Service	**Non-Diabetic Hyperglycaemia (NDH) Local Commissioned Service (LCS)**
Commissioner Lead	Oxfordshire Clinical Commissioning Group (CCG)
Provider Lead	Primary Care
Period	01 Jan 2020 to 31 March 2020
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

See Appendix E for national / local context and case for change

This LCS is to enable payment for GP practices to perform retrospective case finding for people in Oxfordshire who may have Non-Diabetic Hyperglycaemia (NDH) (previously; pre-diabetes). To enable this one-off payment, GP practices will be required to:

- Set up a register named "NDH Register" to include those with a HbA1C of 42-47 (6.0 – 6.4%) or fasting plasma glucose (FPG) of 5.5 – 6.9 mmol
- Identify patients from the retrospective search that are appropriate to be referred to the National Diabetes Prevention Programme (NDPP)
- Refer patients identified as above
- Submit total retrospective referral numbers to OCCG

Opportunistic referrals made following the initial payment for referrals are considered to be normal clinical practice.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- Reduce the number of patients with pre-diabetes
- Reduce the number of pre-diabetic patients who progress to Type 2 diabetes
- Improve patient experience of care

- High levels of patient satisfaction by empowering the patient to be involved in decisions about the care they receive
- High levels of patient satisfaction by empowering the patient to make sure they access care / treatment in a timely manner
- Strengthen continuity of care
- Increase the number of pre-diabetic patients who exercise regularly

3. Scope

3.1 Aims and objectives of service

The NDPP has been commissioned by NHSE for a further 3 years following the successful roll out across England. This will continue to help reduce the risk for selected individuals of developing Type 2 diabetes by offering education on diabetes, healthy eating and physical activity. The number of expected referrals has been agreed in a Memorandum of Understanding between Oxfordshire CCG and NHSE (see Appendix F). ICS Health & Wellbeing is the community provider that has been awarded the contract across Oxfordshire, Buckinghamshire and Berkshire West to deliver the behavioural intervention programme.

3.2 Service description / care pathway

GP practices signing up to this LCS will be expected to do the following (further detail in Section 6):

- Refer patients at risk of diabetes to the NDPP (Patients deemed to be at risk are categorised as having a HbA1C result of 42-47 (6.0 – 6.4%) or a fasting plasma glucose (FPG) result of 5.5 – 6.9 mmol – latest result in previous 12 months)
- Ensure each individual patient's clinical record is appropriately Read Coded using the national codes set out in Appendix A.
- Patients must be 18 years or over and have had the blood test result identified within 12 months of the search being run
- Ensure opportunistic referrals are initiated through GP / Nurse face to face contact,
- GP practices will be notified on a quarterly basis of the number of patients who have joined the Programme and have attended their first sessions
- GP practices will be informed of those patients that did not attend their appointment or dropped out of the Programme.

3.4 Population covered

Patients registered with an Oxfordshire GP practice who fall into the eligible category outlined in 3.2.

Currently in Oxfordshire, according to a GP practice register audit carried out in August 2019, 8035 patients had been identified as 'at risk' of developing diabetes, this is before the exclusion criteria detailed below has been applied. This equates to approximately 106 patients per 10,000 population.

3.5 Exclusion criteria and thresholds

As per the NDPP service specification, the following individuals are excluded from this LCS:

- Individuals with blood results confirming a diagnosis of Type 2 diabetes
- Individuals with a normal blood glucose reading on referral to the service
- Individuals aged under 18 years
- Pregnant women

3.6 Interdependence with other services/providers

- NDPP Community Service Provider (ICS Health & Wellbeing)

- Oxfordshire County Council (NHS Health Check Programme commissioners)

4. Location of Provider Premises

4.1 The NDPP commissioned provider (ICS Health & Wellbeing) will deliver the behavioural intervention sessions from various locations across Oxfordshire according to local demand and accessibility requirements. These locations are to be confirmed and may change according to need. Referrals into the programme from primary care will be generated from GP practices.

5. Monitoring Requirements

5.1 Monitoring
As a minimum, GP practices will need to ensure that they keep activity information for service delivery at an individual patient level. The GP practice is required to supply Oxfordshire CCG with such information it may reasonably request for the purposes of monitoring the GP practice's performance of its obligations under this LCS. To reduce the workload of GP Practices searches have been produced which will outline the number of patients on the NDH Register, this will be published by the Commissioning Support Unit (CSU). These searches will be used for the retrospective referrals; the number of letters sent in relation to this will need to be recorded to ensure correct payment. (See Appendix G)

5.2 Monitoring Requirements
GP practices will be required to submit monitoring requirements as follows:

Submission Requirements	**Deadline**
Claim Form (Appendix G): (27th March 2020 to 31 March 2020**)** • Total number of eligible patients sent a letter advising they are eligible for the programme and inviting them to contact the NDPP provider. (ICS Health & Wellbeing) **For reference all NDPP Read Codes are attached in Appendix A.**	**4 weeks after LCS is published**

6. Practice Requirements / Payment

6.1 Practice Requirements / Administration Process (process chart in Appendix H)

6.1.1 Mobilisation

- Searches will be provided by CSU to identify those patients within the 'at risk' range according to the criteria in 3.2. The GP Practice is to run the search and review this eligible list of patients to exclude patients as appropriate e.g. end of life patients, and therefore identify those eligible for invite onto the NDPP. Once reviewed and finalised, this list of patients should be used for the Retrospective referral process outlined below.
- GP practice to upload the NDPP referral form into their system (EMIS/Vision), if not already done so to be used for Opportunistic referral of patients onto the NDPP and also for individuals invited through Retrospective searches who have not self referred. The information required for a referral is automatically collected using the referral form.
- GP practice to provide email address to ICS Health & Wellbeing for patient progress

reports within NDPP to be sent back to the GP practice on a quarterly basis. Patient progress is to be appropriately Read Coded by the GP Practice upon receipt of information from ICS Health & Wellbeing.

- GP practice to ensure all staff are briefed on the NDPP and understand the importance of using motivational conversation skills to support behavioural change e.g. 'Making Every Contact Count' to encourage uptake. For more information on training to support this initiative email: occg.yoc@nhs.net

6.1.2 Retrospective referral

- GP practice to inform identified and eligible patients, by use of the standard invite letter made available to Practices, that they are at risk of diabetes and are recommended for referral onto NDPP. Practices may choose to also send text or email reminders to patients who are eligible and as reminders to self-refer onto the programme. To confirm their agreement to referral and participation on the NDPP, the patient can self-refer via the NDPP website (https://preventing-diabetes.co.uk/self-referral/), via email to info@preventing-diabetes.co.uk or by calling 0333 577 3010.
- For self-referrals the individual will require the following details (this information is automatically populated within the invite letter)
    - NHS Number
    - Latest HbA1c or FPG reading
    - Date of blood test
    - GP Surgery Name
- The letter to the patient should include a 'Healthier You' patient information leaflet an example of which is at Appendix D, these are available within the invite letters in the system.
- If the patient contacts the GP Practice to 'opt-in' after receiving an invite letter the same process as an opportunistic referral should be completed by the GP Practice.
- If the patient declines the referral this should be Read Coded as 679m3 / XaeDG and the patient considered for eligibility into other lifestyle services

Important note: SNOMED CT is the clinical terminology chosen to replace Read codes within the NHS. Coded information that is currently received from GP systems is as Read codes; this will change to SNOMED CT following implementation which is now scheduled for later in 2019 in England. SNOMED codes will be confirmed at a later date, the specification currently shows Read codes.

6.1.3 Opportunistic referral

- Eligible patients seen face to face by a health care professional at the GP practice should be advised about the NDPP and informed that they will be referred onto the Programme unless they 'opt-out'.
- The NHS Health Check Programme includes an existing diabetes filter within the Risk Assessment that will opportunistically identify patients with NDH. All individuals who are recorded as having NDH should receive an annual blood test in line with NICE guidelines.
- If the patient agrees to join the Programme, the GP practice is to refer the patient to ICS Health & Wellbeing using the EMIS/Vision referral form. The referral forms can be downloaded from https://www.oxfordshireccg.nhs.uk/professional-resources/clinical-guidelines/referral-pro-formas.htm if not already done so. Completion of the referral form will result in all required referral information being sent to ICS Health & Wellbeing via secure email. The patient's record should be Read Coded appropriately as 679m4 / XaeDH.
- Opportunistic referrals are considered to be part of normal patient care and will not be

paid for.

6.1.4 Non-attendance

- If a patient has been referred but not attended the Programme, GP practices are expected to discuss this with the patient at their next face to face consultation to encourage the patient to re-consider and participate in the Programme. If the patient agrees, the opportunistic referral process should be followed.
- GP practice to Read Code all patient non-attendances and drop-outs when notified by ICS Health & Wellbeing through patient progress reports.

6.1.5 Referral monitoring

GP practice to monitor and Read Code the number of patients invited onto the Programme (in accordance with 5.2)

6.2 Payments

6.2.1 Mobilisation payment

£400 will be paid to the practice upon:

- Completion of all mandatory mobilisation tasks outlined in s.6.1.1
- Completion of the claim form, and sending form to: occg.plannedcare@nhs.net
-

6.2.2 Payment per patient sent a letter

£1.50 will be paid to the GP practice for the administrative costs for each patient sent a letter to refer onto the NDPP under the Retrospective referral process set out under 6.1.2. Payment will be made to the GP practice after submission of data, based on the number of letters sent, which is reported through the monitoring requirements set out in 5.2.

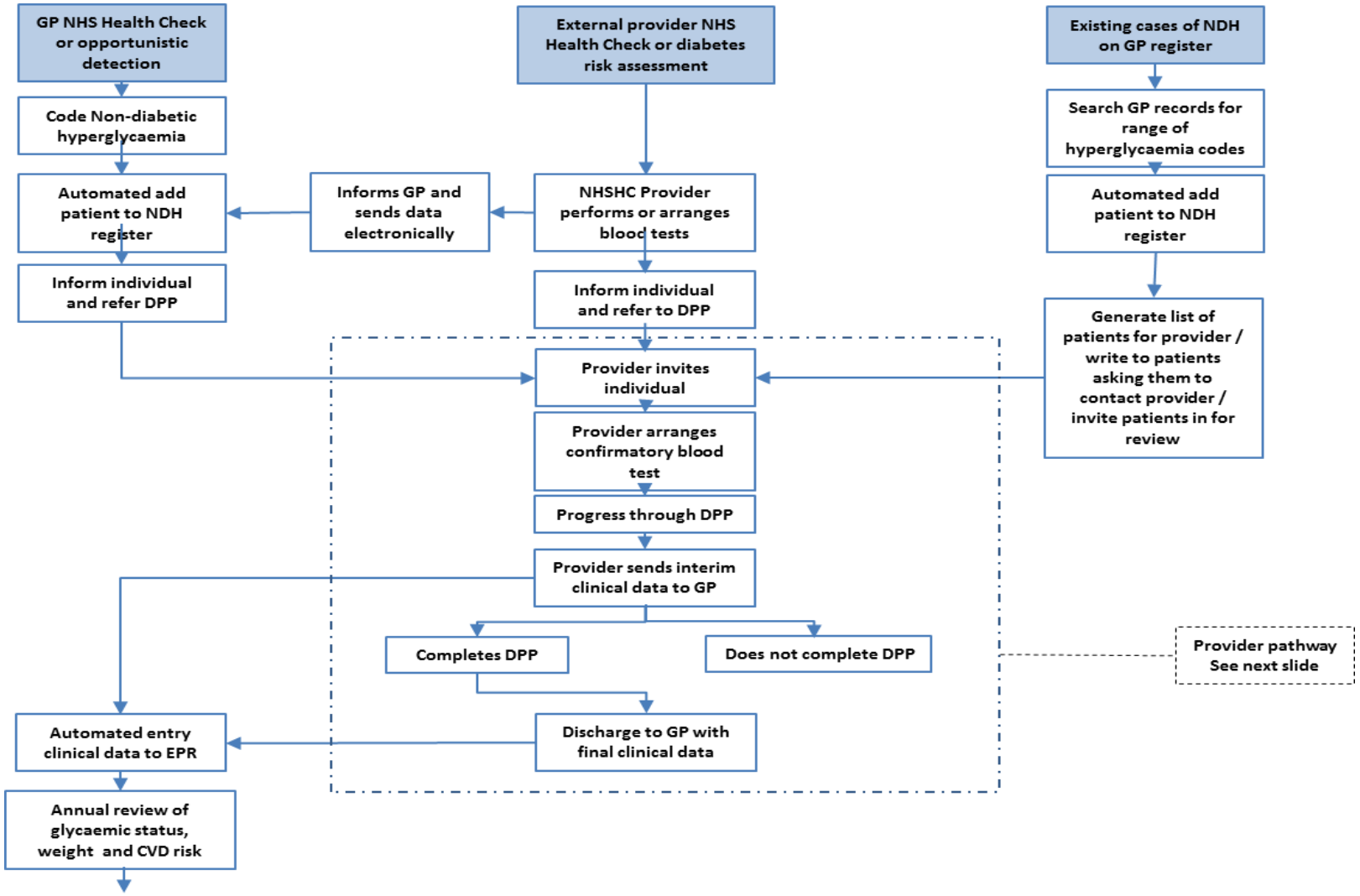
Appendix A: Read Codes

Public Health England

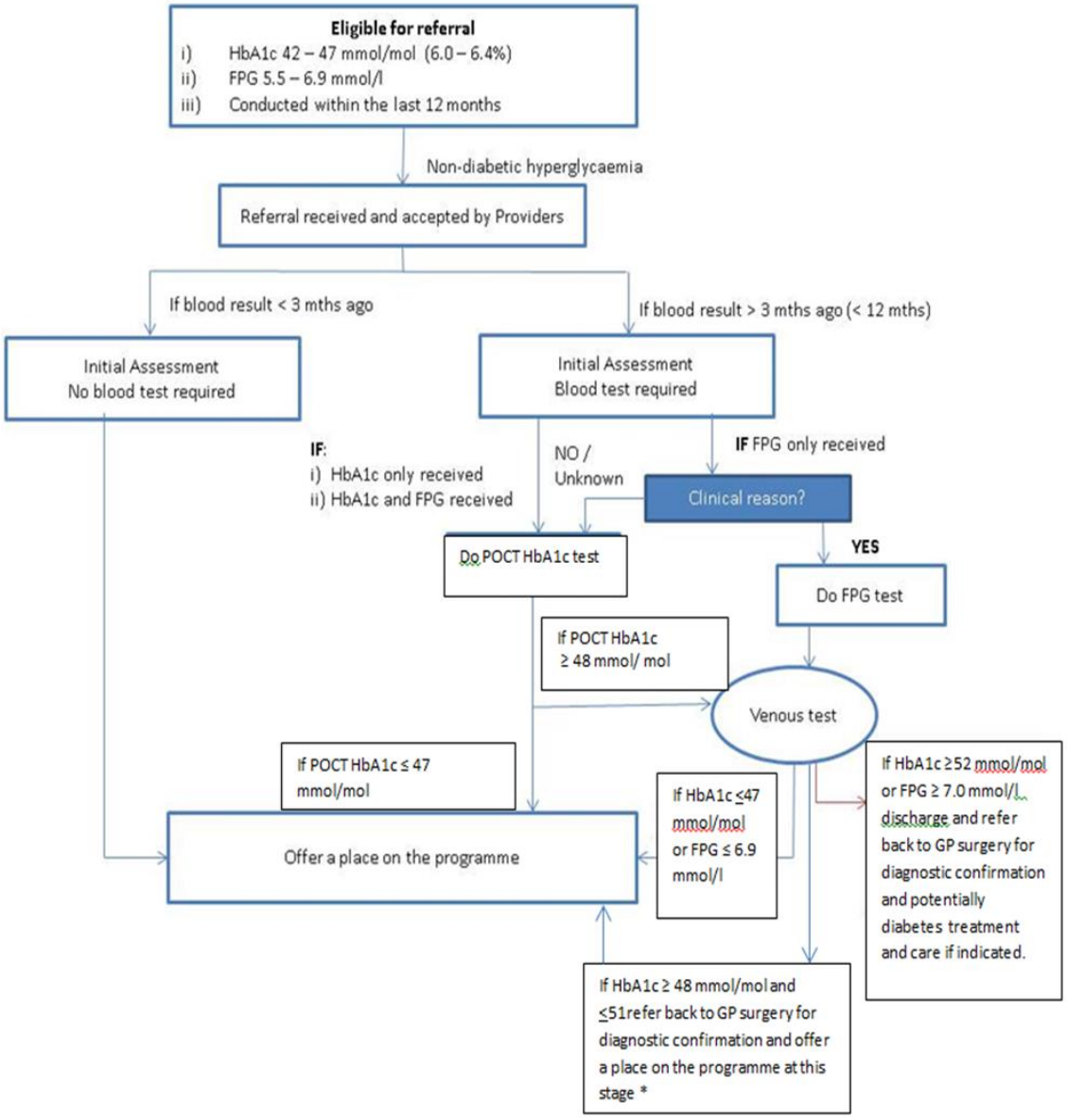
NHS England

RSP No	V2	V3	SNOMED CT
19516	38VZ. Leicester Diabetic Risk Score	XaeDt Leicester Diabetic Risk Score	1025571000000101 Leicester Diabetic Risk Score (assessment scale)
19910	C317. | Non-diabetic hyperglycaemia	XaaeP | Non-diabetic hyperglycaemia	700449008 | Non-diabetic hyperglycemia (disorder)
19517	679m4 Referred to NHS Diabetes Prevention Programme	XaeDH Referred to NHS Diabetes Prevention Programme	1025321000000109 Referred to National Health Service Diabetes Prevention Programme (procedure)
19518	679m3 Referral to NHS Diabetes Prevention Programme declined	XaeDG Referral to NHS Diabetes Prevention Programme declined	1025301000000100 Referral to National Health Service Diabetes Prevention Programme declined (situation)
19519	679m2 NHS Diabetes Prevention Programme started	XaeD0 NHS Diabetes Prevention Programme started	1025271000000103 National Health Service Diabetes Prevention Programme started (situation)
19520	679m1 NHS Diabetes Prevention Programme completed	XaeCz NHS Diabetes Prevention Programme completed	1025251000000107 National Health Service Diabetes Prevention Programme completed (situation)
19521	679m0 National Health Service Diabetes Prevention Programme not completed	XaeCw NHS Diabetes Prevention Programme not completed	1025211000000108 National Health Service Diabetes Prevention Programme not completed (situation)

Appendix B: NDPP Referral Pathways



Appendix C: Eligibility and testing process



* Individuals who express a preference to stay on the programme should not be excluded until after their GP referral in order to support continuity for the individual on the programme for those that subsequently decide to stay on.

Appendix D: NDDP Patient Information Leaflet

This leaflet and other NDDP leaflets will be available from ICS Health & Wellbeing.

P4186 ICS H&W patient info sheet v4.

Appendix E: National / Local Context and case for change

Current Position

There are an estimated 3.2 million people in England with diabetes, of which 2.8 million have been diagnosed. It is estimated that a further 5 million people in England are at high risk of Type 2 diabetes, and by 2030 more than 4 million people in England will have the disease. Diabetes accounts for nearly £10 billion of NHS spend in the UK every year with 80% spent on managing complications. The health and financial burdens of this disease are high and this will continue to grow unless more is done to prevent it.

90% of people with Type 2 diabetes could have been prevented or delayed. Randomised control trials have shown 30-60% reductions in incidence of Type 2 diabetes, over three years, in adults at high risk who received intensive behavioural interventions (compared to control groups).

NHS Diabetes Prevention Programme (NDPP)

The NHS 'Long Term Plan' 2019 outlines that prevention is a key area to focus on, specifically diabetes prevention through obesity reduction, and this is evident by the NDPP being commissioned for a further 3 years. The NDPP will continue to deliver an evidence based diabetes prevention programme, based on proven UK and international models focused on weight, increasing physical activity and improving diet in those individuals who are identified at high risk of developing Type 2 diabetes.

Oxfordshire, Buckinghamshire and Berkshire West

Oxfordshire, Buckinghamshire and Berkshire West are jointly collaborating with NHSE and the new provider ICS Health & Wellbeing to continue the NDPP. The overall aim of the programme is to identify the number of people at risk of developing type 2 diabetes and help them to make lifestyle changes to prevent or delay the onset of diabetes.

Appendix F: Oxfordshire CCG anticipated number of NDPP referrals

Year	Month	Referral Numbers
2018/19	August	194
	September	233
	October	300
	November	300
	December	167
	January	367
	February	300
	March	300
	April	300
	May	300
	June	300
	July	300
Year 1 Total		**3361**
2019/20	August	247
	September	247
	October	247
	November	247
	December	167
	January	320
	February	267
	March	247
	April	247
	May	247
	June	247
	July	247
Year 2 Total		**2977**
2020/21	August	217
	September	217
	October	217
	November	217
	December	167
	January	267
	February	217
	March	217
	April	217
	May	217
	June	217
	July	202
Year 3 Total		**2589**

Appendix G: Claim Form

Non-Diabetic Hyperglycaemia (NDH) Local Commissioned Service (LCS)

NDPP Retrospective Referral Claim Form

Please return this claim form to occg.plannedcare@nhs.net upon completion of the initial case-finding and referral of patients by 31st March 2020

Name of practice **Practice code**

Requirement	Value	Date
Number of eligible patients sent a letter indicating referral to NDPP provider (ICS Health & Wellbeing) as set out under the Retrospective referral process in s.6.1.2. An NDPP Patient Information Leaflet should be included with each letter/email.	Number	
Referral form uploaded onto practice IT system.	Y/N	
All other mandatory mobilisation tasks detailed in s.6.1.1 are complete.	Y/N	

Name **Position in practice**

Signed **Date**

Appendix H: NDPP Mobilisation and referral processes