OCCG Primary Care Contract 2019-20

Oxfordshire Diabetes Locally Commissioned Service (LCS)

Summary

Commencement date: 1 April 2019
End date: 31 March 2020

Section	Practice Requirement
Year of Care Planning	Each practice will need to continue implementation of Year of Care Planning (YOC) for the management of diabetes patients. The practice can extend this to all long term conditions patients, which will generate the most efficiencies and benefit. For support, contact occg.yoc@nhs.net
Diabetes Multi-Disciplinary Team (MDT) Meetings at Primary Care Network level	Each practice will participate in quarterly Diabetes multi-disciplinary team meetings (MDTs) within their Primary Care Network. The meetings will include secondary and community care clinicians specialising in diabetes care with the aim of improving the care of people with diabetes. These meetings will commence from 1st July 2019, therefore there will be 3 meetings in 2019-20. Patients discussed in the PCN MDT should have the Read code **66Aq** applied.
Insulin initiation	Each practice will provide initiation of insulin for all people with Type 2 Diabetes requiring conversion. Primary Care Networks can decide that a practice will deliver the service on behalf of the network. The Read code that must be used to ensure payment for insulin initiation is **66Ap**.
Care Process and NICE Treatment Target achievement for Type 2 diabetes patients	Each practice is expected to meet its individual practice target (**Appendix A**) for the completion of all 8 care processes and the achievement of all three NICE treatment targets (triple target) for Type 2 patients. Performance against targets will be assessed by the Diabetes Dashboard, not the National Diabetes Audit. An improvement plan is to be submitted by **28th February 2020** if targets won't be met.
Other essential items	Each practice will also: a) Apply complete coding for all diabetes structured education activity using nationally standardised codes[1] (see pages 7-8 below). b) Apply complete diabetes eye screening coding (see page 8). c) Make data available for the Oxfordshire Diabetes Dashboard. d) Ensure a lead GP and lead Practice Nurse for Diabetes are nominated as main points of contact for the CCG, with contact details provided. e) Ensure full submission to the National Diabetes Audit.

[1] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-structured-education-data

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1. Oxfordshire Diabetes Transformation – aims and objectives

The overarching aim of diabetes transformation in Oxfordshire is to establish an integrated 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 objectives, and therefore the scope of the transformation programme are to:

- Improve outcomes and reduce unwanted variation of care for people with diabetes across Oxfordshire.
- Improve patient experience of diabetes care and achieve high satisfaction against patient experience measures to be agreed as part of the project.
- Reduce complications arising from diabetes, in particular in renal replacement therapy and heart failure.
- Improve achievement of the Triple Target and Eight Care Processes for people with Type 1 and Type 2 Diabetes, with a target of reaching at least the highest (national) quartile for Type 2 diabetes in the short term and to go on and reach the highest (national) decile in the medium term. It is also an aspiration to achieve similar performance for attendance at structured education. It is an ambition for 50% of newly diagnosed patients (within 12 months) to achieve the Triple Target.
- Reduce the rate of growth in the costs of care for people with diabetes to support Oxfordshire's health care system. Informed by experience, to agree future investment based on the growing predicted prevalence of diabetes, taking into account predicted savings.

2. National Diabetes Audit 2017-18: Type 2 Baselines, Top Quartile and Variation

2.1. Baselines and Top Quartile

	Oxfordshire (Diabetes Dashboard – March 2019)	Oxfordshire (NDA 2017-18)	England Top Quartile (NDA 2017-18)	England Top Decile (NDA 2017-18)
% of Type 2 patients receiving all 8 Care Processes	69.6%	66.8%	72.1%	80%
% of Type 2 patients achieving NICE Triple Target	40.2%	39.2%	45.3%	50%

	Oxfordshire (Diabetes Dashboard – March 2019)	Oxfordshire (NDA 2017-18)	England Top Quartile (NDA 2017-18)	England Top Decile (NDA 2017-18)
(HbA1c <=58, BP <=140/80, Chol <5)				
% of newly diagnosed (within 12m) Type 2 patients offered structured education	63.7%	76.5%	100%	100%
% of newly diagnosed (within 12m) Type 2 patients attended structured education	12.7%	7.6%	25%	33.3%

2.2. Variation across Oxfordshire practices

% of Type 2 patients receiving all 8 Care Processes (NDA 2017-18)	43 out of 70 practices were between the national benchmark 25th and 75th percentile. 2 practices were below the 25th percentile. 25 practices were above the 75th percentile. (Range: 11.4% - 88.6%)
% of Type 2 patients achieving NICE Triple Target (HbA1c <=58, BP <=140/80, Chol <5) (NDA 2017-18)	41 out of 70 practices were between the national benchmark 25th and 75th percentile. 17 practices were below the 25th percentile. 12 practices were above the 75th percentile. (Range: 23.5% - 58.3%)

2.3. Effect on outcomes and variation for Oxfordshire if all practices achieve LCS 2019-20 targets (see Appendix A)

	Oxfordshire – projection for end March 2020
Outcome: % of Type 2 patients receiving all 8 Care Processes	73.8%
Variation: % of Type 2 patients receiving all 8 Care Processes	34 practices would be between the national benchmark 25th and 75th percentile (NDA 2017-18). No practices would be below the 25th percentile. 35 practices would be above the 75th percentile. (Range: 70% - 88%)
Outcome: % of Type 2 patients achieving NICE Triple Target (HbA1c <=58, BP <=140/80, Chol <5)	43.1%
Variation: % of Type 2 patients achieving NICE Triple Target (HbA1c <=58, BP <=140/80, Chol <5)	50 practices would be between the national benchmark 25th and 75th percentile (NDA 2017-18). No practices would be below the 25th percentile. 19 practices would be above the 75th percentile. (Range: 40.2% - 53.2%)

3. Practice requirements and payments

The **Sign Up Form (Appendix E)** and **End of Year Claim Form (Appendix F)** need to be completed and submitted to occg.plannedcare@nhs.net to confirm participation and enable payment.

Section	Practice Requirement	Payment	Information reporting
3.1 Year of Care Planning	Oxfordshire CCG regards the implementation of Year of Care Planning[2] as key to the effective clinical management of people with long term conditions. Practices participating in this LCS are expected to complete the following. Each practice will need to continue implementation of Year of Care Planning (YOC) for the management of diabetes patients. The practice can extend this to all long term conditions patients, which will generate the most efficiencies and benefit. The practice will be reimbursed for the cost of an extra letter for each diabetes patient as per the Year of Care process. Each practice will need to ensure the following remains in place from initial implementation, or ensure completion. a) Complete the Year of Care Planning Practice Checklist* b) Assign a named clinical champion for YOC in the practice. This YOC champion will: ○ lead implementation, ○ run practice meetings initially YOC specific then as a standing item on practice meeting, ○ disseminate YOC learning to whole practice team,	Each practice will be paid **£1.50** per registered Type 2 diabetes patient (Diabetes Dashboard) to cover the costs of an additional letter to each patient. See Schedule of Payments by Practice (**Appendix B**) for exact payment per practice.	Record of the status of all implementation tasks. This should be provided in one email by financial year end to: occg.plannedcare@nhs.net

[2] Year of Care website: www.yearofcare.co.uk

Section	Practice Requirement	Payment	Information reporting
	o engage with OCCG YOC Coordinator c) Engage in evaluation of YOC using patient and healthcare professional (HCP) assessment tools*. Including YOC self-assessment tool for staff to check understanding/skills and to identify further skills development and refresh. d) Agree to engage in a review one year post-implementation. ** The Year of Care Practice Checklist and Evaluation Tools are available on request to* ***occg.yoc@nhs.net***		
3.2 Diabetes multi-disciplinary team meetings at Primary Care Network level	Each practice will participate in quarterly Diabetes multi-disciplinary team meetings (MDTs) within their Primary Care Network. The meetings will include secondary and community care clinicians specialising in diabetes care with the aim of improving the care of people with diabetes. These meetings will commence from 1st July 2019, therefore there will be 3 meetings in 2019-20. Meeting and preparation/follow up time is expected to be up to 3 hours with 1 GP plus 1 Practice Nurse participating from each practice. The MDT is to review the diabetes dashboard, review complex diabetes patients with specialist diabetes clinicians to improve patient care, share best practice and ensure best health outcomes for their diabetic population. One of the practices in the Primary Care Network will be responsible hosting the meeting, producing high level notes (patient identifiable information removed) and sharing the notes with the diabetes specialists. Each practice is responsible for running relevant searches in preparation for the meeting and	This is a set payment irrespective of practice size, and it is based on the practice taking part in 3 meetings in the 2019/20 year starting from 1 July 2019. The total payment for 3 meetings is **£884**.	A record of the meetings that documents: date/time of meeting, attendance, issues discussed and number of patients discussed (patient identifiable information not to be included). Record of meeting to be sent through to: **occg.plannedcare@nhs.net** Patients discussed in the PCN MDT should have the code **66Aq** applied.

Section	Practice Requirement	Payment	Information reporting
	taking away and following up on their own actions from the meeting.		
3.3 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 E**. Primary Care Networks can decide that a practice will deliver the service on behalf of the network to provide resilience and capacity. OCCG needs to be formally notified of the agreement of all practices in the network to this arrangement when decided. All people with Type 1 Diabetes are to be either seen at OCDEM[3] or, if stable (achieving good NICE standards, i.e. good glycaemic control, personalised HbA1c and low hypoglycaemia) discussed with an OCDEM consultant twice a year and actions implemented.	Per patient payment for insulin initiation: **£122.15** Insulin initiation payment will be paid on a per patient basis. The amount practices are paid in total for insulin initiation will therefore vary according to the number of patients initiating insulin in the year. As numbers are anticipated to be relatively low, payment for insulin initiation will be made as part of the final reconciliation process for locally commissioned services at financial year end.	Read coding of all patients initiated on insulin. The read code that must be used to ensure payment is **66Ap**. This will be verified through a quarterly search. Email verification of attendance at insulin initiation training to: **occg.plannedcare@nhs.net** For those patients attending OCDEM/Horton apply code **66aF** – 'attends outpatients'. For those patients not willing or not appropriate to attend OCDEM/Horton apply code **66An** – 'Diabetes Type 1 Review'.
3.4 Care Process and NICE Treatment Target achievement for Type 2 diabetes patients	Each practice is expected to meet its individual practice target for the completion of all 8 care processes (set out in **Appendix C**) and the achievement of all three NICE treatment targets (triple target) for Type 2 patients. The NICE treatment targets are: • **HbA1c ≤ 58mmol/mol** • **BP ≤ 140/80** • **Cholesterol < 5mmol/L** Specific targets for each practice are set out in detail in **Appendix**	Payment per registered Type 2 diabetes patient (verified through the Diabetes Dashboard): **£6.87** Please refer to **Schedule of Payments (Appendix B)** for the anticipated values for each practice. Payment for this element will be made after the	Submission of End of Year Claim Form and verification through the end March 2020 Diabetes Dashboard. If the practice deems necessary, a diabetes improvement plan is to be submitted by **28th February 2020**.

[3] For patients resident in North Oxfordshire under the care of OCDEM, they will be seen in the Horton Diabetes Clinic.

Section	Practice Requirement	Payment	Information reporting
	A which will determine payment. The baseline to set the target and the measure of performance against the targets is determined by the Oxfordshire Diabetes Dashboard. Practice achievement requirements have been broadly determined according to the following principles: • **Quartile 1 (bottom) practices:** achieve the Oxfordshire average (70%) for 8 care processes and the Oxfordshire average (40.15%) for the Triple Target • **Quartile 2 practices:** achieve the Oxfordshire average (70%) or improve performance by at least 1% compared to March 2019 Diabetes Dashboard for 8 care processes and achieve the Oxfordshire average (40.15%) for the Triple Target or improve performance by at least 1% compared to March 2019 Diabetes Dashboard. • **Quartile 3 practices:** improve performance by 1% compared to March 2019 Diabetes Dashboard. • **Quartile 4 (top) practices:** maintain or improve upon March 2019 Diabetes Dashboard performance. Performance against targets will be assessed by the Diabetes Dashboard, not the National Diabetes Audit. Each practice should track their performance against these expected outcomes on the Diabetes Dashboard over the year to assess whether they may achieve all targets. If a practice judges that they will not achieve all the outcomes, they should produce a plan of improvement through multi-disciplinary involvement of the Diabetes Specialist Teams. The plan should set out; an	year end on receipt of the **End of Year Claim Form** (**Appendix F**). Practice achievement targets are set out in **Appendix A** and achievement will be determined by the Diabetes Dashboard to the end of March 2020. If the practice does not achieve all care process and triple target outcomes by the end of the year but has submitted an improvement plan by **28th February 2020**, the practice will receive the payment. To receive this payment all practices must also ensure delivery of essential items in **section 1.5** by the end of the year.	

<table>
<tr><th>Section</th><th>Practice Requirement</th><th>Payment</th><th>Information reporting</th></tr>
<tr><td></td><td>assessment of performance and any progress to date (including a review of progress against any 2018/19 diabetes improvement plan), barriers to achievement, how challenges will be overcome and targets achieved. This should include how the practice involved the Diabetes Specialist Teams in developing and agreeing the plan and how it will work with them to improve. The plan should include timescales and any implementation progress at point of submission. Completing the improvement plan will enable the practice to be paid for this element if they miss their target. The improvement plan needs to be submitted by 28th February 2020.</td><td></td><td></td></tr>
<tr><td>3.5 Other essential items</td><td>Each practice will also:

a) Apply complete coding for all diabetes structured education activity using nationally standardised codes[4]. This is to include referral, declines, attendance, non-attendance and completion of structured education. This should include coding of education for both Type 1 and Type 2 patients.
b) Apply complete diabetes eye screening coding.
c) Make their data available for the Oxfordshire Diabetes Dashboard.
d) Ensure a lead GP and lead Practice Nurse for Diabetes are nominated as main points of contact for the CCG, with contact details provided. It is understood that not all diabetes care will be undertaken by just one Practice Nurse and GP in all practices.
e) Ensure full submission to the National Diabetes Audit.</td><td></td><td>Structured Education - Continuation of read coding of referral to structured education with the addition of read coding all outcomes of structured education with the following standard[5] read codes for EMIS and Vision.

<table>
<tr><th>Outcome of referral to diabetes structured education</th><th>EMIS/Vision Read Code</th></tr>
<tr><td>Diabetes structured education declined</td><td>9OLM</td></tr>
<tr><td>Did not attend diabetes structured education</td><td>9NiA</td></tr>
<tr><td>Attended* diabetes structured education</td><td>9OLB</td></tr>
<tr><td>Diabetes structured education completed</td><td>9OLF</td></tr>
</table>
</td></tr>
</table>

[4] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-structured-education-data
[5] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-structured-education-data

Section	Practice Requirement	Payment	Information reporting
			Where a structured education course consists of more than one session, and the patient only attends some of the sessions then, enter a Read Code of attended. If the patient attends all the sessions and completes the course enter a Read Code of completed.* Coding will be monitored through the Diabetes Dashboard. **Diabetes Eye Screening - Coding will be monitored through the Diabetes Dashboard. Read Code for Diabetic Eye Screening is: **68A8**. **Diabetes Dashboard** - Relevant data made available for pull into diabetes dashboard on a monthly basis.

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.

APPENDIX A: TYPE 2 DIABETES REGISTER AND 2019-20 LCS DIABETES OUTCOMES TARGETS BY PRACTICE

Practice Code	Practice Name	No. Type 2 Adult Diabetes Patients (incl. others) - end March 2019 Oxfordshire Diabetes Dashboard	2019-20 LCS Target: % of Type 2 patients receiving all 8 Care Processes	2019-20 LCS Target: % of Type 2 patients achieving Triple Target (HbA1c <=58, BP <=140/80, Chol <5)
K84054	Abingdon Surgery	515	74.59%	48.35%
K84613	Alchester Medical Group	688	70.00%	40.15%
K84010	Bampton Surgery	418	70.00%	40.71%
Y02754	Banbury Health Centre	134	75.63%	40.55%
K84021	Banbury Road (172)	170	71.00%	48.82%
K84032	Bartlemas Surgery	499	72.14%	40.15%
K84016	Beaumont St (19)	244	70.00%	44.44%
K84049	Beaumont St (27)	135	78.52%	40.15%
K84080	Beaumont St (28)	125	88.00%	52.00%
K84035	Bell Surgery	298	71.81%	43.95%
K84023	Berinsfield Health Centre	314	79.94%	41.45%
K84052	Bicester Health Centre	631	70.00%	44.58%
K84058	Bloxham Surgery	290	77.90%	51.72%
K84025	Botley Medical Centre	628	70.00%	40.15%
K84075	Broadshires Health Centre	425	70.00%	40.15%
K84047	Burford Surgery	323	74.07%	45.27%
K84610	Charlbury Surgery	212	70.00%	40.15%
K84030	Chipping Norton Health Centre	668	70.00%	41.12%
K84033	Church Street Practice	663	70.38%	45.58%
K84034	Clifton Hampden Surgery	119	79.83%	43.86%
K84618	Cogges Surgery	251	78.30%	43.23%
K84063	Cowley Road Medical Practice	255	70.00%	40.15%
K84056	Cropredy Surgery	188	78.30%	40.15%
K84055	Deddington Health Centre	427	78.45%	43.86%
K84002	Didcot Health Centre	793	70.00%	40.15%
K84004	Donnington HC	685	81.61%	44.36%

Practice Code	Practice Name	No. Type 2 Adult Diabetes Patients (incl. others) - end March 2019 Oxfordshire Diabetes Dashboard	2019-20 LCS Target: % of Type 2 patients receiving all 8 Care Processes	2019-20 LCS Target: % of Type 2 patients achieving Triple Target (HbA1c <=58, BP <=140/80, Chol <5)
K84006	Eynsham Medical Centre	658	75.77%	41.73%
K84071	Goring & Woodcote Health Centre	366	78.05%	41.44%
K84045	Gosford Hill Medical Centre	392	84.69%	45.58%
K84001	Hart Surgery	320	77.56%	43.81%
K84009	Hedena Health	793	70.00%	40.15%
K84059	Hightown Surgery	500	75.40%	40.15%
K84048	Hollow Way Medical Centre	386	84.20%	53.11%
K84040	Horsefair Surgery	721	70.00%	40.15%
K84003	Islip Surgery	209	78.95%	52.63%
K84078	Jericho Health Centre (Leaver)	93	70.00%	45.58%
K84605	King Edward Street	47	73.34%	43.55%
K84079	Long Furlong MC	269	78.44%	43.75%
K84066	Luther Street Medical Centre	10		
K84027	Malthouse Surgery	903	78.30%	40.53%
K84044	Manor Surgery Headington	668	70.00%	41.57%
K84041	Marcham Road Health Centre	555	78.30%	50.09%
K84036	Mill Stream Surgery	197	85.28%	47.21%
K84038	Montgomery House Surgery	732	70.00%	40.15%
K84014	Morland House Surgery	408	85.05%	53.19%
K84015	Nettlebed Surgery	141	87.23%	43.55%
K84019	Newbury Street Practice	648	71.99%	40.15%
K84072	Nuffield Health Centre	634	70.40%	42.48%
K84624	Oak Tree Health Centre	293	70.00%	42.30%
K84026	Observatory Medical Practice	279	71.61%	40.15%
K84065	Sibford Gower Surgery	89	70.00%	47.19%
K84020	Sonning Common Health Centre	324	71.68%	40.15%
K84617	South Oxford Health Centre	120	79.17%	46.67%

Practice Code	Practice Name	No. Type 2 Adult Diabetes Patients (incl. others) - end March 2019 Oxfordshire Diabetes Dashboard	2019-20 LCS Target: % of Type 2 patients receiving all 8 Care Processes	2019-20 LCS Target: % of Type 2 patients achieving Triple Target (HbA1c <=58, BP <=140/80, Chol <5)
K84013	St Bartholomews MC	354	70.77%	40.15%
K84060	St Clements Surgery	190	76.79%	44.16%
K84011	Summertown Health Centre	366	70.00%	42.80%
K84007	Temple Cowley Health Centre	426	70.00%	44.66%
K84082	The Key Medical Practice	621	78.58%	43.83%
K84031	The Leys Health Centre	555	70.00%	40.15%
K84050	The Rycote Practice	479	75.32%	40.15%
K84037	Wallingford Medical Centre	673	77.82%	45.58%
K84008	Watlington & Chalgrove Surgery	312	70.00%	40.15%
K84028	West Bar Surgery	855	71.06%	40.15%
K84051	White Horse Practice	688	73.24%	40.15%
K84017	Windrush Health Centre	757	77.49%	47.56%
K84024	Windrush Surgery (Banbury)	479	70.00%	40.15%
K84043	Woodlands Medical Centre	618	70.00%	46.76%
K84062	Woodlands Surgery	342	70.00%	40.15%
K84042	Woodstock Surgery	370	72.08%	51.62%
K84046	Wychwood Surgery	243	74.66%	48.15%

APPENDIX B: SCHEDULE OF PAYMENTS BY LCS SECTION AND PRACTICE

Practice Code	Practice Name	Year of Care Planning	Diabetes MDTs (x 3 meetings in 2019-20)	Insulin Initiation (approx 2 per practice - to be confirmed through coding)	Care Process and Triple Target Outcomes	Total Payment
K84054	Abingdon Surgery	£773	£884	£244	£3,537	£5,437
K84613	Alchester Medical Group	£1,032	£884	£244	£4,725	£6,885
K84010	Bampton Surgery	£627	£884	£244	£2,871	£4,626
Y02754	Banbury Health Centre	£201	£884	£244	£920	£2,249
K84021	Banbury Road (172)	£255	£884	£244	£1,167	£2,550
K84032	Bartlemas Surgery	£749	£884	£244	£3,427	£5,303
K84016	Beaumont St (19)	£366	£884	£244	£1,676	£3,170
K84049	Beaumont St (27)	£203	£884	£244	£927	£2,258
K84080	Beaumont St (28)	£188	£884	£244	£858	£2,174
K84035	Bell Surgery	£447	£884	£244	£2,047	£3,621
K84023	Berinsfield Health Centre	£471	£884	£244	£2,156	£3,755
K84052	Bicester Health Centre	£947	£884	£244	£4,333	£6,408
K84058	Bloxham Surgery	£435	£884	£244	£1,992	£3,555
K84025	Botley Medical Centre	£942	£884	£244	£4,313	£6,383
K84075	Broadshires Health Centre	£638	£884	£244	£2,919	£4,684
K84047	Burford Surgery	£485	£884	£244	£2,218	£3,831
K84610	Charlbury Surgery	£318	£884	£244	£1,456	£2,902
K84030	Chipping Norton Health Centre	£1,002	£884	£244	£4,588	£6,717
K84033	Church Street Practice	£995	£884	£244	£4,553	£6,676
K84034	Clifton Hampden Surgery	£179	£884	£244	£817	£2,124
K84618	Cogges Surgery	£377	£884	£244	£1,724	£3,228
K84063	Cowley Road Medical Practice	£383	£884	£244	£1,751	£3,262
K84056	Cropredy Surgery	£282	£884	£244	£1,291	£2,701
K84055	Deddington Health Centre	£641	£884	£244	£2,932	£4,701
K84002	Didcot Health Centre	£1,190	£884	£244	£5,446	£7,763
K84004	Donnington HC	£1,028	£884	£244	£4,704	£6,860
K84006	Eynsham Medical Centre	£987	£884	£244	£4,519	£6,634
K84071	Goring & Woodcote Health Centre	£549	£884	£244	£2,514	£4,190
K84045	Gosford Hill Medical Centre	£588	£884	£244	£2,692	£4,408
K84001	Hart Surgery	£480	£884	£244	£2,198	£3,806

Practice Code	Practice Name	Year of Care Planning	Diabetes MDTs (x 3 meetings in 2019-20)	Insulin Initiation (approx 2 per practice - to be confirmed through coding)	Care Process and Triple Target Outcomes	Total Payment
K84009	Hedena Health	£1,190	£884	£244	£5,446	£7,763
K84059	Hightown Surgery	£750	£884	£244	£3,434	£5,312
K84048	Hollow Way Medical Centre	£579	£884	£244	£2,651	£4,358
K84040	Horsefair Surgery	£1,082	£884	£244	£4,952	£7,161
K84003	Islip Surgery	£314	£884	£244	£1,435	£2,877
K84078	Jericho Health Centre (Leaver)	£140	£884	£244	£639	£1,906
K84605	King Edward Street	£71	£884	£244	£323	£1,521
K84079	Long Furlong MC	£404	£884	£244	£1,847	£3,379
K84066	Luther Street Medical Centre					
K84027	Malthouse Surgery	£1,355	£884	£244	£6,201	£8,684
K84044	Manor Surgery Headington	£1,002	£884	£244	£4,588	£6,717
K84041	Marcham Road Health Centre	£833	£884	£244	£3,811	£5,772
K84036	Mill Stream Surgery	£296	£884	£244	£1,353	£2,776
K84038	Montgomery House Surgery	£1,098	£884	£244	£5,027	£7,253
K84014	Morland House Surgery	£612	£884	£244	£2,802	£4,542
K84015	Nettlebed Surgery	£212	£884	£244	£968	£2,308
K84019	Newbury Street Practice	£972	£884	£244	£4,450	£6,550
K84072	Nuffield Health Centre	£951	£884	£244	£4,354	£6,433
K84624	Oak Tree Health Centre	£440	£884	£244	£2,012	£3,580
K84026	Observatory Medical Practice	£419	£884	£244	£1,916	£3,462
K84065	Sibford Gower Surgery	£134	£884	£244	£611	£1,873
K84020	Sonning Common Health Centre	£486	£884	£244	£2,225	£3,839
K84617	South Oxford Health Centre	£180	£884	£244	£824	£2,132
K84013	St Bartholomews MC	£531	£884	£244	£2,431	£4,090
K84060	St Clements Surgery	£285	£884	£244	£1,305	£2,718
K84011	Summertown Health Centre	£549	£884	£244	£2,514	£4,190
K84007	Temple Cowley Health Centre	£639	£884	£244	£2,926	£4,692
K84082	The Key Medical Practice	£932	£884	£244	£4,265	£6,324
K84031	The Leys Health Centre	£833	£884	£244	£3,811	£5,772
K84050	The Rycote Practice	£719	£884	£244	£3,290	£5,136
K84037	Wallingford Medical Centre	£1,010	£884	£244	£4,622	£6,759
K84008	Watlington & Chalgrove Surgery	£468	£884	£244	£2,143	£3,739

Practice Code	Practice Name	Year of Care Planning	Diabetes MDTs (x 3 meetings in 2019-20)	Insulin Initiation (approx 2 per practice - to be confirmed through coding)	Care Process and Triple Target Outcomes	Total Payment
K84028	West Bar Surgery	£1,283	£884	£244	£5,872	£8,282
K84051	White Horse Practice	£1,032	£884	£244	£4,725	£6,885
K84017	Windrush Health Centre	£1,136	£884	£244	£5,199	£7,462
K84024	Windrush Surgery (Banbury)	£719	£884	£244	£3,290	£5,136
K84043	Woodlands Medical Centre	£927	£884	£244	£4,244	£6,299
K84062	Woodlands Surgery	£513	£884	£244	£2,349	£3,990
K84042	Woodstock Surgery	£555	£884	£244	£2,541	£4,224
K84046	Wychwood Surgery	£365	£884	£244	£1,669	£3,161

APPENDIX C: 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, which are covered as part of QOF (subject to release of latest business rules), 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 D: 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 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 E: Sign up Form

Diabetes Locally Commissioned Service 2019-20

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 implementation: By the end of the year, the practice will deliver the requirements set out in section 3.1 of the specification.	**See Schedule of Payments by Practice**
Diabetes MDTs at Primary Care Network level: By end of the year, the practice will have prepared for and attended 3 Diabetes MDTs.	**£884**
Insulin Initiation: Practice will provide initiation of insulin for all Type 2 Diabetes patients requiring conversion in line with the specification set out in Appendix D.	**£122.15 per patient initiated on insulin**

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 **28th February 2020**.

Outcomes
Eight Care Processes: Delivery of all 8 care processes to the percentage of Type 2 diabetes patients set out for the practice in Appendix A of the specification.
NICE Treatment Targets: Achievement of the percentage of Type 2 diabetes patients meeting all three NICE treatment targets (HbA1c ≤58mmol/mol, BP ≤140/80, Cholesterol <5mmol/L) as set out for the practice in Appendix A of the specification.

Name: **Position in practice:**

Signed: **Date:**

This form is to be sent to occg.plannedcare@nhs.net along with confirmation of practice diabetes leads and their contact details. Initial payment for the service will be made to the practice on receipt of this form.

APPENDIX F: End of Year Claim Form

Diabetes Locally Commissioned Service 2019-20

Confirmation of achievement of outcomes

Name of practice: **Practice Code:**

The practice confirms that it has achieved the following 8 care process and treatment target outcomes as specified in the service specification. The practice confirms it has also completed all essential diabetes items set out in section 3.5 of the specification.

Y/N *Please delete as appropriate.*

Eight Care Processes	The practice has delivered all 8 care processes to the percentage of Type 2 diabetes patients set out for the practice in Appendix A of the specification.
NICE Treatment Targets	The practice has achieved the percentage of Type 2 diabetes patients meeting all three NICE treatment targets (HbA1c ≤58mmol/mol, BP ≤140/80, Cholesterol <5mmol/L) as set out for the practice in Appendix A of the specification.

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 CCG by **28th February 2020**.

Y/N *Please delete as appropriate.*

Name: **Position in practice:**

Signed: **Date:**

This form is to be completed and returned to occg.plannedcare@nhs.net by 30th April 2020. Outcomes payment will be made to practice following receipt of this form.