NHS Somerset Clinical Commissioning Group

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|---|---|
| **Service Specification No.** | 11X-11-V2 |
| **Service** | Insulin Initiation |
| **Commissioner Lead** | Sheryl Vincent, Commissioning Manager |
| **Provider Lead** | |
| **Period** | 1 April 2018- 31 March 2019 |
| **Date of Review** | TBC |

## 1. Population Needs

**National/local context and evidence base**

1.1 Diabetes is a major health issue in Somerset currently affecting more than 21,000 people[1], with numbers expected to rise year on year, fuelled by Somerset's ageing population and increasing rates of obesity. Standards of services and health outcomes, although above the national average, vary significantly across the county.

1.2 It has been estimated that 21% of patients with diabetes in Somerset are undiagnosed and at risk of serious complications, including heart attacks, strokes, blindness, kidney failure and amputation.

1.3 The model of care for adult patients with diabetes, endorsed by the NHS Somerset Professional Executive Committee in February 2009, aims to increase the capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, with care provided in the right place at the right time and with the right amount of expertise.

1.4 An overview of the model of care is provided in Appendix 1 attached. The full service specification is available on the NHS Somerset CCG website.

1.5 Insulin Initiation in the community is a core component of the model of care. The Insulin Initiation Local Enhanced Service (LES) offers General Practices who are already delivering core primary care to a threshold standard the ability to enhance the level of care they provide to their patients with type 2 diabetes within primary care. Patients should be offered the choice of being referred to an Insulin Initiation Service delivered by their practice, where this is available, or by the Intermediate Diabetes Specialist Nursing and Dietetics Service.

## 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**

Not Applicable

[1] 2008/09

## 3. Scope

**Aims and objectives of service**

3.1 The LES will contribute to the achievement of the targets for the Somerset CCG area as a whole set out in the performance framework for the model of care by:

- providing additional resources to practices to enable them to start their patients on insulin thereby enabling patients the option of having more of their diabetes care in the practice setting
- contributing to the achievement of targets for improved glycaemic control

**Service description/care pathway**

**ELIGIBILITY CRITERIA**

3.2 Practices are required to satisfy the following criteria to be eligible to participate in the Insulin Initiation LES:

- already be providing the full range of core primary care (Appendix 2) and achieving a basic level of service deliverables for their patient population (see Appendix 3 for details)
- have a minimum of 2 healthcare professionals (GP and Practice Nurse) trained and accredited to provide the LES
- participating in quarterly Miquest searches
- participating in the National Diabetes Audit
- agree to participate in Somerset training programmes on diabetes care once these become available

3.3 Practices wishing to take up the LES should complete the attached form (Appendix 4).

**DURATION**

3.4 The period covered by the LES will be concurrent with the Somerset Clinical Commissioning Group financial year with renewal being made on the 1 April each year. Practices that commence the LES part way through the year will have agreement up to 31 March.

3.5 Practices will be required to provide evidence of relevant professional updating to qualify for contract renewal.

**SERVICE REQUIREMENTS**

3.6 Healthcare professionals delivering the LES will be required to be familiar with the wider care pathways for patients with diabetes and to work cooperatively with the Somerset Specialist Nursing and Dietetics Service.

3.7 The Insulin Initiation Service will comprise of the following care provided by an accredited practice healthcare professional:

- assessment of patient suitability for insulin initiation in accordance with best practice
- referral to the Somerset Specialist Nursing and Dietetics Service for dietetic assessment at a level as provided by a specialist diabetes dietician[2]

[2] Accredited practices should normally expect the patient to have access to a Diabetes Dietetic Specialist Nurse within 2 weeks of submitting their referral

- consideration of other alternative treatments to improve glycaemic control, such as lifestyle and other medication
- initiation and ongoing adjustment of insulin
- educating patient and carers on self-management and self-adjustment of insulin doses
- providing lifestyle modification and weight management advice
- providing social and psychological support
- providing in hours advice and support for patients as required
- keep appropriate records as outlined in section 7.2
- liaising with Diabetes Specialist Nurse Service for advice in the event of difficulties in glycaemic control

3.8 The Service will be provided to patients with Type 2 diabetes who satisfy the following criteria:

- are not achieving HbA1c targets with maximum tolerated oral combination therapy
- do not have other reasons for requiring hospital assessment (for example complex co-morbities)
- are over 18 years of age
- are not pregnant
- the patient or carer is deemed capable of safely managing their insulin, including being able to undertake home blood glucose monitoring, inject insulin and adjust their own dose
- express an intention to start insulin, having been advised of what this involves and the risks associated with the treatment and being aware of the choice of provider available
- have received a specialist dietetic assessment, education and lifestyle advice prior to insulin initiation

3.9 If insulin initiation does not result in adequate glycaemic control the patient may need onward referral to the Somerset Specialist Nursing and Dietetics Service.

3.10 The practice should meet with the Somerset Specialist Nursing and Dietetics Service Clinical Lead mid-year to review the practice's performance and address any issues such as further training.

3.11 The Insulin Initiation Local Enhanced Service will be delivered in accordance with the National Service Framework Delivery Strategy for Diabetes (DH, 2003) and the NICE Guidance on Type 2 Diabetes (updated in 2008).

**CONSENT**

3.12 Practices will be required to ensure that Informed consent is sought – this may be in the form of implicit consent (where patient chooses the Service).

**HEALTH RECORD**

3.13 Participating practices will be required to provide or procure the information management and technology services necessary to deliver the requirements of the Local Enhanced Service.

3.14 For the contracted period, practices must keep accurate and comprehensive records for all of

their patients started on insulin, under the Local Enhanced Service including:

- service user name
- general practitioner
- service user NHS number
- service user date of birth
- ethnicity
- HbA1c level prior to insulin treatment and approximately at 3/6/12 months following initiation
- details of adverse events associated with treatment
- where treatment provided (e.g. at the practice, in care home)
- details of any onward referral to the Somerset Specialist Nursing and Dietetics Service/Specialist Level 3 Services
- diabetes medication (including insulin type)
- agreed care plans

**SERVICE USER EXPERIENCE**

3.15 Participating practices will be required to ensure that patients are treated with privacy, dignity and respect at all times and that all aspects of their service comply with the ten key components of 'The Dignity Challenge.' (Department of Health, 2007). In addition, practices must not permit documentation containing confidential service user information to be left where it may be seen by unauthorised persons and service user information will be treated confidentially by all Staff.

3.16 Methods for obtaining feedback may include service user interviews, focus groups, questionnaires and audits.

**EQUALITY AND DIVERSITY**

3.17 The Service must conform to legislation prohibiting discrimination and should be open to all patient groups including housebound and groups services find hard to reach.

**COMPLAINTS AND COMMENDATIONS**

3.18 Participating practices are required to establish and operate a complaints and commendations procedure in line with NHS guidelines to deal with any complaints in relation to any matter connected with the provision of services. All complaints should be monitored, audited and appropriate action taken when required.

**PRESCRIBING**

3.19 Participating practices must ensure prescribing is in line with NICE guidance and national recommendations and should comply with the NHS Somerset CCG formulary.

**INFECTION CONTROL**

3.20 Practices must ensure that all relevant employees are trained in and comply with relevant infection control techniques, in accordance with best practice.

**SERVICE CONTINUITY**

3.21 Practices will be required to demonstrate contingency plans for failure of or breakdown in the Service as part of the Practices overall Business Continuity arrangements.

**SIGNIFICANT / ADVERSE EVENTS**

3.22 The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.

3.23 The Practice should be aware of the various reporting systems such as:

- the National Patient Safety Agency National Reporting and Learning System
- the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices
- the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.24 In addition to any regulatory requirements the Somerset CCG wishes the Practice to use a Significant Event Audit system (agreed with the CCG) to facilitate the dissemination of learning, minimizing risk and improving patient care and safety.

3.25 In addition to their statutory obligations, the Practice will give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the Practice under this Enhanced Service, where such admission or death is or maybe due to the Practices treatment of the relevant underlying medical condition covered by this specification. Notifications are to be sent to the Director of Quality, Safety and Governance with a copy to the Primary Care Commissioning Manager for the specific locality.

**TRAINING AND ACCREDITATION**

3.26 To be eligible to deliver the Service Practices must have a minimum of two health care professionals (GP and Practice Nurse) who are accredited to provide insulin initiation to the practice's patients, having successfully completed a Meeting Educational Requirements, Improving Treatment (MERIT) course in insulin initiation, or equivalent (as agreed with the clinical lead for the level 2 service), and having been assessed by the Somerset Specialist Nursing and Dietetics Service as competent to deliver the service. The MERIT courses are based on the Skills for Health Competency Framework and lasts for 3 days. There is no charge to practices for this course.

3.27 Assessment for accreditation will take the form of 'observed practice' based on a competency framework with a Diabetes Specialist Nurse which will take place for the first five initiations or until the Diabetes Specialist Nurse is assured that the practitioner is delivering the appropriate standard of care.

3.28 Renewal of the contract will be subject to evidence of relevant continuing professional development (MERIT update – 1 day per annum or equivalent) and maintenance of a satisfactory standard of service delivery as assessed by the Diabetes Specialist Nursing and Dietetics Service.

**OUTCOMES**

3.29 Participating practices will be required to conduct an annual review which should include as a minimum an audit of:

- patients continuing on insulin at six months from initiation
- the % patients at different levels of HbA1C (7 or less, 8 or less and or less)

**REMUNERATION**

3.30 The fee structure for the Insulin Initiation LES is based on the expected resource required for an average insulin start, including an overhead, and a profit assumption.

3.31 Practices will receive a fee of £175 for each patient started on insulin.

3.32 Payment will be in 2 parts. The first part payment (50% of full payment) will be payable when the patient has completed assessment of suitability for insulin treatment to include:

- specialist dietetic assessment
- consideration of other alternative treatments to improve glycaemic control, such as lifestyle and other medication

3.33 The second part payment will be paid on receipt of confirmation of insulin continuation at 6 months.

3.34 Practices will receive payment from the start of the Service including during the initial supported period prior to being accredited.

3.35 Practices will be required to submit a detailed and auditable activity report to Somerset CCG on a quarterly basis in a format to be agreed with commissioners.

3.36 The LES may be subject to change due to changing clinical guidelines, in which case the Somerset CCG will give practices three months notice of the change.

**PATIENT AND PUBLIC INVOLVEMENT**

3.37 The Service will conform to professional and legal requirements especially clinical guidelines and standards of good practice issued by the National Institute for Clinical Excellence (NICE) and professional regulatory bodies, and legislation prohibiting discrimination. It is anticipated that for the majority of enhanced services translated information will be available via the Department of Health. If a patient wishes to communicate via a language that is not covered via these leaflets please let the Somerset CCG Equality and Diversity Lead know and use the commissioned interpretation and translation service[3] to facilitate the consultation and provision of information to the patient. Use of the interpretation/translation service should be recorded in the patient's lifelong medical record including confirmation of the first language of the patient.

3.38 Practices should encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to patients, particularly if there are plans to alter the way a service is delivered or accessed.

**REFERENCES**

3.39 *Specification for the Provision of Services for Adult Patients with Diabetes in Somerset*, NHS Somerset, 2009.

3.40 **Population covered**

**Any acceptance and exclusion criteria and thresholds**

3.41 Not applicable

**Interdependence with other services/providers**

3.42 Not applicable

[3] Somerset CCG Interpretation and Translation Service – the PIN for accessing this service has been given to each provider, for queries please email: translations@somerset.nhs.uk.

## 4. Applicable Service Standards

**Applicable national standards (e.g. NICE)**

4.1 The Management of Type 2 Diabetes (update) NICE 2008

**Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

4.2 Diabetes National Service Framework, DH, 2007.

**Applicable local standards**

4.3 Not applicable

## 5. Applicable quality requirements and CQUIN goals

5.1 **Applicable Quality Requirements (See Schedule 4A-D)**

5.2 **Applicable CQUIN goals (See Schedule 4E)**

## 6. Location of Provider Premises

6.1 **The Provider's Premises are located at:**

As defined in Schedule 5 Part A of the Contract Particulars

## 7. Individual Service User Placement

Not applicable

# APPENDIX 1

## MODEL OF CARE FOR SOMERSET DIABETES SERVICE FOR ADULTS

## VISION FOR FUTURE DIABETES SERVICES

The model of care for the Somerset Diabetes Service has been designed with the aim of increasing the capacity of the healthcare system as a whole to meet the needs of growing numbers of people with diabetes, ensuring equity of access and the highest possible standards of care.

The vision is for care to be more integrated and accessible, with an increased focus on:

- preventing illness and helping people stay well,
- earlier diagnosis and better care to reduce the risk of complications
- support for patients to manage their own care

The objectives are to:

- improve the care and health outcomes of adult patients with diabetes in Somerset
- promote partnership working and a shared care approach between providers so patients experience appropriate care, seamlessly, and in a timely manner
- provide accessible services as close to patients' home or work as possible
- optimise resources

The Somerset Diabetes Service will provide care that is personalised, responsive and holistic delivered in the context of how people want to live their lives.

Key deliverables will include:

- community based services
- seamless care provided as close to home or work as possible
- healthy eating and physical activity programmes, accessible through patient choice
- systematic and opportunistic case finding in the community
- support for patients to manage their own condition
- patient education programmes which empower patients to self-care
- care plans agreed with patients
- accessible specialist care when needed
- equity of access and choice

A major goal of the Service will be to address the differences in the standards of diabetes care that exist across Somerset.

## OVERVIEW OF THE MODEL OF CARE

Elements of care required for each stage of the patient's journey have been identified and allocated to one of the following levels:

- Level 1: core primary care
- Level 2: intermediate care
- Level 3: specialist care

The levels reflect the complexity of care and level of skills required to deliver the care. They are not necessarily an indication of location.

In line with the objective to deliver care as close to the patient as possible, the majority of care for adult patients with diabetes will take place in community settings, with only those elements of specialist care (level 3) that it is not practical to provide in the community being provided in acute care hospitals.

All levels include an emphasis on prevention of complications, early intervention and support for self care.

GP practices will provide core primary care (level 1) to agreed standards with some opting to provide specific aspects of intermediate care (level 2), for example insulin initiation.

Opportunistic case finding for early identification of diabetes will be encouraged in GP practices and through pharmacies, local councils and voluntary groups. Systematic case finding will occur through the Health Checks Programme as well as in primary care.

A county-wide, community based, Diabetes Specialist Nurse Service will provide specified level 2 care, such as insulin initiation and support for patients with sub-optimal glycaemic control. This intermediate service will be delivered by nurse-led teams with medical support from specialist acute care services. The composition of these teams will include as a minimum a Diabetes Specialist Nurse and a Specialist Diabetes Dietician. It is anticipated these teams will also provide training and support for practices, structured education for patients and support for self-help groups.

Existing level 2 services, such as podiatry will be enhanced and strengthened to improve access. These services and related specialist care (level 3), wherever possible, will either be at co-located sites in the community, at multidisciplinary clinics or using telemedicine technology.

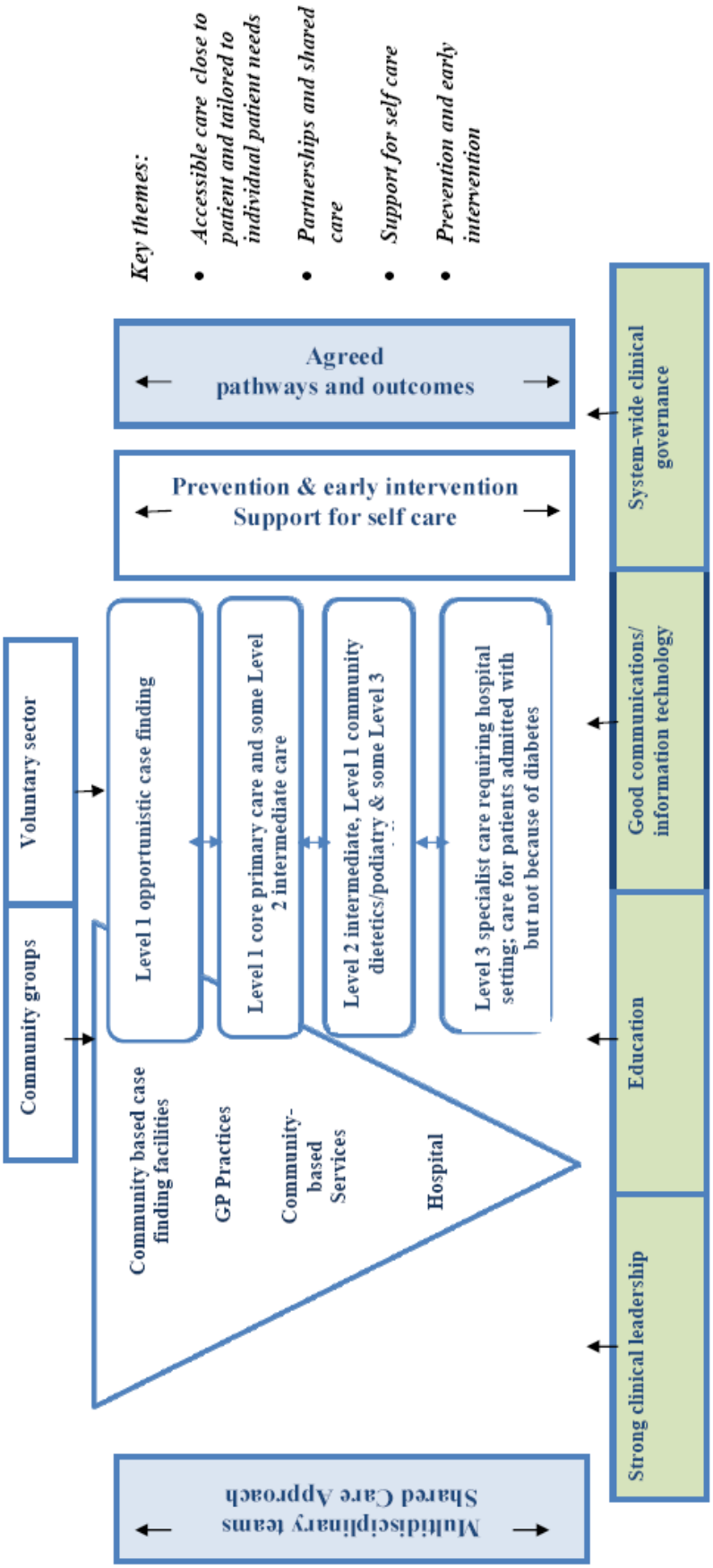
Acute hospital care will be provided for complex cases and there will be an enhanced level of care for patients admitted to hospital with but not because of diabetes, thus improving the patient experience whilst in hospital and reducing lengths of stay.

The new arrangements will involve:

- a shift of level 2 services from acute hospitals to the community
- an expansion of nurse-led level 2 services, based in the community
- a strengthening of other existing level 2 services (e.g. podiatry, dietetics)
- support for GP practices to achieve core standards of primary care and support for those practices opting to provide level 2 care, such as insulin initiation
- freeing up capacity in acute hospitals to focus on most complex cases
- training and support for general ward staff in hospitals to provide improved care for patients admitted with diabetes but not because of their diabetes

The model of care which underpins the planned developments is shown diagrammatically below (Annex 1).

## Annex 1: Model of Care for Adult Patients with Diabetes



## APPENDIX 2

## CORE PRIMARY CARE: SERVICE REQUIREMENTS AND THRESHOLD STANDARDS FOR PARTICIPATION IN INSULIN INITIATION LES

| Element of Care | Evidence |
|---|---|
| 1. Raising awareness of signs and symptoms of diabetes complications, to include: use of advertisements/leaflets | |
| 2. promoting healthy lifestyle 1:1 support | |
| 3. systematic and opportunistic case finding for diabetes, to include: testing of patients referred from the Health Checks Programme | service user Record |
| 4. maintenance of diabetes register | MIQUEST |
| 5. initial clinical assessment of patients newly diagnosed (within 3 months of diagnosis), to include: Lifestyle(weight, exercise, alcohol,smoking), glycaemic control, vascular risk assessment, renal assessment, neuropathy and foot assessment, plus education for people at risk of foot ulcers, medication review, psychological review and care planning. | service user record<br>MIQUEST |
| 6. agreement and documentation of care plan for all patients with Type 2 diabetes | service user record<br>MIQUEST<br>National Diabetes Audit – service user experience survey |
| 7. providing information to patients diagnosed with diabetes, to include: Diabetes UK information pack to newly diagnosed service users with type 2 diabetes signposting to Diabetes UK Website and help-line and local self-help groups, where available | service user record.<br>National Diabetes Audit – service user experience survey |
| 8. referral to structured education (DESMOND) or relevant specialist(s) if not accessing any form of structured education eg Community Dietician | service user record.<br>National Diabetes Audit – service user experience survey<br>MIQUEST (codes to be identified to record service user's referral to/attendance at structured education course. |
| 9. providing advice where necessary, to include:<br>advice on eating healthily and exercise<br>reporting to DVLA<br>sick day rules<br>self-monitoring | service user record<br>National Diabetes Audit – service user Experience Survey |
| 10. psychological support (low level) to include: | Service user record |

| Element of Care | Evidence |
|---|---|
| lifestyle/change management , education and adjustment strategies, management of minor depression/anxiety, encouragement and support for self-care | National Diabetes Audit – service user Experience Survey<br>MIQUEST |
| 11. participating in retinopathy screening programme | service user record<br>National Diabetes Audit – service user experience survey<br>MIQUEST |
| 12. appropriate day to day support and clinical review (minimum annual) to meet individual service user need, to include:<br>Lifestyle (weight, exercise, alcohol) glycaemic control, vascular risk assessment, renal assessment, neuropathy and foot assessment plus education for people at low risk of foot ulcers, medication review , psychological and social review, care planning | service user record<br>National Diabetes Audit – service user experience survey<br>MIQUEST |
| 13. referral to Level 2 or Level 3 services according to service user's need, choice and agreed referral criteria | service user record<br>MIQUEST |
| 14. early review of service users discharged from Level 2 or 3 services | service user record<br>National Diabetes Audit – service user experience survey |
| 15. ongoing signposting as necessary eg, Diabetes UK | service user record |
| 16. referral for ongoing support for self-care eg, DESMOND, Expert service user programme | service user record |
| 17. offering women of child-bearing age contraceptive advice, referring to Level 2 when considering pregnancy | service user record |
| Practices will make arrangements to provide care for service users who are housebound or otherwise have difficulty attending the practice for appointments | service user record |

## APPENDIX 3

### Threshold service delivery outcomes (average for practice patient population)

80% of newly diagnosed type 2 patients offered DESMOND structured education in last year.

Increasing % of service users with type 2 diabetes have a care plan in the last year which
they have agreed with a healthcare professional in the Practice.

### Demonstration of achievement of standards

In order to demonstrate achievement of above threshold standards Practices will be required to:

- participate in the National Diabetes Audit
- participate in quarterly MIQUEST searches

## APPENDIX 4

## APPLICATION TO TAKE UP LOCAL ENHANCED SERVICE FOR INSULIN INITIATION FOR ADULT PATIENTS WITH TYPE 2 DIABETES

| **PRACTICE INFORMATION** | |
|---|---|
| Practice name | |
| Practice address | |
| Diabetes Lead GP<br>Contact telephone number /email | |
| Diabetes Lead Nurse<br>Contact telephone number/email | |

| **CONFIRMATION OF ELIGIBILITY** | |
|---|---|
| The Practice provides the full range of Core Primary Care for Diabetes as set out in Appendix 2 and meets threshold requirements stated in Appendix 3 | **Yes/No** |
| Percentage of newly diagnosed type 2 patients referred for structured education in the last year | |
| Percentage of patients with a care plan which they have agreed with a Health Care Practitioner in the Practice in the last year | |
| Percentage of patients with a care plan which they have agreed with a Health Care Practitioner in the Practice in the preceding year | |
| The Practice participated in the NHS Somerset CCG quarterly MIQUEST searches in the last year | **Yes/No** |
| The Practice participated in the National Diabetes Audit in the last year | **Yes/No** |
| The Practice agrees to have 2 healthcare professionals (GP and Practice Nurse) trained and accredited to provide the Insulin Initiation service and to release these staff for annual professional updating | **Yes/No** |
| The practice agrees to participate in Somerset Training Programmes on Diabetes Care once these become available | **Yes/No** |

| **Volume** | | |
|---|---|---|
| Anticipated number of patients requiring insulin initiation | Year 1 | Year 2 |

| **SIGNED FOR ON BEHALF OF THE PROVIDER** | |
|---|---|
| Name (block capitals) | |
| Signature | |
| Date | |

Please return by email to NHS Somerset CCG Enhanced Services at enhancedservices@somersetccg.nhs.uk.