Service	Diabetes Structured Education - Diabetes Specialist Nurses and Type 2 Education Programme (Bassetlaw)
Service specification number	DB01

1.1 National/local context and evidence base

There is exponential rise in diabetes prevalence. The number of people diagnosed with diabetes has increased and research demonstrates that the incidence of diabetes is increasing.

Bassetlaw aims to improve diabetes care by:

- Supporting and improving the care provided within primary care
- Enhancing patient empowerment to improve self-care via care planning and structured education, as well as personalised advice.
- Ensuring top quality care is delivered to service users (those referred into the service, those who will benefit from indirect interventions with primary care or those on a discharge pathway), including housebound patients, by health care professionals who are adequately trained and kept up to date (ensure a good level of training within the direct team and that they promote a reasonable level of training within primary care), wherever the patient accesses help and ideally close to home.
- Working with secondary care specialists to maximise quality of care for all patients with diabetes who are admitted to hospital, as well as improving discharge planning and support post admission where needed.
- To contribute to improving outcomes including reduced rates of amputation, attendances at A&E and admissions.

Enhancing education of the public in a major thrust to help prevention of progression to diabetes, by liaising with public health initiatives to tackle obesity and promote healthier lifestyles through education and signposting to relevant services. There are two key components to delivering these aims in a community model which supports primary care provision and works closely with secondary care. Primary care-based Diabetes Specialist Nurses (DSNs) would improve management of complex cases to achieve cost effective improved outcomes. The second component is Delivery of a Structured Education Program (DESMOND) to adults with Type 2 diabetes. Structured education should be offered to all Type 2 patients and those at high risk of diabetes as a key part of systematic care. High quality programmes have been shown to lead to improved glycaemic control, a reduction in complications and be cost effective.

Local defined outcomes

1. Reduced A&E attendances and hospital admissions
2. Reduced secondary care attendances for complex cases as service users are managed more effectively in primary care
3. Rationalised and appropriate prescribing
4. Better educated primary care staff, community staff and care home staff through primary care training and advice and up-skilling provided by the Primary Care DSNs
5. Improved discharge planning and post-admission management to prevent re-admissions
6. Focussed support (limited time on a caseload) for house-bound patients with complex needs to reduce complications
7. Integrating all elements of care through primary and secondary care
8. Improving patient's ability to manage their condition and influence their own quality of life
9. Helping patients and their families plan for the future
10. Increasing choice for patients
11. Enabling patients to remain in their homes and communities

The service will contribute to the above but is not solely responsible for their achievement.

3.1 Aims and objectives of service

<u>Diabetes Specialist Nurses</u>

The Diabetes Specialist Nurses provision will support management and provide complex case advice for adult diabetes patients. They will not provide core diabetes services such as annual reviews or hold a case load. They will work alongside the existing care provided by

primary care and liaise closely with secondary care to provide an integrated approach to quality care.

The primary role is to support primary care with complex patients (short term) and generally (unless part of an agreed step down) will not accept referrals for patients under the care of a care consultant.

Key principles:

1. To act as a support to GPs, nurses and community matrons for adult complex cases. DSN input will be limited to 4 to 6 weeks
2. To act as support to GPs, nurses and community matrons for insulin initiation and management, where that skill is not present, to help deliver a high standard of care to people with Diabetes in Bassetlaw.
3. To act as a source of advice to health professionals and GPs
4. To act as a source of advice and support to nursing and care staff in local nursing / residential homes, for patients with diabetes
5. To provide visits to diabetic-unstable house-bound patients post-discharge, to aid stabilisation
6. To contribute towards reducing inappropriate referrals to secondary care via support to and education of primary care staff
7. To liaise with A&E based community matron to reduce frequent attendees
8. To liaise with secondary care DSNs and discharge teams to assist with discharge planning for only patients with complex diabetes needs

<u>DESMOND Programme</u>
The DESMOND Programme will provide evidence based training on diabetes and self-care to all adults with Type 2 diabetes which will enable them to self-manage and better control their diabetes, achieve an improved quality of life, improve their health and reduce the demand on NHS services.

Key principles:

1. A specialist education role to work within primary care to facilitate the provision of high-quality diabetes management within Bassetlaw.
2. To facilitate education and training for all staff.
3. To implement the applicable NICE and NSF guidelines
4. To provide structured education (DESMOND programme) to adults with Type 2 diabetes.

3.2 Service description/care pathway

<u>Diabetes Specialist Nurses</u>
The DSNs will work predominantly in primary care but will liaise closely with the secondary care diabetic specialist nurses and the consultants at Bassetlaw Diabetes Centre, thereby continuing to update and maintain their expert skills.

These nurses are NOT to have a case load, as they will act in a consultancy manner, helping troubleshoot acute problems with high intensity users, poorly controlled or complex patients and to advise the primary care staff (GPs, practice nurses, district nurses and matrons) how to continue with the care of these patients. The DSNs will not take on the care, but simply advise and help where difficult problems arise.

Support to all practices (allocated in time sessions based on need and existing clinical skills in the practice) will include:

- Offer practice visits to support GPs and nurses with complex patients for insulin initiation, GLP1 initiation and management where that skill is not present
- Run occasional joint clinics for complex patients in each practice in Bassetlaw to maximise the DSN expert advice and enhance continued education of the GPs and nurses involved, who can then continue the care of those patients seen
- Offer phone call advice during normal office hours (Monday to Friday) to GPs and practice nurses who have complex problems in patients with diabetes

- Visit house bound patients whose GPs need help in ensuring patients with unstable or complex diabetes are supported to attain best management and control of their diabetes, according to their individual need. Care of these patients will be short term, not exceeding one month
- Ensuring a post-discharge contact for unstable or complex patients who have been admitted to secondary care. Care of these patients will be short term.
- Visit nursing and care homes in Bassetlaw, to train and support the care staff in supporting and caring for their residents with diabetes, as well as addressing individual problems with patients with unstable or complex diabetes needs
- Liaise with community matrons to support them in their care of their complex patients with multiple co-morbidities
- Work closely with inpatient diabetes nurse to pick up frequent attendees and ensure the best pathway of care is planned in conjunction with secondary care for when returning home following hyperglycaemia thereby reduce re-attendance and admission rates
- Liaise with secondary care nurses and discharge teams to assist with discharge planning of patients with diabetes and further advising their GP and the district nurse team
- Involvement in Bassetlaw diabetes clinical forum and events as appropriate.

Type 2 Structured Education Programme

Department of Health and Diabetes UK Patient Education Working Group set out clear guidance for patient education programmes. The training will be delivered in line with the most recent guidance regarding accredited evidence based structured education programmes.

- All programmes should be evidence based, with specific aims and objectives.
- Programmes should have a structured, theory driven curriculum with effective supporting materials.
- Programmes should be delivered by educators trained in education theory; and
- Programmes should be quality assured, reviewed by independent assessors and with outcomes regularly audited (minimum annually)

The Education Programme is:

- An accessible service to highly specialised advice
- Education /training from skilled practitioners

Individuals will be able to access services which are evidence based and of the best quality delivered by competent professionals. Outcomes include:

- Person centred care planning tailored to support those who want to take on a greater role in managing their own care
- Supported self-management of people with Type 2 diabetes recognised and respected for their everyday work to manage their condition resulting in increased numbers of people maintaining healthy lifestyle gains e.g. weight reduction
- Improved quality of life, reduction in anxiety and depression and reduction in risk factors for those with diabetes
- Contribute to the reduction in mortality and premature morbidity in those with cardio-vascular disease

3.3 Population covered

To provide a service to all adult patients registered with a Bassetlaw General Practitioner or who are unregistered but reside within Bassetlaw.

3.4 Any acceptance and exclusion criteria and thresholds

Diabetes Specialist Nurses

Adult patients with type 2 diabetes (and occasionally, where skills exist, type 1 patients where the needs of the patient can be met by the Primary Care DSNs) with unstable or complex needs. The service will only provide a service to housebound patients where there is a complex need.

A complex patient can be defined as a patient whose diabetes is difficult to control, who over a reasonable length of time has not responded to standard management strategies.

The service is available for advice or support for complex care for all Bassetlaw primary or community health professionals who provide care for the patient group.

The service will accept referrals following discharge if complex needs are evidenced.

The service is not an emergency or urgent service.

DESMOND Programme
Adults aged 18 years of age and over

Newly diagnosed type 2 diabetes patients or patients identified as at risk of diabetes. Patients can self-refer.

3.5 Interdependence with other services/providers

Integrated Neighbourhood Teams
Primary care GPs and nurses
Community health professionals
Community matrons
Secondary care diabetes consultants
Secondary care DSNs
Bassetlaw Diabetes Centre health professionals
Telehealth providers
Discharge teams
Care home staff
Psychological Services

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

Nurses will meet competency standards for diabetes nursing as set out by the Royal College of Nursing.

Tier 2 education will be offered in line with the standards of the National DESMOND Programme (or equivalent programme as agreed with Commissioners)

Promotion of Service

The provider will ensure the service is promoted with all GP practices and care homes to ensure that all unstable or complex patients and their care teams can benefit from the access to specialist advice.

Promotion of the service will take place at intervals. The provider will audit uptake of the service from primary care and care homes and target education and promotion of the service appropriately.

The Provider's Premises are located at:

The DSN service will be provided in GP surgeries, hospitals and patient homes.

The DESMOND Programme will be provided in a variety of appropriate and accessible community venues.