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**Service Specification for Diabetes Mellitus: Insulin Initiation**

**Period 1st April 2017 to 31st March 2018**

**Date of Review: Annual**

**Introduction**

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients.

This specification outlines the more specialised services to be provided. The specification of this 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.

# Background

Many diabetics are on suboptimal treatment despite maximum oral therapy. By reducing Hba1c, control of diabetes is improved therefore leading to a reduction in immediate complications, long-term complications, hospital admissions and outpatient referrals.

This service should help to improve the quality of life for patients with Diabetes Mellitus, improve the patient’s understanding of his or her condition and reduce referrals to secondary care which will make the service more local and accessible to patients.

Diabetes NICE guidance on lowering blood glucose in type 2 diabetes recommends use of insulin where other therapies and lifestyle modification have failed to adequately control the sugar levels.

# Aims

* To improve the quality of care provided in the community to patients with Type 2 Diabetes by making the service more accessible and responsive

#### To reduce HbA1c

##### To reduce the long term complications of Diabetes

* To reduce non-elective hospital admissions in patients with diabetes.
* To work towards NHS Doncaster CCG’s objectives of delivering care closer to home

# Service Outline

The service detailed in this service specification must have a designated lead within the practice; this can be a GP or practice nurse. Insulin Initiation must be provided by the practice and its employed nursing staff and not by community or specialist nurses.

This enhanced service will fund practices to identify patients suitable for Insulin initiation, (Hba1c>8)

Provide patients with Education around lifestyle and titrate insulin dose

The Frequency of appointments is agreed on an individual basis with the patient:

The service will include:

* Initial Assessment of patient for Insulin Initiation
* Agree Treatment Plan
* Dosing and titration of Insulin through the below regimes as clinically appropriate:

(Once daily, Twice daily, Basal bolus)

* Education should be given as per *Community Insulin Education Protocol*(see appendix 2)
* Healthcare Professionals initiating insulin are to monitor the effect of treatment and potential side effects and establish a plan for review. Initially regular contact by telephone may be required for support and guidance.
* When blood glucose levels are stable and education checklist completed the patient can then maintain telephone contact with their Practice Nurse or General Practitioner. If involved District Nurses to contact the insulin initiator with any problems by fax or by telephone or through local community services.
* If in the future the glycaemic control is not acceptable or the patient develops complex needs, then referral to the Community Diabetes Specialist Nurse or Consultant can be made either by the patient themselves or the healthcare professional managing their diabetes.

# Accreditation

Staff involved in the delivery of this service will be appropriately trained and competent in the provision of the services offered.

The services delivered by this enhanced service will be subject to clinical audit.

Practitioners involved in insulin initiation must receive a certificate from an accredited course or similar which they may be required to submit to NHS Doncaster CCG.

Practitioners who have been carrying out insulin initiation for some years without accreditation will continue to be able to do so upon demonstration of the core competencies contained within an accredited insulin initiation course. **(See appendices 3 and 4)**. Practitioners must also be able to demonstrate a level of activity sufficient to have maintained their skills.

Practitioners will be expected to provide evidence of continuing clinical competency around the delivery of insulin initiation, which is to include evidence of 2 hours of CPD education and the continuing delivery of insulin initiation, this should be demonstrated on an annual basis.

**Performance and Payment**

Activity data should be submitted on a monthly basis to the CCG

The practice will be required to submit audit information on request.

Activity should be submitted within 14 days of month end for activity undertaken in month.

Activity for March 2018 should be submitted within 7 days of month end. DCCG reserve the right to withhold payment on activity not received within these time scales

###### **APPENDIX 1 – DRAFT TEMPLATE**

###### Baseline Assessment – Suitability for Insulin Initiation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Results……………..** | **Action required / time scale……………** | **Review………..** | **Comments………..** |
| **General Measurements**Blood PressureHt, Wt, BMITrend in weight |  |  |  |  |
| **Current medication / Dose**Oral HypoglycaemicsAnti-hypertensiveCholesterol loweringAnti-thrombotic |  |  |  |  |
| **Hypoglycaemia**DaytimeFrequency/severityNight-timeFrequency/severity |  |  |  |  |
| **Complications**NephropathyRetinopathyNeuropathyErectile DysfunctionCardiovascular disease |  |  |  |  |
|  | **Results** | **Action required / time scale** | **Review** | **Comments** |
| **Blood Tests – last 2 months**HbA1cU/ETotal cholesterolHDL / LDL TriglyceridesLFTTFT  | HDL- LDL- |  |  |  |
| **Urinalysis -** albumin Micro-albuminuria Albumin/creatinine ratio | Positive / negative |  |  |  |
| **Self Monitoring** – meter |  |  |  |  |
| **Concerns / Social History** |  |  |  |  |

**Appendix 2**

**Education Protocol for Patients with Type 2 Diabetes Requiring Insulin Therapy**

Insulin Therapy should be offered to people with diabetes whose current treatment is not achieving glycaemic control (HbA1c>8%) or any person with type 2 diabetes who has developed complications and / or symptoms which may benefit from a change to insulin therapy.

# Insulin Education Survival Skills

The following is the minimal amount of information required to allow the patient to manage insulin independently.

* Brief explanation of Insulin Therapy and why it is needed
* Review/teach self blood glucose monitoring including recording and interpreting of results
* Teach insulin injection technique and storage of insulin
* Basic dietary advice (refer to dietician)
* Management of hypoglycemia
* Need to carry identification and glucose at all times
* Driving restrictions and insurance
* How to obtain prescriptions and supplies
* Sick day

The patient must also have the following (leaflets are only written backup to verbal advice already given)

* How to Treat Hypos Leaflet
* Driving Advice Leaflet
* Diabetes and Insulin Leaflet
* Correct instructions for insulin device chosen
* ID Card
* Enough supplies for at least 1 week
* Prescription list
* A follow up appointment
* Contact arrangements to be made for insulin titration
* Contact number for DSN (Novo Nordisk insulin only – out of hours Help Line number available)
* District Nurse Referral (ICCP) as appropriate

The health professional should document in the patient records and complete the education checklist on an on-going basis.

**Continuing Education**

Education should be paced to suit the individual needs and appointments negotiated with the patient. Diabetes education should be planned documented, monitored and evaluated.

**Appendix 3**

**Core competencies- Insulin Initiation**

* Optimise glycaemic control through the use of hypoglycaemic agents and lifestyle intervention
* Advanced understanding and knowledge of different insulin therapies and their use
* Use insulin confidently in combination with other treatments
* Access people with diabetes and identify the need for initiation on insulin in an efficient manner
* Explain and address the psychological issues and barriers around insulin therapy
* Start patients on insulin and follow then up safely and competently

**Appendix 4**

**Insulin for Life**

**Once Daily Insulin in Type 2 Diabetes in Primary Care**

Competency Framework for the monitoring of Participating GP’s and Practice Nurses

|  |  |  |  |
| --- | --- | --- | --- |
|  | Demonstrated knowledge in practice | Discussed with trainer | Further action required and timescales agreed |
| The practitioner:Has a certificate to prove accredited study in diabetes management. Can demonstrate continuing education and attend usual update sessions. |  |  |  |
| Is able to distinguish between Type 1 and Type 2 Diabetes |  |  |  |
| Understand the national guidance for management of diabetes - treating to target in type 2 diabetes; Consensus statement |  |  |  |
| Has an awareness of the main types of insulin and their time action profiles and their place in insulin regimes |  |  |  |
| Understands the local guidelines for the care of people with diabetes requiring insulin initiation |  |  |  |
| Has a clear awareness of the indications for early initiation of insulin |  |  |  |
| Is able to identify the risk factors for Type 2 diabetes and their management  |  |  |  |
| Understands the importance of using the baseline assessment and the planning of treatment targets suitable to the individual |  |  |  |
| Is able to teach the person with diabetes the management of:* Hypoglycaemia, causes, management, insulin dosage adjust
* Effects of alcohol
* Sick day management
* Driving insurance advise
 |  |  |  |
| Is confident to teach:* The use and care for pen devises
* Principles and practice of injection technique
* Storage of insulin
* Safe disposal of sharps
 |  |  |  |
| Has an ability to teach blood testing, use of monitoring to inform on-going care / management and safe titration |  |  |  |
| Has demonstrated the ability to reflect on care delivery and to make appropriate changes to improve and develop service provision |  |  |  |
| Has access to adequate supplies of up to date patient education materials |  |  |  |
| Has completed Insulin treatment records on 5 patients and has reflected on 10 consultations using reflective practice guidance |  |  |  |