Local Enhanced Service for the Monitoring of Type 2 and Stable Type 1 Patients on Insulin

1. Introduction

All practices are expected to provide the essential and additional services they are contracted to provide to all their patients. This specification outlines a more specialised service to be provided. The specification of this service is designed to cover enhanced aspects of clinical care of the patient, that go beyond the scope of essential services. No part of this specification by commission, omission or implication defines or redefines essential or additional services.

"Our plan for a primary care service for Wales up to March 2018" described how patients with chronic conditions would receive more of their care in the community from skilled multi-disciplinary teams based in primary care and lead by GPs. The All wales Diabetes Group has set up a working group, with a wide range of stakeholders, to develop new models of diabetes care outside of hospital.

Previously, the Quality and Outcomes Framework (QOF) has rewarded practices for ensuring that systematic care has been provided; this enhanced service intends to remunerate practices who offer care beyond the requirements of QOF. This is based on one of the optional modules from the suite of enhanced services for diabetes management, and in Hywel Dda is being introduced in the form of a *Local* Enhanced Service or LES. All practices providing this enhanced service must also undertake to provide the Prudent Structured Care Reviews for Adults with Type 2 Diabetes Directed Enhanced Service (DES) alongside.

This LES outlines a more specialised service to be provided to those adult patients with Diabetes Mellitus whose condition is currently stable and who may benefit from continuing insulin.

2. Background

Diabetes mellitus is a common endocrine disease affecting all age groups. Effective monitoring and control of risk factors can reduce morbidity and mortality. General practitioners and their primary care teams can undertake most of the monitoring and management of patients with diabetes, particularly for those with Type 2 disease.

GP practices are encouraged to engage in this enhanced service.

3. Service Aims

The purpose of this enhanced service is to enable the delivery of a more comprehensive, structured package of diabetes care to patients in primary care. The intention is to improve access to diabetic care closer to home and to reduce the number of routine patients seen and reviewed by Consultant Diabetologists and their teams within secondary care. The aim is to release specialists to provide rapid response to appropriate complicated patients. Successful outcomes include the reduced rate of diagnosed diabetic patients being admitted as an inpatient or needing to see a secondary care consultant as an outpatient. Improved preventative care and self-care of diabetes, properly resourced, will ultimately reduce diabetic complications.

This LES is designed to increase the proportion of patients with Diabetes Mellitus who receive care and medication appropriate to their clinical need in a setting closer to home.

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This enhanced service follows prudent health care principles;

- An emphasis on co-produced management plans at a holistic annual review.
- Recognition that not all patients require the same intensity of support from the practice team so those with the greatest need are offered the greatest input through the year.
- Do only what is needed, and not just tick boxes.
- An evidence based approach to care, participating in National Diabetes Audits and following RCGP Year of Care approaches

This more personalised approach to diabetic care, prioritising those patients with greatest need has been highlighted (as per the 4 principles illustrated above) as part of a prudent healthcare promoted by Welsh Government.

This enhanced service provides an incentive to practices to manage **adult patients with diabetes mellitus largely within primary care;** with only those patients at high risk, or with complicated diabetes, being cared for in secondary care. Thus, this enhanced service does **not** apply to unstable patients with Type 1 Diabetes Mellitus, children and adolescents, or pregnant women unless agreed with the Secondary Care Consultant. There is no patient exception reporting as part of these enhanced services as practices are only expected to care for patients within their level of competence and not to meet a particular percentage.

Practitioners are reminded that enhanced service audit standards should not replace or supersede JBS or NICE guidance. Practitioners should continue to work towards ideal personalised treatment targets for individual patients. Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the national and local Diabetes Delivery Plan standards and promote a safe, coordinated shift of patients and resources from secondary care to primary care.

The primary aims of this LES are:

1. To continue to support the development and maintenance of high quality care for people with diabetes in primary care.
2. To increase the proportion of people with diabetes being cared for outside of hospital and enable the referral and discharge of patients from Secondary Care in accordance with appropriate clinical guidance.
3. To support all patients being cared for in Primary Care to receive a holistic Annual Review conducted by the practice.
4. Using prudent healthcare principles, to provide the necessary supportive monitoring reviews according to clinical guidance.
5. To ensure that all newly diagnosed patients with diabetes receive an enhanced review promoting awareness of the condition; self-care; on-going education and monitoring.

6. To provide data to clusters, LHBs and Welsh Government to inform the design and development of services for patients with Diabetes Mellitus.

4. Conditions for Service Delivery

The "Gateway" module (DES) must be delivered by all practices who undertake all other diabetes management enhanced services in Hywel Dda. The other enhanced services, of which this is one, are optional and cannot be provided without already delivering the "Gateway" module - Prudent Structured Care Reviews for Adults with Type 2 Diabetes Directed Enhanced Service.

Funding for the LES will be conditional on all the following criteria being achieved:

1. **Maintenance of an accurate Diabetes Register:** The practice must be able to produce an up to date register of all patients with diabetes, whether the patient is managed exclusively in Primary Care or by Shared Care.
2. **Consistent Read coding:** The practice must ensure consistent coding of each care episode on the clinical IT system using approved Read codes (based on QOF Read codes – see below also). Use of National Templates is strongly encouraged.

   The following Read codes are recommended:

   - use the following 2 Read codes from the DES:
     - 'diabetic annual review **66As**' for recording that an holistic annual review has occurred; and
     - 'diabetes care plan agreed **8CS0**' to record that a co-produced management plan has been agreed;
   - plus a combination of the following:
     - 'diabetic on insulin **66A5**'; and
     - 'follow up diabetic assessment **66A2**'.
3. **National Diabetes Audit:** All Practices delivering the LES will be required to actively engage with the data submission and review process of the National Diabetes Audit. This means that practices must allow data extraction using Audit+ software.
4. **Sharing Data:** Practices must agree to share data collected in the course of providing this enhanced service with clusters, the local Health Board and Welsh Government for the purpose of informing the design and development of diabetes services. For example; clusters may wish to use the data to support a business case for recruitment of community diabetes specialist nurses, or LHBs may wish to determine whether patients seen in outpatient clinics actually receive a full annual review.
5. **Practice leads for Diabetes:** All practices will have a named GP lead for diabetes and a named Practice nurse lead for diabetes (note the educational accreditation required in section 8).
6. **Practices will have the responsibility for selection of patients to have personalised care and extra reviews:** Practices will describe their methods of prioritising intervention to those patients who will benefit most and share those methods in peer discussions at the cluster meetings.

In these cases, the practice may offer the service (see section 6 below) and claim the usual payment.

5. Patient Cohort

All patients with Diabetes Mellitus aged 25 years or over who are likely to benefit from continuing insulin and whose condition is currently stable are to be included in this LES.

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Patients excluded from this LES would include the 'Super Six' categories[1], unless agreed with the Secondary Care Consultant as safe for Primary Care monitoring only, or who are diagnosed with Type 1 diabetes and are currently unstable.

Any patient who receives this enhanced service from the contractor must not concurrently be seeing a consultant diabetologist, or be on the waiting list to be seen in an outpatient diabetologist clinic (note the clinical governance around this, in section 7 below).

6. Service Requirements

Service Outline:

1. Monitoring of insulin in line with NICE guidance, the BNF and/or the local health board formulary.
2. The contractor will write a letter (based on a template to be agreed with the Health Board) to the secondary care consultant, if necessary, to inform him/her that the GP is taking over diabetes care from secondary care before commencing this enhanced service for a patient.
3. The contractor will inform the patient of the transfer of diabetes care if necessary, and will record the conversation, or letter if needed (a template letter will be provided), in the GP clinical record.

Patient Documentation & Information:

A **care plan** will be co-produced and shared with the patient (based on a national template).

- The contractor shall provide an *Insulin Passport* to the patient.
- The care plan could take the form of **an online website** (e.g. *Patient Knows Best,* or a development of My Health Online) or **printed from on-screen forms/literature**.
- **Information Prescriptions**, supported by Diabetes UK, can be shared or printed from within EMIS or Vision, and form part of the agreed care plan.
- **Pocket Medic** videos, supported by Diabetes UK, show powerful educational messages on different aspects of care for people with Diabetes.

Record-Keeping:

The contractor will record all clinical encounters in the lifelong computer clinical records of the patients held by the practice, using Read codes agreed with the Local Health Board or in a national template.

7. Clinical Governance

The GP who performs this enhanced service will hold medical responsibility for the patient. Any patient who receives this enhanced service from the contractor must not concurrently be seeing a consultant diabetologist, or be on the waiting list to be seen in an outpatient diabetologist clinic.

This means that the contractor must liaise with the consultant who is currently providing outpatient diabetes services and inform the consultant of the transfer of diabetes care and clinical responsibility for the monitoring of insulin medication to the GP. A template letter (to be provided) should be used for this purpose. If the patient is not currently under a diabetologist, then the GP already holds full clinical responsibility.

[1] A 'Super Six' category patient is defined as one of the following:

a) Pregnant
b) Severe Renal Disease
c) Children and Young people
d) Active Severe Foot disease
e) Insulin Pumps
f) Current Hospital Inpatients

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If the services of a Diabetes Specialist Nurse are used to support a patient, then the overall clinical responsibility for the patient must rest with the contractor, not a secondary care specialist.

Subject to local agreement with secondary care colleagues, consultants may be willing to provide specialist advice lines to support GPs to manage these patients. These are not required to be in place for this enhanced service to be commissioned.

A contractor is free to seek specialist advice if clinically needed, which may be by email, telephone or a face-to-face assessment with a secondary care specialist

8. Accreditation

A practice may be accepted for this enhanced service only if it has a GP Principal or Salaried GP who has the necessary skills and experience to carry out the contracted care. The minimum level of skills and experience required is:

Practice lead GPs must demonstrate their competence by satisfactory completion of a recognised training course in diabetic care, or by recording an aspiration to complete such a course within 2 years of initiating the enhanced service. For example:

- Chronic Disease Management of Diabetes, Multidisciplinary Masters Module, Swansea University/University of Wales;
- All Wales Foundation Course in Diabetes for General Practitioners, University of Wales College of Medicine;
- Warwick CDIC course or equivalent as agreed by the Health Board;
- Bradford University 'Diabetes Care in Clinical Practice' or 'Evidence-based Diabetes' courses or their equivalent agreed by the Health Board/Associate Medical Director for Primary Care;
- Other courses, attending and online, are available as agreed by the Health Board/ Associate Medical Director for Primary Care.

If a Practice Lead GP has been undertaking the services described within a module for several years, but does not possess an accredited qualification, then the Local Health Board/Associate Medical Director for Primary Care will consider each application to conduct the enhanced service on its merits.

Any such accredited doctor will work in line with the principles of the generic GPs with special interests (GPwSI) guidance[2] or as deemed appropriate by the LHB.

All practice lead GPs and lead Nurses will be expected to engage in appropriate updates to maintain their clinical knowledge every year and discuss their role as diabetes practice lead, annually with their appraiser.

It should be noted that each individual clinician undertaking these enhanced services will be required to meet the accreditation standards. It is the responsibility of the Practice to ensure that accreditation is sought as appropriate in order to provide the services

For 2018-19, every GP who was already accredited for the old HDUHB Diabetes Management LES will have their accreditation transferred for the purposes of providing this new LES. Thereafter and for all those practices signing up for the first time to this enhanced service, please use the accreditation form found on the Primary Care intranet pages here:

http://howis.wales.nhs.uk/sitesplus/862/page/56523

Please note that the accreditation form is an amalgamated form for all the diabetes mellitus enhanced services, to allow you the opportunity to sign up once for more than one service if you wish to. Your GP lead should fill in the accreditation form and sign it before it is sent. **All GP accreditation requests should now be sent to Contracts Management, NWSSP, Pontypool.**

[2] see https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/improved_quality_of_care_p3_accreditation.pdf

For those practices signing up to the service in a subsequent year, please sign up via the Annual Return or Intention to Provide Form, as appropriate for the year in question. The UHB will be in touch regarding periodic accreditation updates if required.

9. Collaboration

Practices can collaborate with neighbouring practices to provide this service to patients.

The practice ('primary practice') at which the patient is registered holds clinical governance responsibility. The 'primary practice' must ensure that the clinicians of the second practice are accredited to provide this enhanced service by the LHB.

The 'primary practice' must advise the LHB of any such arrangements in their application to provide the enhanced service **before** any service is provided. The LHB must agree to any collaborative arrangements **before** they commence, including that the clinicians are suitably accredited, and advise the practices on claiming and payment mechanisms in these individual cases.

10. Notice Period

The contractor or the local health board may terminate this contract by giving three months' notice in writing.

Where care of the patient would need to be continued after the termination of this contract under a specialist (whether by a secondary care service or a cluster service or community service), the practice will take the responsibility to notify the patients of the new service, after discussion with the Local Health Board.

11. Significant Events

The contractor will give notification to the Associate Medical Director or Primary Care Manager - Quality of the LHB within 72 hours of the information becoming known to the contractor of all emergency admissions or deaths of any patient covered under this contract, where such admission or death is or may be due to the performance of the contract in question or directly attributable to the underlying medical condition.

12. Indemnity

The contractor must ensure that its practitioners are adequately indemnified/insured for any liability arising from the work performed under the enhanced service.

13. Payments

The optional modules from the WG diabetes suite, of which this is one, are paid on a fee-for-service basis.

For each patient undergoing insulin monitoring, exclusively managed by the contractor - **per person per year (per patient per month), paid monthly in arrears.**

The contractor will be deemed to be monitoring a patient if all of the following conditions apply:

- The contractor has the full clinical responsibility for the care of the patient's diabetes mellitus; AND
- The contractor has issued the patient with at least one prescription for insulin in the preceding 3 months, unless there is a robust clinical justification for prescribing at less frequent intervals for an individual patient.

The practice shall submit a claim each month with the number of patients it has monitored in the preceding month.

The contractor cannot claim for monitoring a patient on insulin in the same month that the contractor has also claimed for initiation of insulin.

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GP practices will only be eligible for payment for this service in circumstances where all of the following requirements have been met:

a) All patients in respect of whom payment is being claimed were within one of the eligible cohorts (as specified in this specification, section 5 above) at the time of their reviews.

b) The practice submits the claim by 30th June following the end of the current financial year at the absolute latest. The Health Board may set aside this requirement if it deems there are exceptional circumstances that make this a reasonable course of action.

c) Payment will be made on a monthly basis i.e. the monthly count multiplied by ███:

monthly payment	=	number of stable patients on the diabetes mellitus register who meet the following criteria: ▪ full clinical responsibility for diabetes care, including insulin monitoring, rests with the GP practice; **and** ▪ at least one prescription has been issued for insulin in the last 3 months, unless a robust clinical justification for prescribing at less frequent intervals has been recorded in the patient's notes; **and** ▪ no claim for initiation has been made in the same month for the same patient.	x	███

The amount calculated as payment for the financial year falls due on the last day of the month following the month during which the practice provides the information specified above. All claims for payment should be made either through the Exeter system or by utilising the current monthly single claim form to Contractor Payments, NWSSP Swansea, as appropriate.

Payment under this service, or any part thereof, will be made only if the practice satisfies the following conditions:

a) the practice must make available to Hywel Dda Health Board (HDUHB) any information under this service, which HDUHB needs and the practice either has or could be reasonably expected to obtain, including audits and other information required by the post payment verification team acting on behalf of the Health Board;

b) the practice must make any returns required of it (whether computerised or otherwise and do so promptly and fully; and,

c) all information supplied pursuant to or in accordance with a) and b) above must be accurate.

If the practice does not satisfy any of the above conditions, HDUHB may, in appropriate circumstances, withhold all of the payment, or any part of it, due under this service that is otherwise payable.

Post-Payment Verification:

A 'high trust, low touch' culture will prevail in the administration of this enhanced service. Claims may be subject to established post-payment verification check mechanisms.

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