

ADULT DIABETES SERVICE MODEL FOR DORSET

Core Principles

The overall aim of the Diabetes Services in Dorset is to ensure the provision of care to people with diabetes and their carers is:

- Comprehensive;
- Co-ordinated;
- High quality;
- Cost effective; and
- Integrated across primary care and specialist services.

This will be enabled by breaking down the “**artificial boundaries**” between Specialist and Generalist care, between health and social care, all of which get in the way of care that is genuinely co-ordinated around what people need and want.

To achieve a high quality integrated diabetes pathway in Dorset;

The Services shall:

- Provide an integrated, evidence-based diabetes pathway which delivers high quality care closer to home, improves outcomes, represents good value and is responsive to local needs, national guidance and policy.
- Reduce barriers to co-operation across the health economy so people are supported to access the care they need when they need it.
- Ensure all services achieve the high quality care set out in the Diabetes National Service Framework (NSF), NICE diabetes guidance and Quality Standards.

At all times the services shall ensure the provision of care incorporates the following general principles:

- People are individuals and have the right to dignity, privacy and independence.
- All those involved in providing the Services shall acknowledge and respect an individual's gender, sexual orientation, age, race, religion, culture, lifestyle and values.
- People shall be encouraged and enabled to exercise control over the services they receive.
- Services shall be supportive of people and their carers and empower individuals to be confident to self-care.
- Ensure that services are able to respond sensitively and flexibly to the patient's changing needs.
- Provide equitable access to services across Dorset.

Services shall support Self-Care and Patient Empowerment:

- Promotion of healthy behaviour through every interaction; as staff will be trained in behaviour change management and motivational interviewing.

- Joint care planning; individualised, collaborative personalised care plans.
- Offer of assistive technology to all people where clinically appropriate.
- Easy access to care advice, using standardised literature across the County.
- Support people to access Health and Wellbeing services in the community; smoking cessation, physical activity, weight management.
- Ensure that all carers are fully informed, involved, and valued, and that they receive the right support, at the right time in the right place.

Psychological Support

Up to 30% of people with diabetes can need additional psychological support. Many of these people are not clinically depressed but have disease distress requiring additional support. All people whom need access to mental health services will be able to access psychological support services such as 'Steps to Wellbeing', either self-referring or through a health professional referral.

Most people will not need this mental health service and will seek support from the professionals with whom they are in contact for their diabetes management. Therefore, it will be important to ensure that there are core competencies to adequately support people across the various disciplines and service both in primary and secondary care.

PRIMARY CARE SERVICE MODEL FOR DORSET

Roles and Responsibilities of Primary Care Services

GP's and predominantly Practice nurses shall act as care co-ordinators within their practice for the people with Diabetes. Care co-ordination is often the single most important role involved in the care of any individual person. This role will be key in supervising multidisciplinary care by bringing together the different specialists whose support the person's needs. The co-ordinator is also responsible for monitoring and evaluating the care delivered. The key co-ordinator of care will need to have a predominantly non-medical approach to supporting people to live healthier lifestyles and decrease their risk of complications of diabetes.

The anticipation is that up to 50% of Type 1 and 90% of Type 2 people with diabetes will have their care provided in primary care with support, if clinically indicated, from the Dorset Diabetes Care Service via virtual/real MDT meetings, telephone/email advice or consultation appointments. It is also recognised that specialist support will be required at different times for different patients throughout the course of their illness.

Each practice will have a nominated lead nurse and GP for diabetes care and participate annually in the National Diabetes Audit.

Primary Care will be supported by the Dorset Diabetes Care Service but all GP practices shall provide the following **core services**:

- Comprehensive annual reviews covering the 9 core care processes and 15 healthcare essentials (Diabetes UK). Retinal screening is not provided by primary care but primary care plays a key role in promoting uptake and the need for retinal screening. The routine testing of micro-albumin in every patient continues to be recommended based clinical judgement and individual patient need.
- Care plans for every person updated at least annually, promoting healthy behaviours/lifestyle. Onward referrals to public health initiatives to support healthy lifestyles will be considered.
- In year follow up agreed in line with individual's needs and their care plans.
- Foot examinations will document risk category in line with NICE Guidance, and this will inform need for more specialist services:
 - Ulcerated or Charcot
 - High risk (i.e. Have had an ulcer)
 - At increased risk (i.e. have not had ulcer but have an increased risk due to neuropathy, absent pulse etc.)
- People whom are at low risk of developing a diabetic foot problem, will as a minimum have annual foot assessments, emphasising the importance of foot care, and advising how to avoid progressing to moderate or high risk (as per NICE definition) should diabetic control be sub-optimum.

- All newly diagnosed type 2 people with diabetes will have an initial assessment and personalised care planning appointment within 4 weeks of presentation to primary care.
- All newly diagnosed type 1 people with diabetes will have a rapid initial assessment of treatment needs and referral to the Dorset Diabetes Care Service to agree a joint personalised care plan. It is expected that a significant number of these people will have their care provided within primary care with support from specialist services as needs change.
- Newly diagnosed people with diabetes will be referred into an educational programme within 6 months of diagnosis with access to a diabetes self-management refresher programme as and when clinically indicated i.e. in the event of poor control of diabetes, recurrent hypoglycaemia etc. Patients should always be given the appropriate information and advice to enable them to make an informed choice as to when to attend an educational programme, as their readiness to attend will differ dependant on their individual needs.
- Annual follow up of all women who have had gestational diabetes, due to their high risk of developing Type 2 diabetes (in line with NICE guidance).

Preconception advice

- Women of child bearing age with diabetes will be supported to understand the benefits of pre-conception glycaemic control and of any risks, including medication that may harm an unborn child. NICE guidelines recommend explaining to women with diabetes who are planning to become pregnant that establishing good blood glucose control before conception and continuing this throughout pregnancy will reduce the risk of miscarriage, congenital malformation, stillbirth and neonatal death.
 - Plans should be developed in primary care to refer into structured patient education programmes, especially for women with Type 2 diabetes. The programmes should cover the risks of pregnancy, and how to prepare for pregnancy.

Women with diabetes should plan pregnancy. The problems/risks associated with diabetes in pregnancy should be explained.

The key things to be discussed at annual review for women with diabetes planning pregnancy include:

- Dietary and lifestyle information
- Folic acid supplements
- Signposting to further information and peer support
- Any Women whom are actively planning pregnancy will be referred to the Specialist Service for support/advice.
- Wider management of CVD risk for people with diabetes:
 - pulse checks for all people over 45 years;
 - For Type 1 & 2 diabetics lipid modification treatments in line with NICE guidance will be considered following QRISK2 risk assessments; and

- Breathlessness assessments for all people over 65yrs. For those that are assessed as being in Class II or above (New York Heart Association breathlessness scale, or equivalent), consideration of Brain natriuretic peptide (BNP) testing.
- Consideration will be given for a referral to an appropriate weight management programme up to and including Tier 3 and potentially bariatric surgery on successful completion of such a programme.
- People with diabetes at end of life will have an Anticipatory Care Plan, enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing (see additional reference below for EOL care).
- The Practice lead GP and nurse for diabetes will undertake regular audit of clinical care using the Diabetes PRIMIS tool and develop an annual improvement plan. Advice and feedback from the Dorset Diabetes Care Service will inform practice plans.
- Case finding of people at risk of developing diabetes will be undertaken as a minimum on an annual basis. PRIMIS will be used, in order to identify those people where a referral into the local Diabetes Prevention Programme is appropriate.
- An annual audit of practice prescribing will consider adherence with the Dorset CCG formulary and optimal medication management e.g. glucose meters, testing strips.

Core Skills in Each Practice:

- Diabetes diploma held by lead practice nurse for Diabetes within each practice or clinical oversight/support sourced from another practice within locality.
- All nursing staff involved in annual reviews including Health Care Assistants (HCA's) to undertake foot care training face to face 3 yearly, with yearly online updates www.diabetesframe.org.
- All new nursing staff involved in annual reviews including HCAs to undertake the web based foot care training as part of their induction.
- All Practice nursing/HCA staff involved in peoples annual reviews to attend yearly educational update delivered by the Dorset Diabetes Care Service.

Additional/Networked Primary Care Services

Due to the variation in the number of people with diabetes in each practice and taking account of the of new models of working across primary care it may be cost and clinically effective for practices to network to deliver the following **additional/networked primary care services**. Whether a

practice provides alone or in conjunction with other practices people with diabetes should have access to the following at a practice level:

- Insulin/GLP1 initiation within each individual practice by either the practice nurse or a locality practice nurse, with support from more specialised services if clinically indicated.
- Support for medicines optimisation where there are poly-pharmacy issues as well as more complex diabetes medicines.
- Annual reviews and treatment plans for housebound people with diabetes who reside in residential/nursing homes or their own homes.
- A service which targets hard to reach/engage people i.e. non-ambulatory, Mental Health/Learning Disability and Transient population.
- A service able to access and provide higher level motivational interviewing skills to support more complex patient care.

Practices will ensure that new staff have a comprehensive induction and have access to a primary care focused diabetes induction led by a practice nurse, with a diabetes diploma which covers the core roles and responsibilities listed above.

End of Life Care.

The Locality Integrated Team supports people at End of Life. Diabetes is the most common metabolic problem in our ageing society and it will be important to ensure that the core competencies of these teams include diabetes care. The lead practice nurse for diabetes and the patient's care co-ordinator may or may not be the same person.

People with Diabetes whom are on End of Life Care are particularly susceptible to infection and diabetic foot disease. These individuals will have their care co-ordinated and managed via a cohesive Multi-disciplinary approach and to inform the appropriateness of interventions.

Specialist Diabetes
Care Services -
Provision of a Single
Countywide
Networked Service for
Dorset

Roles and Responsibilities of the Dorset Diabetes Care Service

The role of the specialist service will increasingly be about system leadership of the Dorset Diabetes Care Services across Dorset, whilst using their expertise to help develop the confidence and competence of other health and social care professionals involved in supporting people with diabetes through working collaboratively to enhance peoples care in the community.

The Service shall provide an integrated approach to the management of diabetes. Integrated care by its definition requires all professionals involved in a person's care to work in partnership, including generalists, specialists, allied health professionals, social care, third sector and support staff with the person living with diabetes and his/her family at the centre of their care.

The Service shall place priority upon developing robust systems of communication between existing diabetes specialist services to ensure that people are effectively managed and risk is reduced and the predominant provider of diabetes care, Primary Care, is well supported.

The Service will offer specialist advice, education and training to health professionals in Primary Care diagnosing and treating people with diabetes.

The Service will be clinically led, with consultant, specialist nursing and allied health professional support. The consultant lead must be suitably qualified to lead a NHS Diabetes service.

The Service will steer the personalised care planning agenda for people with diabetes and ensure relevant services are aware of its development e.g. ambulance services.

The Service will hold a clinical caseload and will assist and support primary care clinicians in optimally managing people with Diabetes. It is expected that no more than 50% of Type 1 Diabetics and 10 % Type 2 Diabetics in Dorset will be managed in specialist services. It is recognised that specialist support will be required at different times for different patients throughout the course of their illness. It is envisaged that it will take time to move toward this position as patients transition back to primary care with support.

A Single Countywide Networked Service for all Specialist Services will provide:

Leadership

- Provide annually, Primary Care Diabetes Update Event in 3 venues across the County covering best practice, new NICE guidance, foot care, dietetics and other priorities set by commissioner. The update should be based on the principles of shared learning.
- Provide 3 times a year, Diabetes Introduction to Care Programme for new primary care staff, covering patient care planning, motivational interviewing and behavioural change.

- Provide an education programme to support core competencies in the management of diabetes for the following teams:
 - Integrated health and social care teams e.g. District nurses, Community Matrons;
 - Community Mental Health Teams, Learning Disability Teams;
 - Psychiatric Inpatient Teams;
 - Intermediate Care Teams;
 - Community hospitals;
 - pre-assessment services;
 - Staff in residential and nursing care homes, domiciliary care agencies.
- Identify, source or provide standardised diabetes information and literature for use by all practices and the whole service; available on the internet and updated at least annually.
- The Service will emphasise the importance of early diagnosis, self-management and personalised care planning. GPs, practice nurses and community staff will be supported to make personalised care planning a key component of managing any person with diabetes.
- The Service will offer consistent advice and guidance to both health professionals and people with diabetes and their carers at all times.
- The Service will work with the primary care Locality Integrated Team to support people with diabetes at End of Life.
- The Service will provide primary care staff with education and support to enable them to recognise the impact that emotional and psychological complications can have on people with diabetes and their self-management. Primary care staff will be supported to have the skills enabling them to ask sensitive questions, identify and provide care for the emotional and psychological needs of people with diabetes to an appropriate level.

Integrated Services with Primary Care

- The Service will ensure primary care is fully aware of services available to people with diabetes, such as the diabetic foot services and dietetics service, and how to access them.
- The service will ensure all members of primary care are familiar with the programmes of patient education available locally, and that these programmes are integrated with the rest of the care pathway (see more detail below).
- The Service will provide a single point of access 7 days per week for urgent and routine referrals and advice with 24 hour response times; via telephone or email.
- The Service will triage all referrals from primary care and assign to correct pathway within the Dorset Diabetes Care Service resulting in:
 - Referral returned to primary care with advice,

- Diabetic Nurse Specialist (DNS) shared care with practice,
 - Virtual clinic MDT with Practice,
 - Telephone advice and guidance,
 - Consultant led clinic for;
 - Antenatal diabetes;
 - People with associated renal disease;
 - People with foot ulcers;
 - People with unstable Type 1 and Type 2 diabetes;
 - Transition clinics for adolescents;
 - Insulin pump clinics;
 - Diabetes new patient education programme or refresher programme,
 - Other relevant professional i.e. podiatrist.
- Individuals care will be co-ordinated to ensure they are seen by the right professional, in the right place, in a timely manner.
 - Individuals will be discharged from specialist care and the discharge information will be shared with the person with Diabetes and GP and include future management plan and indications for re-referral.
 - Every GP practice will be offered an annual visit by the consultant to update on best practice, and promote other services available to support diabetes management e.g. foot care pathway, dietetics etc.
 - The Service will ascertain which GP practices have high referral and / or emergency admission rates for diabetes, and work with the locality to reduce avoidable admissions.
 - A locality report with key learning points will be provided annually to the locality to inform their service improvement plans.
 - One to one support will be provided to every practice for complex people through either telephone, virtual clinics or joint clinics; with the practice nurse and person with diabetes.
 - The Diabetes Nurse Specialists will support practices as required and agreed in the management of complex people and use every opportunity to support comprehensive foot care assessment competencies.
 - The Service will support GP practices to educate people with diabetes on current best practice and self-management.
 - The Service will be proactive in contacting practices, understanding their diabetes caseload, identifying their skill gaps and training needs, and ensuring the clinician education programme meets primary care needs.
 - The Service will liaise with the locality and primary care clinicians who are referring people that could be managed in primary care, and feedback to the referrer and provide relevant support to assist change in the practice.
 - 'One stop shop' appointments will be offered where possible.
 - The Service will agree with practices those people where the majority of their care is within specialist services or where the person has not fully engaged with primary care. For these people appointments will include annual diabetes checks including foot care assessments, CVD risk assessment and provide appropriate support and guidance for self-care and engagement with primary care. These assessments will be communicated in a prompt and timely manner to primary care.

- The Service will provide joined up specialist pre-conception and pregnancy services for women with diabetes, including direct referral to specialist antenatal service with appropriately skilled staff.
- The Service will provide comprehensive foot care within 24 hours of referral, to people presenting to a health or social care professional, with new or deteriorating diabetic foot disease (see more detail below). On presentation with a foot care emergency the following care should be provided as appropriate to individuals:
 - Initial assessment by an appropriate member of the specialist multi-disciplinary team.
 - Investigation of suspected foot infection.
 - Management of foot infection.
 - Debridement, dressings and off-loading.
 - Assessment of suspected limb ischemia.
- The Service will ensure multi-disciplinary reviews of people with complex diabetes to include; podiatrists, orthotists and consultant specialists in diabetes, vascular, radiology, microbiology.
- The service will work in partnership with Dorset Diabetic Eye Screening Programme to ensure that all people living with diabetes that are eligible are offered and encourage uptake of the annual screening programme for Diabetic Retinopathy.
- The Service will seek to influence and support reducing emergency hypo/hyper glycaemia occurrences and conveyances to hospital and adopt national and local best practice pathways.
- Identify the appropriate service to follow up people who have had hypo/hyper glycaemia occurrences will be agreed with individual practices.
- The Service will in-reach into secondary care for diabetes related emergency admissions and support effective timely discharge.
- The Service will support practice nurses to identify people whom would benefit from consideration for bariatric surgery after Tier 3 weight management programme/NHS Diabetic Prevention Programme has been successfully completed.
- The Service will ensure that a record and audit trail is kept of the information exchange between the service and health care professionals. Advice given verbally will be followed up in writing, either by email or letter depending on the preference of the requester. If the requester is not the GP, the GP should be copied in to the correspondence. The Dorset Shared Record will form the basis of information sharing.
- The Service will work with the local Medicines Management team to ensure cost-effective prescribing of diabetes related treatments, in particular the use of blood glucose testing strategies in people with Type 2 diabetes. It is expected that the Diabetic Nurse Specialists, particularly those individuals working with more complex people, will have nurse prescribing competencies, with access to supervision and updates as dictated by local Trust policy and guidelines.

Psychological Support

The service will ensure that there are core competencies to adequately support people across the both primary and specialist services.

- All elements of the service will be skilled in providing motivational interviewing and behavioural change;
- The Dorset Diabetes Care Service will be able to offer assessment and higher level support for more complex people;
- The Dorset Diabetes Care Service will have a workforce that can train and develop their own and primary care staff;
- Services will be able to access more intensive psychological support directly without requiring people to go through all steps of the Steps to Wellbeing pathway;
- There will be a lead professional within mental health services who is able to provide advice and guidance for a small minority of people with bulimia, anorexia nervosa and insulin dose manipulation.

Patient Diabetes Education Programme

The Service will ensure people with diabetes and/or their carers can access a structured educational programme that meets the nationally best practice guidance:

- A new patient education programme; and
- A diabetes self-management refresher programme.

The following courses will be delivered by the Dorset Diabetes Care Service, it is expected that the same courses will be provided across Dorset and will be led by a Diabetes Nurse Specialist and/or Dietician.

- Type 1 diabetes - BERTIE programme:

Capacity for 120 per year

- Type 2 diabetes - DESMOND programme

Capacity for 2,300 per year

- The service will lead the delivery of a diabetes self-management refresher programme delivered in conjunction with the third sector

Capacity for 600 per year

Type 1 Newly Diagnosed Patient Programme

- The service will offer all people with Type 1 diabetes the commissioned structured education programme no later than 6–12 months after diagnosis. Patients should always be given the appropriate information and advice to enable them to make an informed choice as to when to attend an educational programme, as their readiness to attend will differ dependant on their individual needs.

People with Type 1 diabetes who have not accessed a programme by 12 months after diagnosis, should be offered access to the programme at any time that is clinically appropriate and suitable for the individual.

The Programme will be:

- Delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the person, and who are trained and competent to deliver the principles and content of the programme.
- Programmes will work within the over-riding principles of supporting self-management/personal goal setting.
- Diabetes Education information will be consistent across the programme and include information recommended by Diabetes UK. This information will be available on the internet and reviewed annually.
- Quality assured, and reviewed by trained, competent, independent assessors who measure it against criteria that ensure consistency. i.e. QUISMET
- Audited annually and compared to national benchmarks.
- Providing information about Type 1 diabetes and its management to people from diagnosis onwards, following the principles in NICE guidelines on patient experience in adult NHS services.
- Considering the Blood Glucose Awareness Training (BGAT) programme for people with Type 1 diabetes who are having recurrent episodes of hypoglycaemia, and refer to Wessex Hypoglycaemia Pathway.
- Delivered in different venues and provision of evening/weekend programmes to allow ease of access for people whom work throughout office hours.
- Encourage carers/spouses/partners to attend, in particular when they have caring responsibilities.

Type 2 Newly Diagnosed Patient Programme

The service will offer all people with Type 2 diabetes the commissioned structured education programme 6–12 months after diagnosis.

People with Type 2 diabetes who have not accessed a programme by 12 months after diagnosis, should be offered access to the programme at any time that is clinically appropriate and suitable for the patient.

People with Type 2 diabetes who would benefit from repeating the programme, should be offered access to the programme at 5 yearly intervals.

The Programme will:

- Be delivered by trained educators who have an understanding of education theory appropriate to the age and needs of the programme learners, and are trained and competent in delivery of the principles and content of the programme.
- Programmes will work within the over-riding principles of supporting self-management/personal goal setting.
- Information will be consistent across the programme and include information recommended by Diabetes UK. This information will be available on the internet and reviewed annually.
- Be quality assured, and be reviewed by trained, competent, independent assessors who assess it against key criteria (i.e. QUISMET) to ensure sustained consistency.
- Be audited annually and compared to national benchmarks.
- Ensure the education programme provides the necessary resources to support the educators, and that educators are properly trained and given time to develop and maintain their skills through refresher training/supervision.
- Be group based but offer the opportunity for limited one/one discussions/support.
- Ensure the education programmes available meet the cultural, linguistic, cognitive and literacy needs for individuals in Dorset.
- Ensure education is delivered in different venues and provision of an evening/weekend programmes to allow ease of access for people whom work throughout office hours.
- Encourage carers/spouses/partners to attend, in particular when they have caring responsibilities.

The Service will seek to develop aspects of the Programme that can be placed on the internet in a more interactive way for people to access who are unable/reluctant to attend a group programme.

Diabetes Self-Management Refresher Programme

The Service will offer at a variety of venues across the county a diabetes refresher programme. It is expected that this will be delivered in conjunction with the third sector and that people with diabetes and their carers contribute to the design and update of the Dorset programme.

The Service will seek to develop aspects of the Programme that can be placed on the internet in a more interactive way for people to access who are unable/reluctant to attend a group programme.

Dietetics

A dietetics service is commissioned from a range of Providers to give evidence based advice for both adults and children, assessment and treatment regarding food, nutrition and diet for the promotion of health, prevention of disease and for the diagnosis, treatment and management of nutrition-related disorders.

The dietetics service promotes self-management of health and wellbeing, contributing to the aims of the long term conditions management teams in reducing exacerbations and preventing unnecessary use of hospital services.

The Dorset Diabetes Care Service will ensure that specialist dietetics advice will be incorporated into their training offer for clinical staff.

The Dorset Diabetes Care Service will ensure timely access to dietetics services for people with Type 1 and 2 diabetes.

There will be dietetics services for people with diabetes delivered on a locality or supra-locality/cluster or sub-cluster basis supporting self-management and care.

Services will include:

- Advice and guidance for people pre and post conversion to an injectable therapy.
- Advice and guidance to individuals or groups:
 - who have concerns regarding glycaemic control
 - with unexpected/unwanted weight loss
 - who are overweight and wish to lose weight who are on medication that may result in hypoglycaemia

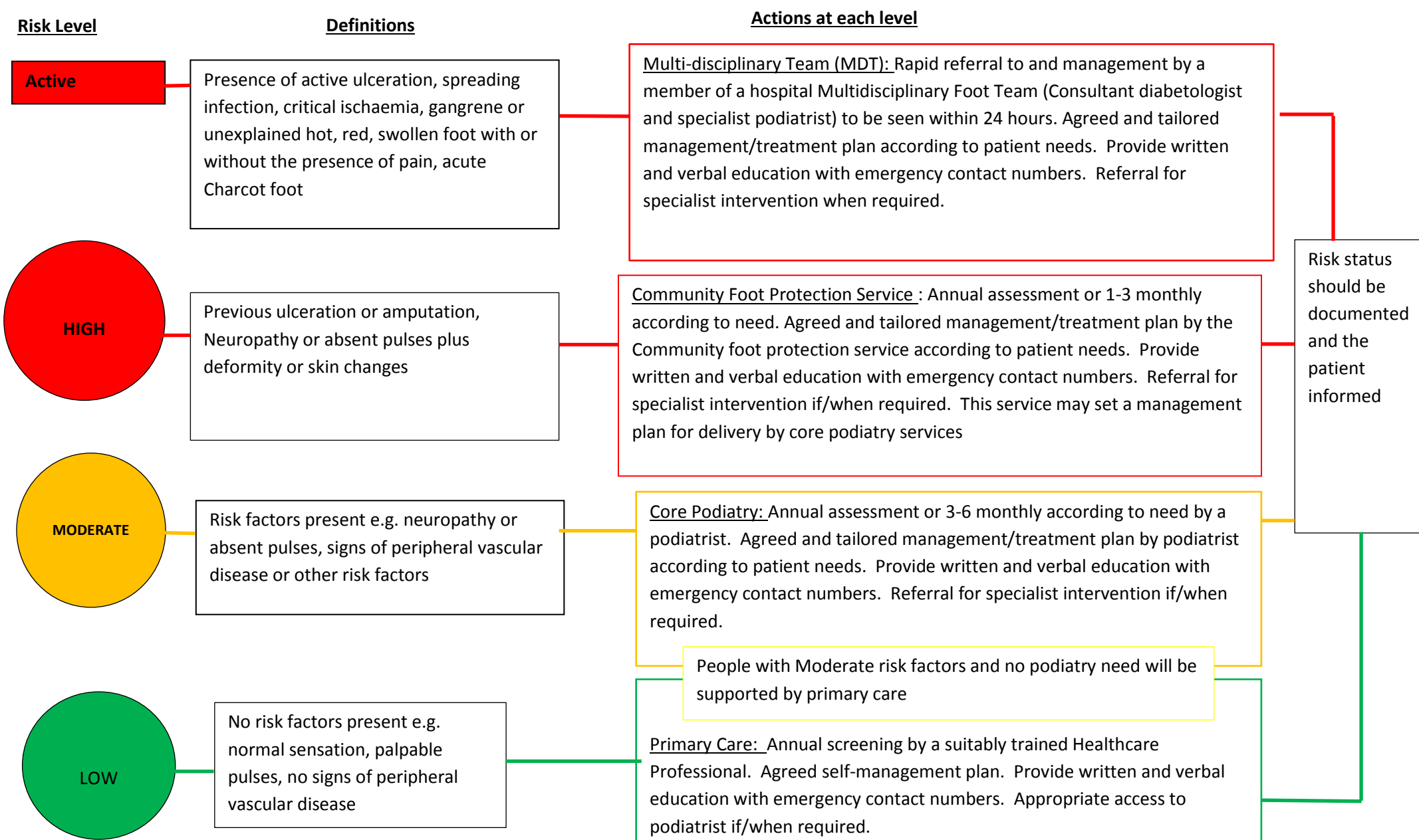
A core component of the Service will to support the development of the skills and confidence in primary care required for the intensification of glycaemic control including supporting insulin and GLP1 initiation.

Comprehensive Diabetic Foot care - Prevention and Management of Diabetic Foot complications.

Diabetes is the most common cause of non-traumatic limb amputation. Comprehensive foot care will be an integral part of specialist diabetes services.

There will be a full spectrum of foot health care services available to people in Dorset. The care to be provided is dependent on risk, progression and severity of a person's condition. The appropriate care and who should perform and be involved in that care should be based on a risk assessment. Referral and transfer of care will be integral to ensure care for people is appropriate as their risk of foot complications increases or decreases. The passage of a person's care will minimise handovers

between services and ensure collaboration. The diagram below details the risk levels of people and where people will receive their care:



1. **Primary Care** management is **not** the function of the Dorset Diabetes Care Service but will support people to self-care and annually assess foot care risks;
2. **Core Podiatry** is **not** a function of the Dorset Diabetes Care Service but will support care for people within the above spectrum with an emphasis of community delivery of services for general practice (and in exceptional circumstances domiciliary) and preventative treatment. Core podiatry is defined as '*the assessment, diagnosis and treatment of common foot pathologies associated with the toenails, soft tissues and the musculoskeletal system with the purpose of sustaining or improving foot health*' (Farndon 2006) This service is focused on the needs of those with low and medium levels of foot health need with referral on to specialised podiatry and extended scope podiatry and signposting to non-podiatric services where clinically appropriate. The Core Podiatry service will provide the following:
 - Treatment of corns, calluses and fissures
 - Metatarsalgia (as per foot and ankle pathway)
 - Treatment for acute bacterial and fungal infections of the foot
 - Toenail deformities
 - In-growing toenails, very thickened toe nails, involuting nails
 - Management and control of pedal ulcers
 - Foot health education
 - Services to people with diabetes who are not high risk and have podiatry needs

The service has the following exclusion criteria:

- Nail cutting for people with normal nails and who have no pathology affecting the feet.
- Nail cutting for those who cannot manage and have no carer or support worker
- People with diabetes, PVD, RA who are classed as low risk (those who have a good blood supply, including good nerve sensation and who have no podiatry needs).
- People with diabetes and classed as having an increased risk and who have no podiatry need.

Foot Care Service Provided by the Dorset Diabetes Care Service include:

- Community foot protection services
- Multidisciplinary Diabetic Foot Care Team (MDT)

Community Foot Protection Services

This diabetic foot protection service will support preventing diabetic foot problems, and treating and managing diabetic foot problems in the community. This will be closely integrated with the core community podiatry service. The need for good foot care and the necessary interventions are summarised in the Diabetes UK 'Putting Feet First' document. The Service will work to the guidelines and pathway set in this document.

The service to people with diabetes will consider:

- Frequency of review
- Need for vascular assessment
- Evaluate footwear
- Provide enhanced foot care education

Referrals will be accepted from podiatrists and the hospital MDT Team. Occasionally GPs will refer people who have moved into the area and have a healed ulcer or amputation and need follow up within the foot protection service but do not require a consultation within the hospital MDT.

The service will ensure:

- Education sessions are made available annually to primary and community professionals on the examination, treatment and care of the diabetic foot.
- Provide a single point of contact for community and primary care professionals to request advice and guidance related to the care of people who have been under the care of the community diabetic foot protection service.
- Meet the needs of people with diabetes who have had previous ulceration, amputation or more than one risk factor present which identifies their feet as being at 'high risk e.g. loss of sensation, signs of peripheral vascular disease with callus or deformity (in line with NICE guidance).
- The Service may identify people who have healed ulcers for more than a year where they can be managed within podiatry services with robust support arrangements with the foot protection team.
- The Service will meet the needs of non-ambulatory people unsuitable for transport services.
- When a patient is identified as suitable for transfer from the MDT clinic for ongoing care and support a transfer timescale will be mutually agreed but no longer than 6 weeks and will ensure continuity of care.
- When a patient is identified as suitable for transfer from the core podiatry service for ongoing care and support a transfer timescale will be mutually agreed but no longer than 6 weeks and will ensure continuity of care.
- All other referrals will be triaged within 3 days.

The Service will not see:

- People with a presenting problem at the ankle or above

The desired outcome for this service is to:

- Prevent or delay the foot complications of diabetes, including peripheral neuropathy, peripheral arterial disease, gangrene and limb loss from amputation.
- Reduce recurrence of ulcers and complications in those who have had an episode of active foot disease.

Multidisciplinary Diabetic Foot Care Team (MDT)

A multidisciplinary foot care service for managing diabetic foot problems in hospital and in the community that cannot be managed by the foot protection service.

- There will be two Multi-Disciplinary hospital sites, operating 5 days per week, 52 weeks per year with 24 hour urgent care access for Charcot's and newly ulcerated feet. These sites will be integrated with vascular networked services.
- One site will provide a weekend MDT service 52 weeks per year for urgent new referrals; aligned with vascular emergency services. Repatriation/transfer of people to their locality site MDT for ongoing care will take place at the earliest opportunity. The transfer of care between services should feel seamless for people.

There will be robust protocols and clear local pathways for the continued integrated care of people with diabetes across all settings, including emergency care and general practice.

The service will annually audit treatment and individuals outcomes, in line with the National Diabetes Foot Care Audit.

Orthotics services are commissioned and covered by a separate service specification. These services accept referrals from both primary and secondary care.

Insulin Pump Clinics.

The Service will identify those people suitable for insulin pump assessment. The Service will provide an effective, efficient and appropriate insulin pump therapy service in line with NICE guidance, providing expertise in the treatment of people on insulin pump therapy. The service will support children to transition to adult services in a co-ordinated way.

The Service will work collaboratively with people, enabling individuals to get the best out of their insulin pump therapy and support them to self-manage, optimising diabetes control. The Service will support care as close to home as possible and home delivery of consumables.

The service should be delivered by a multi-disciplinary team with access to specialist skills from:

- A diabetologist with a specialist interest in insulin pump therapy
- A Diabetes specialist nurse
- A Dietician

The service should deliver a structured education programme covering:

- Necessity for regular self-monitoring of blood glucose
- Advice on diet, lifestyle and exercise appropriate for people using insulin pumps
- Changing from injections or pen to pump use
- Setting up the pump consumables to correctly administer insulin
- Setting of varying basal rates in accordance with patient needs
- Delivery of bolus insulin for meals
- Insertion of cannula to deposit needle under the skin
- Calculation of the glycaemic index for carbohydrate values and necessary insulin
- Awareness of gastro-paresis where people will need insulin dosage spread over a number of hours
- The indications for early removal of the infusion site, ketosis, absorption rates and infection risk
- Appropriate infusion sites
- Basal rate increases in accordance with blood glucose readings due to illness

- Practical issues such as sleeping and bathing with the pump, wearing the pump, changing batteries etc.
- How and where to contact the manufacturer in the case of technical difficulties

Provision of Children and Adolescent Transition Clinics.

Caring for young people with diabetes is a complex process which must be firmly focused on the young person and their family and other carers supported by health care professionals who have skills and expertise in all aspects of diabetes management. NICE guidelines recommend that young people with Type 1 diabetes should be offered an ongoing integrated package of care by a multi-disciplinary paediatric diabetes care team; this includes smooth transition from paediatric to adult services.

The Transition Clinic primary role is to enable **“planned, purposeful movement of the young person from a child centred to an adult orientated health care system”**. It is a process which evolves over an **“individualised, needs specific”** period of time.

Transitional care is a multi-dimensional, multi-disciplinary process that addresses not only the medical needs of young people as they move from a children’s service to a young person’s services but also their psychosocial, educational and vocational needs and the needs of their parents.

The core aims of the transition service will be to:

- Provide high quality, co-ordinated, uninterrupted health-care that is patient-centred, age and developmentally appropriate and culturally competent, flexible, responsive and comprehensive with respect to all persons involved.
- Facilitate transfer from paediatric to adult services which will predominantly be within Primary Care, unless clinically indicated and intensive support is required from the specialist team.
- Promote skills in communication, decision-making, assertiveness and self-care, self-determination and self-advocacy.
- Enhance the young person’s sense of control and move towards independence.
- Provide support for the parent(s)/guardian(s) of the young person during this process.
- Maximise lifelong functioning and potential.
- Offered in a range of community locations, at times that are flexible to the young person with diabetes and parents, i.e. outside school/office hours.

The Service will develop mechanisms by which they support the paediatric diabetic services in delivering the transition service for teenagers with diabetes.

Renal

People with diabetes develop renal impairment both as a direct result of diabetes related pathology and also due to renovascular disease for which diabetics carry an increased risk. Active management of this problem is needed for four reasons.

- It is important to exclude primary or secondary renal disease unrelated to diabetes
- Optimal management of glycaemia and blood pressure prevents or slows deterioration and therefore prevents future morbidity.
- People with diabetes with renal impairment have a significantly increased cardiovascular risk which needs to be actively managed.
- People with severe or progressive renal impairment may need renal replacement therapy. Optimal management requires assessment of these people by a nephrologist at least 2 years before renal replacement is likely to be needed.

The Service will develop a pathway of shared care for these people. This will be led by a consultant diabetologist. The diabetologist will consult with a consultant nephrologist when appropriate and will ensure that the patient is seen by the nephrologist when clinical circumstances require this. Care will be shared between the diabetologist and nephrologist. The Service will support an integrated approach to care and thereby avoid unnecessary attendance at hospital by the patient.

Pregnancy Diabetes Care

The Service will develop mechanisms to support the obstetric service for women who have diabetes.

Specialist Support for Inpatient Service

Acute hospitals and a number of the community hospitals will require specialist diabetes support for in people who are admitted for diabetes care or who develop an acute condition which is related to diabetes. The specialist service will need to actively support the management and care for these people as inpatients, at discharge and where appropriate rapid access to outpatients and community care.

Joint specialist outpatient clinics or joint written care plans will be required with:

- Maternity services
- Paediatric to adult transition (including insulin pump therapy)
- Moderate/severe renal disease (GFR<30)

Inpatients

People with diabetes admitted to hospital for any reason should have their diabetes managed correctly. This may include amongst other measures:

- Education of nursing staff throughout the trust on the safe management of diabetes, insulin and footcare.
- Education of medical staff on the management of diabetic emergencies. Written protocols to be available on wards and other clinical areas.
- Diabetic Nurse Specialist routine review of individuals admitted to hospital for other reasons. DNS to be available for advice to wards and departments.
- Podiatry advice to wards for people with diabetes.

