Service	**LN014 - Diabetes Specialist Nursing**
Commissioner Lead	**Lancashire North CCG**
Provider Lead	**Head of Therapies**
Period	**1 April 2017 – 31 March 2019**
Applicability to Module E	**No**

1. Purpose

Overall principles

- These services are commissioner led. Any significant changes proposed by the provider to the service will be discussed and agreed with the commissioner prior to implementation. Minor changes or temporary changes to accommodation operational issues should be notified to the commissioner as part of the service issues log discussed at the contract meetings.
- The provider is expected to engage with the commissioning body/bodies in all instances of service development or anticipated re-design consultations for the benefit of service delivery across the whole health community.
- The provider is expected to comply with all commissioner policies regarding demand management
- The provider is expected to provide representation on all relevant working or commissioning groups as appropriate.
- The provider is expected to participate in surge planning as part of the wider Health Economy response to pressures throughout the year, whether those pressures are anticipated or unplanned and be prepared to deploy the workforce flexibly where this is indicated. The provider will be expected to notify the commissioning body and key Health Economy stakeholders of agreed levels of escalation. Unforeseen surges in activity as a result of escalation in the health community will be discussed at contract meetings and alternations to activity profiles reviewed.

1.1 Aims

The Adult Diabetes Specialist Nursing Service aims to provide education, clinical care, psychological and emotional support to people with diabetes at significant points in their life. To play a lead role in primary care development and improvements in clinical standards through the delivery of Practice/community support and education.

1.2 Evidence Base

- The Diabetes Nursing Strategy Group (2005) the Integrated Career and Competency Framework for Diabetes Nursing. SB Communications Group, London
- A Professional Toolkit for Nurses Working in Diabetes Care (2005). Eds: Debbie Hicks, Mike Smith, Christine Skivington. Practical Diabetes International, London
- Skills for Health Competence Application Tools (related to Diabetes Care)
- RCN (2004) Adolescent transition care: guidance to nursing staff
- National Service Framework for Diabetes: Delivery Strategy (2002)
- The National Service Framework for Diabetes:(Standards 2001)

1.3 General Overview

The Adult Diabetes Specialist Nursing Service will provide a community based diabetes service which will provide an intermediate level of care supporting the provision of diabetes in primary, community and secondary care settings. Clinical leadership and mentorship will be provided by Consultant Diabetologists and GP's with a special interest in diabetes. The service will support the delivery of the National Service Framework for Diabetes:

Standards (2001), related NICE guidance and the Care Quality Commission (CQC) Essential Standards of Quality and Safety.

The team does not generally provide routine or continuous diabetes monitoring or care; this is carried out within primary care by the GP and the Practice Nurse or in secondary care via the diabetes clinics led by the Diabetes Consultant. However, the service will take a lead on improving diabetes care within primary care practice, in partnership with clinical leads and other appropriate health professionals. The service will delivery and support a range of educational events and training to ensure the on-going personal development for practice and community staff.
The service will also provide a rapid access telephone line for professionals who need urgent advise about patient management

1.4 Objectives

The objectives of the Adult Diabetes Specialist Nursing Service are:

- To deliver, and continue to improve upon, optimum quality of primary, community and specialist diabetes healthcare provision for the population, which will in particular meet the National Service Framework (NSF) for Diabetes, Care Quality Commission (CQC) Essential Standards of Quality and Safety and the specific recommendations set out in Diabetes NICE Guidance.

- To provide a timely and responsive diagnosis, treatment and management support of all patients referred using the identified referral criteria to access the diabetes specialist nursing service

- To promote ease of access to the Adult Diabetes Specialist Nursing service through the delivery of the service from key sites across the community

- To provide individualised care plans based on evidence based interventions to support the patient to achieve personal goals to improve their health outcomes

- To promote emotional health and well-being through supporting the patient during the course of their treatment / care management plan

- To promote cost effective management of patients with long term / chronic conditions in a primary care setting, with access to a specialist as required to plan overall care, with ongoing management within a community setting, where appropriate

- To support partnership between primary, community and specialist care clinicians, building upon the existing high quality capacity and expertise within primary care so as to minimise onward referral where possible, and provide an alternative referral option for patients who can be managed appropriately in the community

- To provide ongoing education for all healthcare professionals involved with the provision of Diabetes Services in the wider community. It is envisaged that this will include collaborative working with the Community Nutrition & Dietetic team, Clinical leads and Commissioners to deliver specified planned activities including formal training sessions, and referral review. This may include the facilitation of external or bespoke training events as identified by the strategic group and on-going needs assessment.

- To provide support for individual practices in reviewing and managing patients with diabetes, establishing a rolling programme of practice visits, supporting patient reviews if deemed appropriate as part of staff education and training.

- To participate as active members of the CCG Diabetes strategic group, offer professional advice, support and co-operation in the development and implantation of the local strategy and action plan.

- Support the delivery of 4 DAFNE patient structured education programmes within a 12 month period, assessing patients for appropriate referral onto the course. Work with Cumbria Diabetes to establish good local networks for delivery of DAFNE. Each course must be delivered by a DAFNE trained DSN and a dietician.

1.5 Expected Outcomes

The expected outcomes of the Adult Diabetes Specialist Nursing Service are:

- Access to flexible and expert specialist nursing service at times of need within agreed time spans
- Education and support to enhance effective self management/care
- Education and support to develop patient empowerment
- Reduction of acute and long-term diabetes related complications
- Joint working with other members of the multidisciplinary team and wider health and social care partners

Holistic care encompassing evidence-based best care practice including advances in care or new treatments

2. Scope

2.1 Service Description

The Adult Diabetes Specialist Nursing Service is community based diabetes nursing specialist service with strong working links to Primary Care, Diabetes Consultants, Podiatry, Dietetics and Retinal Screening to provide a multidisciplinary approach to diabetes care.

This Service will link with primary, community and secondary care healthcare providers to promote a seamless service to meet patient needs.

The Service will contribute to achieving the standards for diabetes care described within the National service Framework: Diabetes (2001)

2.2 Accessibility/acceptability

The Adult Diabetes Specialist Nursing Service will be accessible by all patients who meet the Referral Criteria regardless of ability, cultural background, ethnicity and sexuality.

The Service potentially can have contact with any adult or young person over the age of 16 yrs with diabetes living in Lancashire North CCG Locality at some point during the person's life with diabetes.

The Service will be a point of contact for GP's, Practice Nurses, Secondary Care, Community and other Health Professionals who wish to avail themselves of the Diabetes Specialist Nurses expertise.

The Provider will 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).

2.3 Whole System Relationships

The key relationships of the Diabetes Specialist Nursing Service are:

- Diabetes Multidisciplinary Team for both adults and children
- Diabetes Leads/Commissioners for Lancashire North CCG
- University Hospitals of Morecambe Bay
- Management team and support services
- Primary and Community Clinical Care Teams
- Secondary/Tertiary Care Medical Staff, Urgent Care, Outpatient and Ward Nursing Staff
- Prison Healthcare
- Residential institutions

2.4 Interdependencies

The Adult Diabetes Specialist Nursing Service has interdependency with community-based healthcare teams and secondary care specialist teams to support multi-disciplinary care for patients with complex needs including the Voluntary sector e.g. Diabetes UK

2.5 Relevant networks and screening programmes

NHS North Lancashire Diabetes Strategic Planning Group

2.6 Sub-contractors

None

3. Service Delivery

3.1 Service model

The key functions of the Diabetes Specialist Nursing Service are:

- Nurse-led clinics to provide patient and carers with intensive periods of clinical care, education and psychological support at times of difficulty or life changes, evolution of diabetes, development of complications, need for treatment change. These are delivered at various places including in-reach into prisons.
- Collaborative working with consultants using a parallel clinic system to improve direct communication and consultation between professionals in relation to treatment / management plans for patients
- Support to consultant–led clinics for Young People (16-25 yrs), and Pregnancy clinic, particularly focusing on treatment and self-management issues, blood glucose monitoring, college/work-based issues, exploration of teenage issues / personal concerns.
- Home visits for the housebound, frail or those with a clinical need to support them in the management / treatment of their diabetes, liaising with other community based health-care services for those with complex needs.
- Education and support for staff involved in caring for people with diabetes residing in various community based institutions.
- Diabetes education for significant health care professionals, usually delivered in small groups using both a formal and informal approach, lasting for only an hour or two or the delivery of short courses as identified as part of training needs analysis with Practices or by strategic group, in line with local action plan..
- Improve patient education for patients with Type 1 diabetes, support the local delivery of Type 1 patient education (DAFNE) One DAFNE trained DSN to be available for delivery of 4 DAFNE courses in any 12 month period.
- Liaise with hospital DSN service to ensure appropriate transition from acute to community care.
- Dedicated phone advice and support

3.2 Care Pathways

- Diabetes National Service Framework
- NICE Guidelines (various aspects of Type II Diabetes, Type I Diabetes, Structured Education, Insulin Pumps, Obstetric Care)

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The Diabetes Specialist Nursing Service is available to patients living in the Lancashire North CCG Footprint or those patients who attend UHMB Royal Lancaster Infirmary Out Patient Department for their diabetes/obstetric consultant care.

4.2 Location(s) of Service Delivery

The Diabetes Specialist Nursing Service provides services at:

- Heysham Medical Centre
- Royal Lancaster Infirmary – Out Patient Department or identified community venues
- Home visits for housebound patients

4.3 Days/Hours of operation

The Diabetes Specialist Nursing Service is a 52wk per year service and operates Monday to Friday 09.00 – 17.00 hrs. A dedicated rapid access telephone advice line will be available between 9am – 10am daily

4.4 Referral criteria & sources

Referral Criteria

Adults aged 16 years and older living in the Lancashire North CCG Locality or who attend UHMB Royal Lancaster Infirmary Out Patient Department for their diabetes/obstetric consultant care and are not meeting their management targets

Plus one of the following:

- Newly Diagnosed Type 1 Diabetes Mellitus
- Severe Hypoglycaemia (requiring help from a 3rd party)
- Symptomatic Hyperglycaemia
- Patient on steroids with BG > 15mmols
- Frequent Hypoglycaemia
- Change of treatment
- Pre-operative preparation
- Complications needing to improve control / self-management
- Chronic / Mild Hypoglycaemia
- Poor glycaemic control
- Joint Appointment with Diabetes Dietician
- Weight management;
- Carbohydrate awareness/counting and insulin management
- Pre conception counselling
- Pregnancy
- Insulin Pump therapy

Referral Sources

- Service Users/Self referral
- General Practitioners
- Practice Nurses
- Medical and Nursing staff working within University Hospitals of Morecambe Bay, Lancashire Care Foundation Trust, Health professionals or social care workers who are involved in the care of a person with diabetes
- Other local or national specialist diabetes health care professionals
- District Nurses
- Medical and Nursing staff working with the local prisons, and residential and nursing homes.

Onward Referrals

- General Practitioners
- Dietetics
- Podiatry
- Community Nursing / Care teams
- Primary Care
- Consultant Diabetologist

- Consultant Obstetrician
- Psychology Service
- Mental Health services.

4.5 Referral route

Referrals will be accepted via telephone, letter, fax, referral form to the DSN base

4.6 Exclusion criteria

- Patients not residing in Lancashire North or attending UHMB RLI Out Patients
- Patients under the age of 16 years
- Patients identified as being unable or unwilling to self manage
- Initial management of newly diagnosed patients with type 2 diabetes unless presentation is complicated by other medical conditions or treatments

4.7 Response time & detail and prioritisation

URGENT – *appointment within 1 working day*
- Initial contact by telephone
- Newly Diagnosed Type 1 Diabetes Mellitus
- Severe hypoglycaemia (requiring help from a 3rd party)

SOON – *appointment within 1 week*
- Symptomatic Hyperglycaemia
- Patient on steroids with BG > 15 mmols.
- Frequent hypoglycaemia

ROUTINE - *appointment within 4 - 6 weeks*
- Change of treatment
- Pre-operative preparation
- Complications needing to improve control / self-management
- Chronic / Mild Hypoglycaemia
- Poor glycaemic control
- Joint Appointment with Diabetes Dietician
- Carbohydrate awareness/counting and insulin management

5. Discharge Criteria & Planning

Patients are discharged from the Service when:

- their agreed targets have been met,
- there is agreement that no further progress can be made
- patient is not engaged with the service
- the patient is able to self manage
- another service is deemed appropriate to take over the patients care e.g. primary care practice nurse

The Diabetes specialist Nursing team will provide discharge information to the originating referrer with details of planned care interventions and changes to treatment made. This information will also include any onward referrals made to a clinical specialist where appropriate or the voluntary sector.

6. Prevention, Self-Care and Patient and Carer Information

The Diabetes Specialist Nursing team will provide the patient and where appropriate their carer with information and advice re self management of their condition. Actively promoting the take up of services such as annual reviews, podiatry, diabetes eye screening and patient education programmes.

7. Continual Service Improvement/Innovation Plan

Redesigning health services which better meet the needs of patients has never been more critical to the long term success of the NHS. A core component of World Class Commissioning is to drive continuous innovation and improvement. It is therefore the responsibility of the Commissioners to ensure innovation, knowledge and best practice is applied to improve the quality and outcomes of its commissioned services. It will be the responsibility of the Provider to fully cooperate in reviewing and redesigning services at the request of the Commissioner.

8. Quality and Performance Standards

Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*	*Report Due*
Outcomes Percentage of referrals meeting agreed targets	Baseline 13/14	Goals set & agreed from PCIS		Quaterly
Number of avoided admissions as a result of DSN intervention				
Performance & Productivity				
Improving productivity	Proportion of patients who DNA as a % of available treatment slots/contacts/visits	Achieve a DNA rate of no greater than 5%	Report number and % by exception	Quarterly KPI report

9. Activity

Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*	*Report Due*
Engage primary care in patient care planning and education	Baseline	Number of practices engaged		Monthly
All response times to be within agreed referral criteria	100%	Recorded activity		Monthly
To establish patient/practice feedback on Diabetes UK patient information packs		Percentage of returns	Feedback to support on-going funding of packs	Bi-annually
One off Service led survey of GP practices on introduction of dedicated rapid access telephone advice line 6 months post introduction				
Support delivery of DAFNE	4 courses per year	Number of courses delivered		Quarterly
Lead and support education for healthcare		Establish education/training plan		Quarterly

professionals in line with local action plan				