



Birmingham South Central
Clinical Commissioning Group

Birmingham South Central Clinical
Commissioning Group (BSC CCG)

BSC Pre-Diabetes Demonstrator Pilot
Local Improvement Scheme (LIS) 2015/16

1st October 2015 – 30th September 2016

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The BSC CCG Pre-Diabetes Demonstrator Pilot Service is a Local Improvement Scheme.

NHS England has delegated certain primary care commissioning functions to Birmingham South Central CCG under section 13Z of the NHS Act, as set out in the Delegation Agreement between the CCG and NHS England. The Delegated Functions include decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to decisions in relation to Local Improvement Schemes.

Where Birmingham South Central CCG wishes to use resources for improvements in services provided under the GP contract as a fully delegated CCG we need approval from the relevant CCG Committee, this being the Primary Care Committee. The Local Improvement Scheme process is in line with the Delegation Agreement. Local Improvement Schemes can cover:

- Incentives for improvements in the quality of primary medical care services; or
- Funding to support activities such as clinical audit and peer review.

BSC CCG has received approval from the Primary Care Committee to use resources from our budget to support a BSC CCG Pre-Diabetes Demonstrator Pilot Service within the scope of a Local Improvement Scheme (LIS).

This document constitutes the agreement between the GP practice and Birmingham South Central CCG in regards to the provision of the BSC CCG Pre-Diabetes Demonstrator Pilot Scheme.

It is incumbent on all practices that sign up to this LIS to ensure that they adhere to all the contractual requirements within their GMS/PMS contract whilst participating in this LIS. Failure to do so may result in formal contract sanctions being taken by the CCG.

Scope of Service

Background

National Diabetes Prevention Scheme

In March 2015, Birmingham South Central Clinical Commissioning Group (CCG) was selected as one of seven innovative demonstrator sites across the country to pilot a national diabetes prevention scheme to test a range of interventions that aim to reduce the incidence of Type 2 diabetes by 2025. As a demonstrator site, the CCG will receive national support from NHS England and Public Health England to plan and implement this new initiative.

The overall aim of the scheme is to increase by 6% year- on- year the number of people identified to be at risk from developing diabetes and help them make changes so that they fall out of the risk category.

It is anticipated that following the conclusion of the demonstrator site pilots, the schemes will be evaluated to help understand whether any of the initiatives rolled out have helped to reduce the incidence of pre diabetic patients in local populations. If any of the schemes are able to successfully demonstrate this impact, the intention is that they act as the future blueprint for national pre-diabetic care.

BSC CCG Service Model

One of the key responsibilities of the CCG is to work in collaboration with local providers to develop a diabetes risk reduction programme. It is intended that the service model will support practices to signpost patients tested and classified to be at risk of developing diabetes into a number of lifestyle programmes that focus upon exercise, lifestyle and weight management support. The ambition is that participation in the programme will empower patients to make changes to their lifestyles that will help them to fall out of the at risk category for developing diabetes in the longer term.

Gateway Family Services and Health Exchange have each been commissioned to deliver the CCG's diabetes risk reduction programme and both services have individual capacity to see a maximum of 750 patients.

When each the scheme partners has reached the maximum number of patients that they have been commissioned to see, practices will be notified that the capacity of the scheme has been reached. When practices receive this notification, they will be asked to signpost any further patients that they identify as suitable for this service into the *Health Trainer programme.

Patients who are referred to the Health Trainer programme should be coded as follows:

- Referral to Health Trainer (8HIF)
- Referral to Health Trainer Declined (8IAL)

*Health Trainer Programme

Individuals who are aged over 16 years and live in the Birmingham area can be referred into the Gateway or Health Exchange Health Trainers Programme, which offers between six and eight free one-to-one advice and support sessions with a personalised Health Trainer. Patients referred into these services will receive a personalised health plan, with appointments made at a time and place to suit the individual in addition to information about other local services that can help them to achieve their personal goals.

The Gateway or Health Exchange Health Trainer Programme will help to identify the lifestyle changes that individuals need to make and then provide the support,

encouragement, motivation and practical help that people need to maintain the momentum of the lifestyle changes that they make.

*It is important to note that patients who are referred directly into the Health Trainer programme will not form part of the service evaluation for the Demonstrator Pre Diabetes Programme. Therefore, the management and audit of patients referred into these services (although Read Coded) will not be included within the scope of this specification.

Aim of Service

The strategic aim of the scheme is to increase by 6% year- on- year the number of people identified to be at risk from developing diabetes and help them make changes so that they fall out of the risk category.

At a local level, the key aim of the service is to support practices to signpost patients on their High Risk of Diabetes Register to the BSC CCG diabetes risk reduction programme delivered by Health Exchange and Gateway Family Services.

Practices will be required to monitor and Read Code the outcomes for all pre-diabetic patients who are signposted to the risk reduction programme using the codes identified in Section 3.3 of the service specification.

Success Measures for the Scheme

The success measures of the scheme will include:

- Universal practice sign up to the scheme
- Providers reaching full capacity for their individual diabetes risk reduction programmes due to BSC CCG pre-diabetic patient engagement
- Reduction in the number of BSC CCG patients on Pre-Diabetic Risk Registers

Entry Criteria

Practices wishing to join up to the scheme should complete the sign up form detailed on Page 16 of the service specification.

Record Keeping/Data Collection

Data will only be collected that can be justified to be used productively to improve patient care

Data will be used to

- Collate feedback/good practice to support practice and network peer review
- Help the CCG improve the quality and performance of Secondary & Community Providers
- Support GP appraisal
- Verification/audit of the LIS

Interdependencies

The interdependencies that will be required to support delivery of this LIS include the following:

- Practices having consistent access to capacity within the diabetes risk reduction programme delivered by Health Exchange and Gateway Family Services.
- Access to monthly practice and patient level up take data split by provider
- Access to monthly practice and patient level attendance data split by provider
- Access to monthly practice and patient level 'Do Not Attend' (DNA) data split by provider
- Access to monthly practice and patient level completion data split by provider
- Access to monthly practice and patient level Health Trainer up take data split by provider

Training / Education

The service will be supported by the delivery of:

- Pre-Diabetes Education/ Training Programme

Commissioning Responsibilities of BSC CCG

BSC CCG will:

- Collect data on the delivery and impact the intervention described within this specification
- Use this data to monitor practice performance on a quarterly basis and provide feedback to practices bi-annually
- Support practices with clinical advice and signposting to tools and resources that will enhance delivery of the LIS requirements
- Provide mandatory training workshops that will support delivery of the LIS requirements

- Carry out visits to randomly selected practices to monitor any issues arising and quality assure activity delivered as part of this LIS
- Reserve the right to review or update the LIS in line with changes to National Clinical Guidelines or changes in local policy
- Reserve the right to terminate the LIS with a notice period of 3 months.

Service Delivery

Service Model

The service has been commissioned as a 12 month pilot and will run from the 1st October 2015 to 30th September 2016.

Indicator 1 (A) - Pre-Diabetes Demonstrator

Practices signing up to this agreement will be commissioned to send out one single mail shot invitation to patients on their High Risk of Diabetes Register (HbA1c of 42 – 47mmol/mol) who are between 18 years and 75 years and have a Body Mass Index (BMI) of 27.5 or more. The mailshot should be completed by 31st December 2015. Confirmation that this mailshot has been completed is required to be input onto the GPORT System by 31st December 2015.

The invitation letters will signpost patients to the diabetes risk reduction programme by describing the purpose and structure of the service and the reasons why an invitation has been extended to the patient. This will help patients to understand the benefits of joining the scheme.

The invitation letter sent out to patients highlighted in this Section will also include details of the location of programme venues and information / contact details relating to how the patient can join the scheme.

Each practice will be allocated a designated service provider so that they can amend their invitation letter to highlight this provider before they send out their practice mailshot.

The letter template and a GP practice list by designated provider will be made available through the GPORT System

When the mailshot has been sent out, details should be entered onto each individual patient's clinical record using the Read Code below:

- Healthy lifestyle programme offered (9m44)

If a patient is directly signposted to the programme through an opportunistic GP / Nurse face to face contact, practices should enter the following Read Code onto the patient's clinical record:

- Referral to healthy lifestyle programme (8Hlu)
- Referral to healthy lifestyle programme declined (9m43)

Practices will be notified on a monthly basis by service providers' information regarding the number and names of patients who have joined the scheme and have attended their first and / or follow up sessions.

Details should be entered onto the patient's clinical record using the Read Codes below:

- Healthy lifestyle programme commenced (9m40)
- Healthy lifestyle programme DNA'd (9N4v)
- Healthy lifestyle programme not completed (9m41)
- Healthy lifestyle programme completed (9m42)

Outcome Measure

90% of all patients aged between 18 years and 75 years who are included on the High Risk of Diabetes Register (patients with an HbA1c of 42 – 47mmol/mol) and have a BMI of 27.5 or more should be signposted by mailshot or face to face referral to attend the risk reduction programme.

Capacity of the Diabetes Risk Reduction Programme

If capacity of the risk reduction programme is not reached following the completion of the process highlighted in Section 3.1.1 of the scheme, the CCG reserves the right to request that practices repeat the process for the patient group highlighted in Section 3.1.2.1 of the scheme – Please refer to Indicator 1 (B) Pre-Diabetes Demonstrator.

Practices will be notified by the Pre - Diabetes Demonstrator Project Group should this process need to be actioned.

Indicator 1(B) - Pre-Diabetes Demonstrator

As referenced above, practices will only be asked to repeat the process outlined in Section 3.1.1. of the scheme if any additional capacity is identified by the CCG following the completion of the first mailshot. At this point, practices will be contacted and asked to send out one single mail shot invitation to patients on their High Risk of Diabetes Register (HbA1c of 42 – 47mmol/mol) who are between 18 years and 75 years and have a Body Mass Index (BMI) between 25 and less than 27.5.

The invitation letter will describe the purpose and structure of the risk reduction programme and the reasons why an invitation has been extended to the patient. This will help them to understand the benefits of joining the scheme. The letter will also include details of the location of programme venues and information / contact details relating to how the patient can join the scheme.

The letter template and a GP practice list by designated provider will be made available through the GPORT System

Details should be entered onto the patient's clinical record using the Read Code below:

- Healthy lifestyle programme offered (9m44)

If a patient is directly signposted to the programme through an opportunistic GP/Nurse face to face contact, practices should enter the following Read Code onto the patient's clinical record:

- Referral to healthy lifestyle programme (8Hlu)
- Referral to healthy lifestyle programme declined (9m43)

Practices will be notified on a monthly basis by service providers' information regarding the number, names and clinical information gathered for patients who have joined the scheme and attended their first and / or follow up sessions.

Details should be entered onto the patient's clinical record using the Read Codes below:

- Healthy lifestyle programme commenced (9m40)
- Healthy lifestyle programme DNA'd (9N4v)
- Healthy lifestyle programme not completed (9m41)
- Healthy lifestyle programme completed (9m42)

Outcome Measure

90% of all patients aged between 18 years and 75 years who are included on the High Risk of Diabetes Register (patients with an HbA1c of 42 – 47mmol/mol) and have a BMI between 25 and less than 27.5 should be invited by mailshot or face to face referral to attend the risk reduction programme if requested by the Pre - Diabetes Demonstrator Project Group.

Indicator 2 - Pre-Diabetes Demonstrator – Re-engagement of patients who do not attend the programme

Practices should try and re-engage by mailshot all patients on the practice's High Risk of Diabetes Register between 18 years and 75 years with a Body Mass Index

(BMI) of 27.5 or more that have been identified by the provider and read coded by the practice to be in one of the following groups:

- Patient referred but no evidence of engagement (8Hlu)

(The above will be referenced by no further contact by provider to suggest engagement)

- Patient declined referral to healthy lifestyle programme through face to face contact
- Patient did not attend (DNA) Healthy lifestyle programme (9N4v)
- Patient did not complete healthy lifestyle programme (9m41)

The aim of this indicator is for practices to try and re-engage patients who have either not joined the diabetes risk reduction programme or who have at some stage dropped out of the service 8 weeks after the initial referral was made.

The rationale for waiting 8 weeks is to allow time for the patient to initially engage with the programme and the provider notification to be returned to the Practice.

The re-engagement letter template will be made available to practices through the GPORT System.

Outcome Measure

90% of all patients aged between 18 years and 75 years who are included on the High Risk of Diabetes Register and have a BMI of 27.5 or more and have not engaged with the programme at the end of Week 8 following their first invitation, should be followed up by mailshot and sent a second invitation to join the Diabetes Risk Reduction Programme.

Service Exclusions

Practices are not funded to send out a second invitation to re-engage patients on their High Risk of Diabetes Register who have a BMI between 25 and less than 27.5.

Service Read Codes

The Read Codes to be used for the service are highlighted in the table below:

Action	Read Code
Healthy lifestyle programme offered (via mailshot)	9m44
Referral to healthy lifestyle programme (through face/telephone contact)	8Hlu
Referral to healthy lifestyle programme declined	9m43
Healthy lifestyle programme commenced	9m40
Healthy lifestyle programme DNA'd	9N4v
Healthy lifestyle programme not completed	9m41
Healthy lifestyle programme completed	9m42
Referral to Health Trainer	8HIF
Referral to Health Trainer Declined	8IAL

Quality Assurance

Practice Requirements

Practices participating in this LIS will be required to:

1. Work collaboratively with all stakeholders, including internal and external clinical networks, to support the delivery of the scheme
2. Ensure that a minimum of 1 practice GP clinician and Nurse attend all education and training sessions offered by the CCG to support the delivery of the scheme
3. Ensure that all monitoring reports are sent to the CCG by their submission deadlines using the approved CCG reporting templates.

Health Care Standards

1. Practices providing the service defined within this agreement should have adequate facilities available in order to enable them to provide such services properly
2. Adequate and appropriate equipment should be available for healthcare professionals to undertake the service defined within this agreement
3. Providers should fulfil legislative requirements for services and meet assurance markers set out in the Standards for Better Health (<http://www.hcsu.org.uk>)
4. It is expected that practice staff carrying out the initiatives within this specification will be appropriately qualified to do so.

Staff Competence

All individuals providing the service within the scope of this agreement will need to evidence that they have the experience and qualifications to undertake the service. The practice will ensure that all individuals are competent to provide those aspects of the service for which they are responsible and will make sure that all individuals keep their skills up to date.

Consent and Confidentiality

All patients receiving care in accordance with the requirements of the LIS should be fully informed of the purpose of the scheme. Details of their consent to be contacted should be recorded onto their clinical record.

Practices are expected to also ensure patient confidentiality is retained in accordance with BSC CCG's Confidentiality and Data Protection Policy.

Record Keeping and Verification

Practices must manage data and patient records as follows:

- Ensure records are accurate and kept on a secure system
- Record NHS numbers of patients to allow follow up through health care system
- Audits undertaken against the agreed clinical management guidelines
- Demonstrate security, safe storage, and confidentiality of data
- Maintain electronic records.

All records should be kept in such a way that simple or aggregated data is readily available and accessible if requested by the commissioner of the service.

For verification purposes, practices will be required to keep a full data set at practice level in line with this service specification. The CCG may request this information from the practice to substantiate practice activity data.

Practices will be required to retain at practice level a list of patients who have been contacted for the requirements of each of the indicators listed within the service specification as outlined in Section 3 of the scheme. Details of this should be made available to the CCG upon request and may be used for verification purposes during individual practice visits if required to do so.

Governance

Any near events or serious untoward incidents must be reported using BSC CCG's Service Alert System. The CCG will use this information to support the review of service provider contracts and quality indicators to help ensure the optimum quality outcomes for their patient population.

A Practice should record all adverse incidents and these should be reported to BSC CCG within 7 days of their occurrence. Incidents considered to be serious by the Practice should be immediately reported to the CCG's Clinical Governance Lead, and the Clinical Governance Team. An adverse incident is outside of the usual expectations associated with a particular treatment or procedure.

Diversity and Ethnicity Monitoring

BSC CCG expects any provider to show commitment to Diversity and Equality through any appropriate means, e.g. Equal opportunities policy, patient protected characteristics data.

Safeguarding

The Practice will ensure that:

- All staff will be able to recognise indicators and act upon concerns. Their depth of knowledge should be commensurate with their roles and responsibilities.
- Staff should be made aware when they have any concerns to discuss those concerns with a named manager or supervisor as required
- All concerns should be reported through the Local Safeguarding Board (LSB).

Risk Management

- Compliance with relevant legislation
- Accident Reporting / Significant Event Monitoring
- Department of Health 2001 Good Practice in Consent: Achieving the NHS Plan Commitment to Patient centred Consent Practice, HSC 2001/023 DH (2006) Safety First.

Complaints

All complaints must comply with the Local Authority Social Services and National Complaints (England) Regulation 2009.

Quality and Performance Indicators

Quality Area	Quality Measure	Measurement and Reporting Frequency and Format	Threshold	Consequence of Breach
Signposting & Referral	Signposting & Referrals are timely and fit clinical criteria for service provision	Random / Selected Audit by Service Commissioner	90% of all referrals to meet the criteria	Remedial Action Plan as agreed with Commissioner
Re-engagement	Re-engagement is timely and undertaken in line with the clinical and operational criteria for service provision	Random / Selected Audit by Service Commissioner	90% of all referrals to meet the criteria	Remedial Action Plan as agreed with Commissioner

Purpose & Rationale

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life and can reduce life expectancy by up to 15 years. In the United Kingdom (UK), the prevalence of pre-diabetes has tripled in eight years, with more than a third of adults now considered to be at high risk of developing Type 2 Diabetes.

In the absence of intervention, the majority of pre-diabetic patients are likely to develop Type 2 diabetes within five to ten years. However, various studies have shown that a specific range of lifestyle interventions can significantly reduce the risk of developing diabetes. The identification and management of pre-diabetes therefore provides a substantial opportunity for preventing the future burden of Type 2 diabetes within BSC CCG.

Pre-diabetes is now recognized as a reversible condition that increases an individual's risk for developing diabetes. Lifestyle risk factors for pre-diabetes include being overweight and physical inactivity. Evidence suggests that personalised lifestyle and educational interventions can delay or even reverse the disease process for this patient group. Research studies have found that moderate weight loss and exercise can prevent or delay type 2 diabetes among adults at high-risk of diabetes

The service model will support practices to signpost patients tested and classified to be at high risk of developing diabetes into a number of lifestyle programmes that focus upon exercise, lifestyle and weight management support. The ambition is that participation in the programme will empower patients to make changes to their lifestyles that will help them to fall out of the at risk category for developing diabetes in the longer term.

The rationale for the LIS Scheme is to test a range of interventions that aim to reduce the incidence of Type 2 diabetes by 2025.

Expected outcomes of scheme

This specification will result in the following outcomes:

- Reduce the number of BSC patients who are identified to have pre-diabetes
- Reduce the number of BSC pre-diabetic patients who progress on to develop 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 that they access care/treatment in a timely manner
- Strengthen continuity of care
- Increase the number of BSC pre-diabetic patients who exercise regularly
- Reduce the number of BSC pre-diabetic patients who have a BMI of over 25

Monitoring & Financial Details

Monitoring

As a minimum, practices will need to ensure that they keep activity information for service delivery at an individual patient level.

The practice is required to supply the CCG with such information it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the LIS.

It is anticipated that monitoring will be undertaken annually. However, the CCG reserves the right to request activity information on a quarterly basis if required. This request will be made by email to the practice.

Monitoring Requirements

Using the Read Codes Identified in Section 3.3, practices will be required to submit monitoring requirements in accordance with the outcome measures for the service. Details are outlined between sections 3.1.1.2. to section 3.1.3.1. of the scheme.

End of Year Submission Dates for 2015/16

Indicators	Submission Requirements	Submission Deadline
Pre-Diabetes Demonstrator Indicator 1 (A)	End of Year Activity Summary including: <ul style="list-style-type: none"> • Total number of patients on High Risk of Diabetes Register with a BMI over 27.5 • Number of patients who join scheme • Number of patients who decline scheme • Number of patients who attend first appointment • Number of patients who DNA after first session • Number of patients who do not complete the scheme • Number of patients who complete scheme 	End of Year
Pre-Diabetes Demonstrator Indicator 1(B)	End of Year Activity Summary including: <ul style="list-style-type: none"> • Total number of patients on High Risk of Diabetes Register with a BMI between 25 and under 27.5 • Number of patients who join scheme • Number of patients who decline scheme • Number of patients who attend first appointment • Number of patients who DNA after first session • Number of patients who do not complete the scheme • Number of patients who complete scheme 	End of Year
Pre-Diabetes Demonstrator Indicator 2	End of Year Activity Summary including: <ul style="list-style-type: none"> • Number of patients who decline scheme at first invitation and then re-engage 	End of Year

Project Evaluation

A key element of the pilot is to externally validate the outcomes of the project, including the range and success of the interventions offered.

Details of this external evaluation have yet to be agreed. However, practices signing up to this scheme will be expected to support the delivery of this evaluation by helping to provide/complete any audit information required for independent external analysis.

Financial Details

To deliver the requirements of the scheme, practices will be paid £0.30p per patient based upon their weighted practice population.

Practice Payments

Note: This LIS is over two financial years 2015/16 and 2016/17, as it runs from 1 October 2015 to 30 September 2016. Payments will be made to practices quarterly in advance.

Payments for financial year 2015/16

Quarters 3 and 4 was paid in advance, by 30 November 2015. The reason was to support Practices in completing the first mailshot by 31st December 2015.

Payments for financial year 2016/17

Quarter 1 payment for 2016/17 was paid at the end of March 2016. Quarter 2 payment for 2016/17 was paid in June 2016.

Pre-Diabetes Payment schedule:

Financial Year	Financial Quarters	Payment Month
2015/16	Quarter 3 (Oct – Dec 15)	November 2015
	Quarter 4 (Jan – Mar 16)	
2016/17	Quarter 1 (Apr – Jun 16)	March 2016
	Quarter 2 (Jul –Sep 16)	June 2016

The CCG reserves the right to audit practice activity and plans as required.

Clinical Templates

High Risk of Diabetes	
Pilot intervention: for at risk of diabetes LIS	
Please encourage patients at high risk of diabetes to access the pilot Lifestyle Programme (ideally for BMI 27.5+ and age 18-75)	
<input type="checkbox"/> Healthy lifestyle programme offered (mail out code)	17-Sep-2015
<input type="checkbox"/> Healthy lifestyle programme declined	17-Sep-2015
<input type="checkbox"/> Referral to healthy lifestyle programme (practice referral)	17-Sep-2015
Pilot follow up: for at risk of diabetes LIS	
Please enter quarterly information from the programme about the patient attending lifestyle programme pilot	
<input type="checkbox"/> Healthy lifestyle programme commenced	17-Sep-2015
<input type="checkbox"/> Healthy lifestyle programme completed	17-Sep-2015
<input type="checkbox"/> Healthy lifestyle programme not completed	17-Sep-2015
<input type="checkbox"/> DNA Pilot Lifestyle Programme	17-Sep-2015
<input type="checkbox"/> Healthy lifestyle programme declined	17-Sep-2015
Alternative pathway is to refer to the health trainer if needed	
<input type="checkbox"/> Referral to health trainer	17-Sep-2015
<input type="checkbox"/> Referral to health trainer declined	17-Sep-2015

LIS - f/u lifestyle programme

Patient may have DNA'd or failed to complete the lifestyle programme for at risk of diabetes pilot

Please re offer programme.

Double click for template

EM

- LIS - High risk DM annual review due
- LIS - f/u lifestyle programme
- On high risk of diabetes register

On high risk of diabetes register

High risk of diabetes mellitus 11-Jun-2015
 Latest Hba1c = 44 08-Oct-2014
 Latest BMI = 34.9 17-Sep-2015

Healthy lifestyle programme not completed 17-Sep-2015

EM

- LIS - High risk DM annual review due
- LIS - f/u lifestyle programme
- On high risk of diabetes register

Sign Up Form

This document constitutes the agreement between the GP practice and Birmingham South Central CCG in regards to the provision of the BSC Pre-Diabetes Demonstrator Pilot Scheme (1st October 2015 – 30th September 2016).

Practice sign up to this service was via the GP Online Reporting Tool (GPORT). The sign up options on the GPORT system was available to practices from Monday 12th to Friday 23rd October, 2015.