Reference: FOI.ICB-2526/084

Subject: ARRS Expenditure, Local Enhanced Services and Incentive Schemes 2025/26

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Clarification received: Sorry for not being clearer, I've attached a spreadsheet outlining the data we're seeking, which may help clarify, as it's expenditure to date vs allocation for 2025/26 financial year. If the expenditure to date is able to be split and shown as what figure was spent on a role type i.e. clinical pharmacist, that's helpful but the overall expenditure is the main element I'm looking for. If the spreadsheet could be completed it would be much appreciated.	
1. Additional Roles Reimbursement Scheme (ARRS) Expenditure Please provide details of your most recent Additional Roles Reimbursement Scheme expenditure per PCN (by ODS Code), including: i. Total ARRS funding allocated for each PCN ii. Current utilisation rates against allocated funding iii. (if available) Breakdown by role type (e.g., clinical pharmacists, physician associates, social prescribers)	i. As per spreadsheet ii. As per spreadsheet iii. Allocation by role not held, by PCN as per spreadsheet

2. Local Enhanced Services and Incentive Schemes 2025/26 Please provide information about any local enhanced services or locally commissioned incentive schemes in place for general practice for the 2025/26 financial year, specifically: i. Details of schemes focused on long-term condition management ii. Payment structures and rates for these services iii. Eligibility criteria for practices iv. Performance metrics or outcomes require	i. Please find enclosed schemes focused on services for the Long Term Conditions (LTC) management: • Dementia LES • Insulin Start LES – Currently under review ii. Payment Structures: The ICB considers the information relating to specific prices and volumes of the funding formulas commercially sensitive and has therefore applied Section 43(2) to this information. This information has been redacted from the attached specifications. Section 43(2) exempts from disclosure information which would, or would be likely to, prejudice the commercial interests of an organisation. The LES specifications include information relating to the specific prices and funding formulas which the ICB considers commercially sensitive information. Section 43(2) is a qualified exemption and therefore the public interest test has been set out below. The public interest arguments in favour of disclosing the information include the ICB's responsibility to be transparent and accountable in its decision making. The ICB has a responsibility to demonstrate that the LES agreements represent good value for public funding.

	However, disclosing the information would potentially be detrimental to primary care budgets or future service considerations. The ICB has also considered that although funded through the NHS, GP Practices are private businesses and consider information regarding their finances to be confidential information. The ICB recognises that GP Practices expect financial information to be treated as confidential and therefore disclosure of the information may damage relationships between the ICB and GP Practices. The ICB believes that the public interest lies in maintaining the exemption as it is in the public interest for the ICB to be able to commission services at a good value to ensure that primary care services are available. Preserving good relationships with GP Practices enables the ICB to continue to deliver valuable and cost effective services to patients. If these services were not delivered through primary care, there would be an activity increase across other local healthcare services which would impact the ability for other community and acute services to be delivered. iii. Eligibility Criteria: • Dementia LES - this service is available to anyone who has suspected or confirmed dementia registered with the GP practice in BNSSG. • Insulin Start LES - this service is available for all patients registered with a GP practice in BNSSG

	iv. Performance metrics or outcomes required: The metrics and outcomes are set out within the service specifications enclosed.

The information provided in this response is accurate as of 25 July 2025 and has been approved for release by David Jarrett, Chief Delivery Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Additional Roles Expenditue for each PCN for the financial year 25/26

ODS CODE	PCN Name	2025/26 ARRS Allocation (£)	2025/26 ARRS expenditure to date (Apr25-Jun25) (£)
QUY	PCN 001	1,326,927	341,895
QUY	PCN 002	874,058	134,993
QUY	PCN 003	992,811	240,351
QUY	PCN 004	2,313,252	464,240
QUY	PCN 005	1,360,530	327,273
QUY	PCN 006	1,379,075	311,507
QUY	PCN 007	984,594	238,627
QUY	PCN 008	1,232,554	206,268
QUY	PCN 009	1,346,008	300,376
QUY	PCN 010	1,550,665	349,082
QUY	PCN 011	1,215,595	317,649
QUY	PCN 012	1,698,815	407,714
QUY	PCN 013	934,192	233,121
QUY	PCN 014	911,185	328,296
QUY	PCN 015	2,844,598	711,519
QUY	PCN 016	909,873	195,807
QUY	PCN 017	789,085	155,810
QUY	PCN 018	2,099,234	534,686
QUY	PCN 019	899,416	208,622
QUY	PCN 020	1,592,245	324,373
	TOTAL	**27,254,712**	**6,332,208**

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**DementiaLES2426**
Service	**Recognition and Management of People with Dementia and their Family/Carers in General Practices**
Commissioner Lead	**Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire ICB**
Provider Lead	**As per provider signatory**
Period	**1st June 2024 – 31st May 2026**
Date of Review	**January 2023**

1. Population Needs

1.1 National/local context and evidence base

Around 10,700 people across Bristol, North Somerset and South Gloucestershire are estimated to have dementia, however currently only around 67% of them have a diagnosis.

- In Bristol, around 4,200 people are estimated to have dementia, approximately 76% of them have a diagnosis.
- In North Somerset, around 3,300 people are estimated to have dementia, approximately 64% of them have a diagnosis.
- In South Gloucestershire, around 3,200 people are estimated to have dementia, approximately 62% of them have a diagnosis.

General Practitioners (GPs) have a crucial role in ensuring that early concerns about memory problems are detected and responded to.

Following national and local awareness raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practice time. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

The GP practice does not only have a key role in the diagnostic process, it also has an important role in following the person with dementia and their family/carers through the different stages of their condition to ensure all the support is available for the person's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, conducting health checks (for the person with dementia and their family/carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making

and contingency planning, and signposting people to local information, advice and support services as well as end of life care.

Dementia has been an increasing priority both locally and nationally over the past few years. There is evidence to suggest that a majority of patients and carers want a diagnosis and that diagnosis improves access to support and medication where indicated, and that support for carers enables patients to stay longer in their own homes.

This Local Enhanced Service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

2. Outcomes

2.1 NHS Outcomes Framework Domains and 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

It is expected that by delivering the Service, Providers will be able to deliver the following outcomes:

Domain 2 Enhancing quality of life for people with long-term conditions

- ✓ There is a culture in primary care of dementia being viewed and managed as a long term condition

Domain 3 Helping people to recover from episodes of ill-health or following injury

- ✓ There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services

Domain 4 Ensuring people have a positive experience of care

- ✓ People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia
- ✓ Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break
- ✓ BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia

Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm

- ✓ An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care

3. Scope

3.1 Aims and objectives of service

The Provider will work with the Commissioner to ensure that the Service meets the following aims and objectives:

- Ensure people with dementia and their family/carers receive the highest possible level of care.
- Ensure each practice has a lead GP and lead practice nurse/health practitioner for dementia.
- Increase the early recognition and diagnosis of dementia in every GP practice in BNSSG.
- Enable secondary care to support primary care to make a diagnosis of dementia.
- Provide a recall and comprehensive review system for people who are initiated and stabilised on Cholinesterase Inhibitors and/or Memantine in Primary Care with advice and support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a comprehensive review process for people with dementia who are on anti-psychotic medication.
- Practices should aim for GPs to diagnose dementia in the majority of straightforward cases. Patients with atypical presentations such as young, rapid onset, frontal and Lewy Body patients might expect to be diagnosed by or with the support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a holistic package of care to enable more people with dementia and their carers to live fuller lives and avoid crisis admissions.
- Enhance physical care and health promotion advice for all people and carers for people with dementia, especially regarding vascular dementia.

3.2 Service description/care pathway

To participate in the Service, Providers are required to carry out the following:

1. Having a named lead GP and a named practice nurse/health care practitioner for dementia.
2. Named lead GP and named practice nurse/ other health care practitioner participate in yearly dementia training, provided or endorsed by Clinical Leads for Dementia; this could be in person or online and will be a maximum of half a day.
3. The named lead GP for dementia to provide a structured update session on dementia for all the other GPs and practice staff at least once a year.
4. Actively participate in evaluation of the service, this may include sending out surveys to patients/families and practice staff being interviewed.

5. Record carers on the carers register and signpost carers for short breaks, evidenced by at least 6 monthly meetings with the Carers Support Workers,
    - In Bristol and South Gloucestershire this is provided through the Carers Support Centre. In Bristol there is also the Bristol City Council (BCC) Integrated Carers Team.
    - In North Somerset this is provided through the North Somerset Alzheimer's Society Dementia Support Worker Service.
6. :Undertake a diagnosis of uncomplicated dementia (Alzheimer's Disease or Vascular Dementia) within a Primary Care setting and provide appropriate post diagnostic support and signposting information using the supplied EMIS template

7. Carry out reviews of people with dementia and their family/carer (using the agreed template or equivalent) that delivers review of all medication including cholinesterase inhibitors, Memantine and anti-psychotic medication using the supplied EMIS template

Create Care Plans for patients with dementia that where and when appropriate contain anticipation of End of Life Care Planning needs. This would include consideration and discussion of Do Not Artificially Resuscitate orders and a discussion about Preferred Place of Care / type of care preferably avoided (such as Hospital or ITU admission) These Care Plans should be developed using the Dementia EMIS template. For patients in the palliative care phase the appropriate additional shared care template should be used. Providers will need to consider how best to manage the reviews and may wish to work together to appoint a practice nurse to carry out all the reviews across a cluster of practices.

3.2.1 Detailed Description of the Requirement

- Adopting the care pathway including management of people stable on dementia medication.
- To undertake investigations as indicated in Section 4 and investigate any abnormalities to exclude potentially treatable causes.
- To undertake a diagnosis of dementia and initiate medication in line with guidance provided in Section 4.
- To complete a plan (or ensure the practice dementia navigator or AWP equivalent has) for the patient that includes relevant information including where to go for further support and signposting.
- To note the diagnosis of dementia, if made in secondary care or by other providers and record accordingly with relevant read code.
- To review every person diagnosed with dementia at least once a year (6 monthly if on dementia related medication, 3 monthly if on anti-psychotic medication), following the review template provided in the Dementia EMIS template.
- To initiate where appropriate (with advice if needed) and continue the prescribing of Cholinesterase Inhibitors (CEIs) or Memantine. The new BNSSG prescribing guidance confirms that GPs are able to initiate and follow up all three CEI's and Memantine and drugs for BPSD. This is now an expected

part of this Primary Care Service – GPs may want to seek advice about the prescribing from the dementia clinical staff however GPs will do the prescribing. For the purposes of this enhanced service with the benefit of the annual educational events GPs are considered to have this 'specialist' knowledge.

- To notify the Dementia Wellbeing Service for Bristol or AWP for North Somerset or South Gloucestershire of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the person's health that cannot be managed in Primary Care

In order to qualify for payment the Provider must complete the work detailed above.

3.3 Population covered

This service is available to anyone who has suspected or confirmed dementia registered with the GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

This service is available to anyone who has suspected or confirmed dementia and is registered on the GP register and their needs can be best met in Primary Care.

3.5 Interdependence with other services/providers

This service is closely linked with Dementia Wellbeing Service in Bristol and AWP in North Somerset and South Gloucestershire who provide services in a community setting.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The National Institute for Health and Clinical Excellence (NICE) Dementia Quality Standards provides clinicians, managers and service users with a description of what a high quality dementia care should look like. The standards describe markers of high quality, cost-effective care that, when delivered collectively should contribute to improving the effectiveness, safety, experience and care for adults with dementia and their family/carers.

https://www.nice.org.uk/guidance/ng97

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

N/A

4.3 Applicable local standards

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group have a referral pathways tool to provide information for General Practitioners:

http://remedy.bnssgICB.nhs.uk/adults/dementia/

The following information is available for dementia:

- ✓ Pathway for diagnosis of dementia in Primary Care
- ✓ Guidelines for diagnosing Alzheimer's Disease in Primary Care
- ✓ Guidelines for prescribing and Reviewing Donepezil and Reviewing Memantine
- ✓ Guideline for Managing Behavioral and Psychiatric Disorder in People with Dementia

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

N/A

5.2 Applicable CQUIN goals (See schedule 4D)

N/A

Outcomes, monitoring and evaluation

By signing up to this enhanced service the Provider agrees to complete the EMIS template and allow BNSSG to extract data as required.

The service will be measured against the service outcomes as defined in Section 2, using the key performance indicators which will be captured via monitoring forms and an online survey as set out in the table below:

Technical Guidance Reference	Quality Requirement / Outcome	Method of Measurement	Frequency	Used by Commissioner to evidence
Domain 2: Enhancing quality of life for people with long-term conditions				
NHS Outcome Domain 2	There is a culture in primary care of dementia being viewed and managed as a long term condition	Online Survey	Annual	The shift in opinion of dementia
Domain 3: Helping people to recover from episodes of ill-health or following injury				
NHS Outcome Domain 3	There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services	Monitoring form	Quarterly	Effectiveness of service specification
Domain 4 Ensuring people have a positive experience of care				
NHS Outcome Domain 4	People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia.	Feedback from people with dementia who have experienced the service	Annual	To understand how people feel about the management of their dementia

NHS Outcome Domain 4	Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break	Monitoring from the 3 Local Authority carers teams and the Carers Support Centre	Quarterly	To understand the uptake of breaks
NHS Outcome Domain 4	BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia	Training attendance records	Annual	Confirming staff up to date with relevant training
Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm				
NHS Outcome Domain 5	An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care	Monitoring form	Quarterly	To ensure the service is working effectively

Appropriate coding and use of template in EMIS will allow BNSSG to extract data to calculate payment. Payments will be made on a quarterly basis but data will be extracted monthly for monitoring purposes.

Providers will be required to provide evidence of the requirements and the specific numbers of people supported under the agreement. Providers will be supplied with an EMIS template that will guide them through the review process. A random sample of review templates will be scrutinised annually. Practice registers will be monitored in order to triangulate the payment process and to ensure appropriate payment of the incentive part.
An online survey will be sent out to gain feedback on the service to inform the following year.

5.3 Read Codes

Data will be extracted via EMIS search and report. By signing up to this enhanced service you agree for the data be extracted as required. Read codes should be used for reporting, suggested read codes for the identification of people with dementia are the following:

"Alzheimer's disease unspecified"	Eu00z
"Multi-infarct dem'"	Eu011
"Alzheim' disease“	F110
"Lewy body dementia”	F116

SCHEDULE 3 – PAYMENT

A. Local Prices

Dementia

Dementia Diagnosis

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of the codes from the QOF (V48 Release 1.5) Dementia Register (DEM001) where the earliest coding is within the search period AND the consultation type was not 'Scanned document' AND the patient has any of the below codes added in the nine months prior to the end of the search period AND the consultation type where the codes were added (except for a GPCOG or Assessment for dementia code) was not 'scanned document'.

Clinical Code Description	SNOMED Description ID
Assessment for dementia	2247561000000112
TYM (Test Your Memory) test total score	3637929018
Mini-Cog test score	3289307011
Mini-Addenbrooke's cognitive examination score	2015691000006116
Addenbrooke's cognitive examination-III score	2015461000006110
Addenbrooke's cognitive examination revised - score	1554191000000113
General practitioner assessment of cognition patient score	1667281000000112
GPCOG (general practitioner assessment of cognition) score	1667301000000113
6CIT (Six Item Cognitive Impairment Test) total score	2718871000000119

Dementia Review

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Review of dementia advance care plan	1906941000006119
Review of dementia advance care plan	2742991000000115
Dementia care plan reviewed	2439631000000113
Review of dementia care plan	1996991000000118

where the code was added within the search period.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date).

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract used by ICB to inform quarterly payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	InsulinStartLES2425
Service	Type 2 Diabetes Insulin Start LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2025
Date of Review	April 2024

1. Population Needs
1.1 National/local context and evidence base Type 2 diabetes is a chronic metabolic condition characterised by insulin resistance (that is, the body's inability to effectively use insulin) and insufficient pancreatic insulin production, resulting in high blood glucose levels (hyperglycaemia). Type 2 diabetes is commonly associated with obesity, physical inactivity, raised blood pressure, disturbed blood lipid levels and a tendency to develop thrombosis, and therefore is recognised to have an increased cardiovascular risk. It is associated with long-term microvascular and macrovascular complications, together with reduced quality of life and life expectancy. This Local Enhanced Service should help to improve the quality of life for patients with Type 2 Diabetes Mellitus, improve the patient's understanding of their condition and reduce referrals to secondary care which will make the service more local and accessible to patients.
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

Diabetes Insulin initiation occupies an important place in the management of type 2 diabetes. The National Diabetes Audit has shown BNSSG as outliers for 'diabetes treated to target'. Skilled clinicians are required in general practice for recognising insulin as the clear next step and initiating it with confidence as part of normal work.

This Local Enhanced Service specification outlines the process for undertaking treatment initiations in primary care, reducing the need for patient referral to secondary care. It will necessitate additional training for some practice clinicians and as such, will help improve the general management of patients with type 2 diabetes.

This service is an example of integrated primary and community care, with simplified access points for patients to specialised services.

3. Scope

3.1 Aims and objectives of service

To provide an insulin initiation service for patients with type 2 diabetes which is convenient to the patient and provides safe, high quality, evidence based effective care.

The service detailed in this service specification must have a designated lead within the practice/locality. In usual circumstances routine insulin initiation and other non insulin injectable diabetes treatment initiation must be provided by the practice and its employed clinical staff and not by community or specialist nurses.

Objectives:

- To improve the quality of care provided in the community to patients with type 2 diabetes by making the service more accessible and responsive. This is facilitated by the shift from secondary to primary care and removing the need for patients to travel to acute trusts to undergo Insulin Initiation
- This enhanced service will fund practices to identify and initiate patients suitable for Insulin initiation, (HbA1c> 57)
- Provide patients with education around lifestyle and self titration of insulin doses, which in turn will promote the self care agenda as vital in the management of long term conditions such as diabetes
- The frequency of appointments is agreed on an individual basis with the patient.
- To reduce HbA1c to agreed individualised targets
- To reduce the long term complications of diabetes
- To reduce non-elective hospital admissions in patients with diabetes.
- To work towards NHS BNSSG ICB's objectives of delivering care closer to home
- Improve outcomes for patients by optimising glycaemic control
- Facilitate intensification of therapy in primary care, when this requires parenteral therapy
- Improve adherence to the latest NICE guidance
- Deliver safe, effective, and sustainable treatment
- Evaluation the quality of care for patients with diabetes through regular audit process

3.2 Service description/care pathway

The insulins prescribed as part of this LES should be in line with the BNSSG Joint Formulary. Prescribers are also expected to follow the BNSSG guidelines for the prescribing of ancilliary devices for blood glucose monitoring and injecting (needles).

The patient outcomes requiring monitoring as part of this LES are:

- Identification of patients who need intensification of their drug therapy for diabetes
- Have a designated diabetes lead within the practice.
- Intensify drug therapy in line with BNSSG formulary
- Optimise glycaemic control

- Frequency of episodes of hypoglycaemia including emergency admission
- Ensure a patient centred approach to the initiation of insulin therapy which empowers the person with type 2 diabetes to be actively involved in their treatment
- Ensure that cost-effective consumables are supplied to patients
- Patients initiated on insulin therapy are coded on the EmisWeb prescribing system with

Clinical Code Description	SNOMED Description ID
Conversion to insulin	264706016
Insulin treatment initiated	646031000000112

- Provide safe, high quality, evidence based effective care

When starting insulin therapy in adults with type 2 diabetes, primary care should offer to refer patients to a structured education programme (Diabetes and You Type 2), and provide 1 on 1 support to patients, employing active insulin dose titration that encompasses:

- Injection technique, including rotating injection sites and avoiding repeated injections at the same point within sites
- Continuing telephone and/or face to face support
- Self-monitoring
- Dose titration to target levels
- Dietary and lifestyle advice
- Insulin storage
- DVLA guidance (At a glance guide to the current medical standards of fitness to drive)
- Risks/causes and management of hypoglycaemia
- Management of acute changes in glucose control
- Advice regarding management during illness
- Support from an appropriately trained and experienced healthcare professional.

By agreeing to participate in this LES the practice will also be required to provide the following information:

- Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES.

Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/

- Agree to extraction of data to monitor the number of insulin initiations in patients with type 2 diabetes via EMIS Search and Report

BNSSG ICB will obtain information on the number of patients being initiated onto insulin therapy under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

Data extracted will be used to assess delivery of the following measures:

Diabetes Clinical and Social Outcome Measures
LTC 3 - Potential Years of Life Lost (PYLL) in people with diabetes
LTC14 Smoking in people with diabetes
LTC15 Obesity in people with diabetes
LTC16 Episodes of ill health requiring emergency admission in people with diabetes
LTC17 Days disrupted by care in people with diabetes
LTC19 Acute symptoms related to diabetes control
LTC23 Acute Kidney Injury (AKI) in people with diabetes
LTC53 Lower limb amputation in people with diabetes
LTC54 End-Stage Renal Failure (ESRF) in people with diabetes
LTC55 Blindness in people with diabetes
LTC57 Age at onset of first stroke in people with diabetes
LC58 Age at onset of first MI in people with diabetes

Initial Training: To ensure staff have the appropriate skills to deliver this Enhanced Service and are familiar with current treatments, the following pre-requisites for training apply to this LES:

- Practice Nurses/Clinical Pharmacists - completion of the 2 day locally run insulin initiation programme facilitated by the Community Diabetes specialist team, or evidence of further training in diabetes if from outside of area. Prior to taking on insulin initiation training it is expected that a certain level of diabetes care competence has been achieved, this would normally include an accredited module in diabetes course received from an accredited training provider. Examples include:
  - 'Care of the adult with diabetes' module available from the University of the West of England (UWE). https://courses.uwe.ac.uk/UZTR3Q203/care-of-the-adult-with-diabetes
  - Diploma level education available from:
    - Education for Health

https://www.educationforhealth.org/education/z-courses/

- Primary Care Training Centre: https://www.primarycaretraining.co.uk/training/

- GPs - At least one GP from each locality (who will clinically support the initiating clinician) is encouraged to attend the local 2 day insulin programme, or have evidence of attending an equivalent course in the last 2 years.

Assessment of Competency: All practitioners undertaking initiation of insulin shall have up to 10 supervised initiations assessed by the Community Diabetes Nurse Specialist and will be advised when they are deemed competent to initiate without supervision (the number of supervised initiations will depend on the competence of the practitioner). The Practice will not be eligible for payment until competency has been assessed and confirmed, at which point a certificate will be issued.

Ongoing Diabetes CPD- PNs/clinical pharmacists and GPs who initiate insulin are expected to maintain their skills by attending diabetes CPD annually either virtual, national or local meeting/conference

Ongoing advice and guidance – for support with clinical decisions and complex patients practice teams are encouraged to telephone/email the Sirona Diabetes Advice and Guidance service

The service, which is for healthcare professionals only, is available between 8am-5pm, Monday-Friday and run by a team of Community Diabetes Specialists.

For queries requiring same day response, call 0300 124 5908.

For routine advice and guidance, e-mail sirona.diabetesadvice@nhs.net. Please include details of the situation, background, assessment and proposed recommendation requiring advice and guidance review.

3.3 Population covered

This service is for all patients registered with a GP in BNSSG.

3.4 Any acceptance and exclusion criteria and thresholds

The following exclusions will apply:

- Patients under the age of 16
- Patients with Type 1 Diabetes

- Patients with CKD 4 or worse (consultation with diabetes specialist and or renal team required)
- Patients with Gestational diabetes
- Patients with complex complications (unless agreed with secondary care there is appropriate communication mechanisms in place between primary and secondary care)
- Patients who have previously been initiated on insulin

3.5 Interdependence with other services/providers

Community based diabetes specialist services who deliver training and support for clincians to be able to sign up to this LES. If practices do not sign up there will be an expectation for this service to be delivered by the locality in order to meet the needs of the population.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following guidance from NICE:

- Type 2 diabetes in adults: management. NICE Guideline 28 (June 22) http://www.nice.org.uk/guidance/ng28
- NICE Diabetes quality standards: Overview | Type 2 diabetes in adults | Quality standards | NICE

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- https://www.rcn.org.uk/clinical-topics/diabetes/professional-resources Starting injectable treatment in adults with Type 2 diabetes (3rd edition). This resource requires an RCN login to access.

4.3 Applicable local standards

- The Bristol, North Somerset, & South Gloucestershire (BNSSG) Joint Formulary https://www.bnssgformulary.nhs.uk/

- BNSSG Type 1 diabetic blood glucose monitoring guidance https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/
- BNSSG Type 2 diabetic blood glucose monitoring https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/

  The Community Diabetic Nurse Specialist is to be consulted if there are any doubts about the appropriateness of commencing a patient on insulin

Reporting Requirements

BNSSG ICB will obtain information on the number of patients being monitored under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

By agreeing to participate in this LES the practice will also be required to provide the information detailed in schedule 6A

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

N/A

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

Insulin Initiation

EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Conversion to insulin	264706016
Insulin treatment initiated	646031000000112

where the code was added within the search period AND NOT before AND the patient was 16 years or older at the time of coding AND they have type 2 diabetes mellitus coded.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

Payment frequency is Quarterly in arrears.

What will be Paid For?

Practices will receive one payment for each patient initiated onto insulin therapy.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Provide assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions supply.	April each contract year	Declaration with contract sign up	April	**Insulin LES**
During quarter three submit a review of practice monitoring activity as per the provided template	Quarter 3	Template 2425 Insulin initiation LES audit FINAL versic EMIS Web Search Insulin Initiation LES Audit.xml	By 1 December, due each contract year	**Insulin LES**
The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical	Ongoing	Datix	April	**Insulin LES**

reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/				
Number of patients monitored each quarter as part of this LES if Emis Search and Report becomes unavailable.	If required	TBC as required	April	**Insulin LES**