients will include:

- HbA1c ≥ 59mmol/mol (7.5%) for at least 3 months
- Intolerance of or inadequate response to maximised oral medication
- Intercurrent illness / steroids therapy exacerbating hyperglycaemia

The exclusion criteria will be:

- Renal patients with chronic kidney disease including those undergoing CAPD
- Patient currently reviewed by Secondary Care & Community DSN service (unless otherwise discussed)
- Patients with complex complications (usually Secondary Care patient)

B. Insulin Initiation - Over-arching Requirements

Identification of those patients who meet the insulin conversion therapy criteria as specified in the guidance document available on NHS Oxfordshire CCG intranet at:

- Promote full understanding of the need for insulin to both patients and carers
- Provision of a safe and supportive environment in normal daily surroundings
- Initiation of insulin and stabilisation as per the specified local guidelines as above
- Referral to the multi-disciplinary team as required

C. Insulin Initiation - Service Outline

Patients are to have a regular appointment with a GP or Practice Nurse to discuss the need to be converted to insulin therapy. Referral to a GP or Practice Nurse (PN) for an appointment to discuss Insulin Therapy as per Local Insulin Conversion Guidelines (see link below):

The Practice Nurse will review the patient and discuss:

- Current situation and reasons for Insulin Conversion.
- Social and psychological issues addressed.
- Issues relating to commencement of insulin eg. diet, hypo's and driving
- Blood glucose monitoring
- Insulin type and regime (first line use is NPH insulin if HbA1c < 75mmol/mol (9%) but should be either a basal-bolus regimen or twice daily biphasic regimen if HBa1C ≥ 75mmol/mol (9%)) as per guidance available on NHS Oxfordshire CCG internet at: http://www.oxfordshireccg.nhs.uk/clinical-guidelines/insulin-initiation-and-adjustment-in-type-2-diabetes/32324
- Insulin pen device

- Agree time scale to commence the treatment
- Appropriate visits* with the GP/PN, monitoring and follow-up as necessary for individual patients
- Agreed written educational material will be used within the service.
- All staff to work within updated local clinical guidelines.

Close links with the Community Diabetes Nurse Specialists or MMT Diabetes Nurse Specialist to provide support and guidance throughout the process.

*Appropriate visits – recommend weekly titration reviews for at least one month and 2-4 weekly until target achieved. Some reviews could be by telephone.

D. Accreditation and competencies

The contractor will identify a GP or Practice Nurse who is the lead for insulin initiation for the practice. A named doctor or nurse, with insulin management knowledge, will be accessible within working hours to patients.

GPs and Practice Nurses should be able to demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on their competency level and take part in necessary supportive educational activities. They should have a responsibility for ensuring that their skills are regularly updated.

The GP and/or Practice Nurse lead for initiating insulin must attend one of the following and provide evidence of attendance before initiating patients on insulin:

- Local insulin initiation course within the last 3 years
- Warwick courses in insulin initiation
- Intensive management in type 2 diabetes MSc in Diabetes Theory and Practice of Insulin Initiation
- Alternatively they may demonstrate equivalent competencies and experience to undertake insulin initiation safely.

Regular educational updates such as local insulin management & intensification courses should be undertaken as recommended and the practice may be assessed annually for Competency using the competency assessment (Knowledge and Skills framework August 2004; HA11, HA12 HD3 & Trend Competency Framework) to include:

- Demonstrate an understanding of the physiological aspects of diabetes.
- Demonstrate an understanding the role of insulin during everyday life.
- Demonstrate competency in managing insulin therapy and to maintain their skills by regular clinical involvement.
- Demonstrate knowledge of all insulin devices and types of insulin

E. Equipment – minimum requirement

- Insulin/pen device/pen needles/sharps box/safeclip/hypostop
- Blood testing strips - all on prescription
- Blood glucose meter/ finger pricking device provided by the patient

APPENDIX B: Diabetes Care Processes and QOF

There are 9 care processes as outlined by NICE guidelines.

One of these is retinal eye screening which is the responsibility of the Digital Screening Programme.

This leaves 8 care processes as follows, which are covered as part of QOF as follows:

Measurement of Blood pressure	**QOF indicators DM002 and DM003**
Measurement of Cholesterol	**QOF indicator DM004**
Measurement of HbA1c	**QOF indicators DM007, DM008, DM009**
Foot check	**QOF indicator DM012**
Serum creatinine	**Not expressly covered in QOF – likely to form part of routine patient care for most diabetic patients**
Urinary ACR	**QOF indicator DM006**
Smoking	**QOF indicators SMOK002 and SMOK003**
Measurement of BMI	**Not expressly covered in QOF – likely to form part of routine patient care for most diabetic patients. Obesity domain (OB002) within QOF also includes all patients with a BMI of over 30 for which practices receive a payment.**

Appendix C : Sign up Form

Diabetes Locally Commissioned Service 2017-18

Confirmation of intention to participate

Name of practice **Practice Code**

The practice confirms its agreement to implement Year of Care Planning and to carry out all other elements of the Diabetes Locally Commissioned Service as set out in the Service Specification and summarised below.

Activity	Payment
Year of Care Planning: By the end of the year, the practice will: • Ensure one diabetes lead GP and one practice nurse has completed the Year of Care Planning 1.5 day training session or confirm completion of the training within the last two years. • Provide feedback to the practice about the Year of Care approach following training. • Download the Year of Care Planning templates into the practice system (or have equivalent templates in place).	**£1,276**
Locality Diabetes Review Meetings: By the end of the year, the practice will ensure attendance at two Locality Diabetes Review Meetings	**£589**
Total initial payment	***£1,865***

The practice also confirms that it will:

a) achieve the following outcomes by the end of the year; **or**

b) if achievement is not anticipated, provide a plan of improvement to OCCG by 1st December 2017.

Outcomes	Payment
Eight Care Processes Delivery of all 8 care processes to **60%** of Type 2 diabetes patients.	
NICE Treatment Targets Achievement of the Oxfordshire average of **40.2%** of Type 2 diabetes patients meeting all three NICE treatment targets (HbA1c <59mmol/mol (7.5%), BP <=140/80mmHg, Cholesterol <5mmol/L).	

Name: **Position in practice:**

Signed: **Date:**

This form to be sent to occg.primarycarecontracting@nhs.net. Initial payment for the service will be made to the practice on receipt of this form.

Appendix D: End of Year Claim Form

Diabetes Locally Commissioned Service 2017-18

Confirmation of achievement of outcomes

Name of practice **Practice Code**

The practice confirms that it has achieved the following outcomes as specified in the service specification.

Y/N *Please delete as appropriate.*

Eight Care Processes	The practice has delivered all 8 care processes to **60%** of Type 2 diabetes patients.
NICE Treatment Targets	The practice has achieved the Oxfordshire average of **40.2%** of Type 2 diabetes patients meeting all three NICE treatment targets (HbA1c <59mmol/mol (7.5%), BP <=140/80mmHg, Cholesterol <5mmol/L).

The practice confirms that it has not yet achieved the above outcomes as specified in the service specification but had provided an improvement plan to the CCG by **1st December 2017**.

Y/N

Please delete as appropriate.

Name: **Position in practice:**

Signed: **Date:**

This form to be completed and returned to occg.primarycarecontracting@nhs.net by 30th April 2018. Outcomes payment will be made to practice following receipt of this form.

Appendix E: Schedule of payments by practice

K Code	Practice name	Diabetes Register 2015	Insulin initiation (£122.15 per pt.)	Year of Care Planning	Locality Diabetes Review Meetings	Achieve-ment of outcomes	Total excl. Insulin initiation
K84016	19 Beaumont Street	249	As per claims	£1,276	£589	£707.08	£2,572
K84049	27 Beaumont Street	153	As per claims	£1,276	£589	£434.47	£2,299
K84080	28 Beaumont Street	120	As per claims	£1,276	£589	£340.76	£2,206
K84054	Abingdon Surgery	481	As per claims	£1,276	£589	£1,365.89	£3,231
K84613	Alchester Medical Group	600	As per claims	£1,276	£589	£1,703.82	£3,569
K84010	Bampton Surgery	384	As per claims	£1,276	£589	£1,090.44	£2,955
Y02754	Banbury Health Centre	119	As per claims	£1,276	£589	£337.92	£2,203
K84021	Banbury Road Medical Centre	169	As per claims	£1,276	£589	£479.91	£2,345
K84032	Bartlemas Surgery	503	As per claims	£1,276	£589	£1,428.37	£3,293
K84035	Bell Surgery	303	As per claims	£1,276	£589	£860.43	£2,725
K84023	Berinsfield Health Centre	309	As per claims	£1,276	£589	£877.47	£2,742
K84052	Bicester Health Centre	563	As per claims	£1,276	£589	£1,598.75	£3,464
K84058	Bloxham Surgery	283	As per claims	£1,276	£589	£803.63	£2,669
K84025	Botley Medical Centre	637	As per claims	£1,276	£589	£1,808.89	£3,674
K84075	Broadshires Health Centre	356	As per claims	£1,276	£589	£1,010.93	£2,876
K84047	Burford Surgery	305	As per claims	£1,276	£589	£866.11	£2,731
K84009	Bury Knowle Health Centre	725	As per claims	£1,276	£589	£2,058.78	£3,924
K84610	Charlbury Surgery	221	As per claims	£1,276	£589	£627.57	£2,493
K84030	Chipping Norton Health Centre	628	As per claims	£1,276	£589	£1,783.33	£3,648
K84033	Church Street Practice	637	As per claims	£1,276	£589	£1,808.89	£3,674
K84034	Clifton Hampden Surgery	134	As per claims	£1,276	£589	£380.52	£2,246
K84618	Cogges Surgery	218	As per claims	£1,276	£589	£619.05	£2,484
K84063	Cowley Road Medical Practice	241	As per claims	£1,276	£589	£684.37	£2,549
K84056	Cropredy Surgery	164	As per claims	£1,276	£589	£465.71	£2,331
K84055	Deddington Health Centre	397	As per claims	£1,276	£589	£1,127.36	£2,992
K84002	Didcot Health Centre	773	As per claims	£1,276	£589	£2,195.08	£4,060
K84004	Donnington Medical Partnership	778	As per claims	£1,276	£589	£2,209.28	£4,074

K Code	Practice name	Diabetes Register 2015	Insulin initiation (£122.15 per pt.)	Year of Care Planning	Locality Diabetes Review Meetings	Achieve-ment of outcomes	Total excl. Insulin initiation
K84006	Eynsham Medical Centre	637	As per claims	£1,276	£589	£1,808.89	£3,674
K84071	Goring & Woodcote Health Centre	373	As per claims	£1,276	£589	£1,059.21	£2,924
K84045	Gosford Hill Medical Centre	395	As per claims	£1,276	£589	£1,121.68	£2,987
K84001	Hart Surgery	338	As per claims	£1,276	£589	£959.82	£2,825
K84059	Hightown Surgery	489	As per claims	£1,276	£589	£1,388.61	£3,254
K84048	Hollow Way Medical Centre	392	As per claims	£1,276	£589	£1,113.16	£2,978
K84040	Horsefair	829	As per claims	£1,276	£589	£2,354.11	£4,219
K84003	Islip Surgery	211	As per claims	£1,276	£589	£599.18	£2,464
K84078	Jericho Health Centre (Leaver)	95	As per claims	£1,276	£589	£269.77	£2,135
K84605	King Edward Street	53	As per claims	£1,276	£589	£150.50	£2,016
K84079	Long Furlong MC	245	As per claims	£1,276	£589	£695.73	£2,561
K84066	Luther Street Medical Centre	14	As per claims	£1,276	£589	£39.76	£1,905
K84027	Malthouse Surgery	900	As per claims	£1,276	£589	£2,555.72	£4,421
K84044	Manor Surgery	557	As per claims	£1,276	£589	£1,581.71	£3,447
K84041	Marcham Road Health Centre	510	As per claims	£1,276	£589	£1,448.24	£3,313
K84036	Mill Stream Surgery	192	As per claims	£1,276	£589	£545.22	£2,410
K84038	Montgomery House Surgery	657	As per claims	£1,276	£589	£1,865.68	£3,731
K84014	Morland House Surgery	420	As per claims	£1,276	£589	£1,192.67	£3,058
K84015	Nettlebed Surgery	127	As per claims	£1,276	£589	£360.64	£2,226
K84019	Newbury Street Practice	670	As per claims	£1,276	£589	£1,902.60	£3,768
K84072	Nuffield Health Centre	595	As per claims	£1,276	£589	£1,689.62	£3,555
K84624	Oak Tree Health Centre	296	As per claims	£1,276	£589	£840.55	£2,706
K84026	Observatory Medical Practice	298	As per claims	£1,276	£589	£846.23	£2,711
K84050	Rycote Surgery	472	As per claims	£1,276	£589	£1,340.34	£3,205
K84065	Sibford Gower Surgery	103	As per claims	£1,276	£589	£292.49	£2,157
K84020	Sonning Common Health Centre	327	As per claims	£1,276	£589	£928.58	£2,794
K84617	South Oxford Health Centre	103	As per claims	£1,276	£589	£292.49	£2,157
K84013	St Bartholomews MC Cowley	358	As per claims	£1,276	£589	£1,016.61	£2,882
K84060	St Clements Surgery	191	As per claims	£1,276	£589	£542.38	£2,407

K Code	Practice name	Diabetes Register 2015	Insulin initiation (£122.15 per pt.)	Year of Care Planning	Locality Diabetes Review Meetings	Achieve-ment of outcomes	Total excl. Insulin initiation
K84011	Summertown Medical Group	376	As per claims	£1,276	£589	£1,067.73	£2,933
K84007	Temple Cowley Health Centre	420	As per claims	£1,276	£589	£1,192.67	£3,058
K84082	Key Medical Practice	623	As per claims	£1,276	£589	£1,769.13	£3,634
K84031	Leys Health Centre	564	As per claims	£1,276	£589	£1,601.59	£3,467
K84037	Wallingford Medical Centre	614	As per claims	£1,276	£589	£1,743.57	£3,609
K84008	Watlington & Chalgrove Surgery	339	As per claims	£1,276	£589	£962.66	£2,828
K84028	West Bar Surgery	877	As per claims	£1,276	£589	£2,490.41	£4,355
K84051	White Horse Practice	653	As per claims	£1,276	£589	£1,854.32	£3,719
K84017	Windrush Health Centre (Witney)	606	As per claims	£1,276	£589	£1,720.85	£3,586
K84024	Windrush Surgery (Banbury)	437	As per claims	£1,276	£589	£1,240.95	£3,106
K84043	Woodlands Medical Centre	530	As per claims	£1,276	£589	£1,505.04	£3,370
K84062	Woodlands Surgery	321	As per claims	£1,276	£589	£911.54	£2,777
K84042	Woodstock Surgery	413	As per claims	£1,276	£589	£1,172.79	£3,038
K84046	Wychwood Surgery	231	As per claims	£1,276	£589	£655.97	£2,521