Service	Nutrition and Dietetics - Mid Nottinghamshire
Service Specification Number	DT01

National/local context and evidence base

Obesity and overweight are conditions in which weight gain in the form of fat has reached a point of affecting health. Obesity is known to lead to both chronic and severe medical problems. Several conditions are associated with overweight and obesity including Type 2 diabetes, hypertension, coronary heart disease, stroke, metabolic syndrome, osteoarthritis and cancer. Obesity is associated with premature death and increases the risk of a number of diseases including the two major killers- cardiovascular disease and cancer. It is estimated that on average obesity reduces life expectancy by between 2 and 13 years the excess mortality being greater the more severe the obesity. The greatest burden of disease arises from obesity-related morbidity.

For several years, there has been an increase in the focus on the importance of the prevention and treatment of diet related illnesses and there is a considerable body of research to link diet with physical well-being. Evidence shows that the modern epidemics of obesity, CHD and Type 2 diabetes are the result of a more sedentary lifestyle with no adjustment to energy intake to compensate and a combination of dietary change with a moderate increase in activity is likely to be more successful. People with learning disability or mental health problems would generally benefit from lifestyle changes. They are known to be at a health disadvantage, dying, on average, fifteen years before their peers (Department of Health (2006)).

Evidence to support this can be found in a number of documents, namely:

- Department of Health, National Service Frameworks (NSF): The NSF for Coronary Heart Disease (2000), The NSF for Older People (2001), The NSF for Diabetes (2001 and 2002), The NSF for Children, Young People and Maternity services (2004), The NSF for Long Term Conditions (2009), The NSF for Renal Services (2006)
- Choosing Health: making healthy choices easier (DH 2004)
- Scottish Intercollegiate Guidelines Network **(**SIGN) Management of Obesity Guidelines 2010
- Public Health England 2013 local Health Priorities
- National Institute of Clinical Excellence (NICE) 2007 - Obesity: Guidance on the prevention, identification, assessment and management of obesity in children and adults.
- NICE 2011 Preventing Type 2 Diabetes- population and Community interventions;
- NICE 2009 promoting physical Activity for Children and Young People.
- NICE 2013 Managing overweight and Obesity among children and young people lifestyle weight management services
- NICE 2008 CG 63 Diabetes in Pregnancy
- NICE 2010 CG 87 Type 2 Diabetes Newer agents
- Healthy Weight, Healthy Lives: A cross-government strategy for England and Guidance for local areas (2008)
- DH “Our Health, Our Care, Our Say” (2006)
- National Audit Office (2008) Tackling Obesity in England, London, The Stationary Office Healthy Weight,
- Healthy Nottinghamshire Strategy – local guidance aiming to tackle local prevalence of obesity in children and adults and is the delivery plan for the Local Area Agreement obesity indicators
- NICE Guidance: Improving nutrition of pregnant and breastfeeding mothers and children in low income households (2008)
- DH, Standards for Better Health (2004)
- NICE (2006) Management of overweight and obesity in adults and children. Clinical guideline 43 London
- NICE- Nutrition support in Adults (2006) Clinical Guideline 32NICE 2004 Type 1 Diabetes diagnosis and management in children, young p
- eople and adults

- NICE Care Pathways –Chronic Kidney Disease, COPD, Coeliac Disease, Constipation in young Children, Crohns disease, Diabetes, Diet, Eating Disorders, Food Allergy, Familial Hypercholesterolaemia, IBS in adults, Nutrition Support in adults, Obesity, Rehabilitation after critical illness, Ulcerative colitis.

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	**E suring 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

- Reduction in hospital admissions and/or reduction in length of hospital stay by provision of nutritional support
- Promotion of the use of evidence based dietary guidelines to contribute to improved health of individuals and specific population groups
- Offer all referred patients evidence based dietary self-management advice following assessment of dietary needs
- Facilitate the achievement of agreed patient goals
- Audits are carried out against specific department and Provider standards

3.1 Aims and objectives of service

Aims

- To provide a comprehensive, therapeutic dietetic service to adults and children of all age ranges across Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood) in order to improve clinical outcomes, to contribute to the prevention of disease, complications and reduction of hospital admissions
- To be a specialist Nutritional and Dietetic resource for other Health Professionals and service providers across Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood)
- To promote good nutrition and contribute to preventing the incidence of nutrition related ill health across Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood)

Objectives

The Dietetics service will:

- Provide dietetic advice for the dietary management of specific medical conditions for both adults and children
- Promote up to date, evidence based dietary guidelines
- Develop, evaluate and promote evidence based resource materials
- Provide structured advice to patients via a variety of mediums
- Deliver high quality, specialist nutrition and dietetic advice to patients on an individual and group education basis in a variety of settings in order to meet the requirements of the individual

- Evaluate service outcomes

3.2 Service description/care pathway

Service description / care pathway

All aspects of this service specification must be fully complied with. If any aspect is not achieved this constitutes non-compliance and must be discussed with Commissioners at the earliest opportunity for a way forward to be agreed.

The service will provide a clinical dietetic service for referrals of all age ranges, and include conditions such as obesity, diabetes, gastroenterology, elderly care, stroke care, mental health, home tube feeding service, paediatrics, hyperlipidaemia, food based allergies, malnutrition

The service will provide:

A) Therapeutic dietetic services in a range of settings
B) Resource development
C) Consultancy and professional advice
D) Service development

A) Therapeutic dietetic services in a range of settings

The integrated approach between acute and community services will enable the smooth transition of patient care between acute, rehabilitation and community services dependent upon the needs of the client.

Clinical dietetic services in an acute setting will be delivered to patients:

- On the wards of Sherwood Forest Hospital Trust sites
- In specialist outpatient clinics at Sherwood Forest Hospital Trust sites
- General clinics on Sherwood Forest Hospital Trust sites

Areas of intervention will include:

- Nutritional assessment of patients dietary requirements
- Development of nutritional care plans
- Enteral tube feeding and oral nutrition support
- Support to staff within outpatients specialist clinics and wards as required
- Provision of specialised individualised advice for patients (and their carer if required) pertaining to the medical condition i.e., diabetes, stroke, elderly care and others, ensuring quality of life is optimised
- Reassessment and evaluation of intervention with further advice as required
- Smooth transfer to community dietetic services where necessary
- Support for catering for the provision of specialist diets
- Liaison with pharmacy pre nutritional products, stock levels prescribing and availability

Clinical dietetics in a community setting

Will be delivered across Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood):

- At various health centres and clinics and will support patients within the community with specialist dietetic needs, for example patients requiring home enteral feeding.
- Via domiciliary visits

- Within nursing/residential homes

Areas of intervention will include:

- Specialised community paediatric dietetic support for complex paediatric dietary problems, i.e. multiple food allergies, malnutrition, failure to thrive
- Individual consultations for therapeutic dietetic referrals
- Structured telephone advice and/or support to community staff/patients/carers
- Domiciliary visits for housebound patients (and their carers where necessary) with complex nutritional problems to include those patients with permanent physical disabilities, degenerative illnesses and those with palliative care needs
- Support for multidisciplinary (MDT) community clinics and MDT meetings
- Provision and of home enteral feeding equipment in line with National Patient Safety Agency (NPSA) guidance
- Clinical review of home enterally fed patients in line with NICE guidelines
- Liaison with other professionals involved in the care of tube fed patients
- Maintenance of the Home Enteral Feed Database
- Consultation with community professionals regarding prescription and use of appropriate nutritional supplements
- Assess and monitor nutritional needs and progress of those in care/residential homes through domiciliary visits or telephone support
- Provide written support/information to facilitate nutritional care, screening and planning
- Provide group education sessions where appropriate e.g. Coeliac disease, Diabetes, Coronary rehab, Pulmonary rehab)
- Respond to safeguarding investigations as required

The service will provide significant input into the TIIDE and KAREN education programmes for diabetic patients.

B) Resource development

The service will develop and provide literature for first line advise for use by GP practices and community health professionals and will liaise with local resource libraries to ensure the most appropriate and up to date literature i.e. booklets, leaflets regarding aspects of nutrition are available for use by GP practices, community health professionals, hospital professionals and patients of all ages and abilities.

C) Consultancy and professional advice

Dietitians will:

- Adopt and ensure effective communication strategies with patients in the understanding of their medical conditions.
- Communicate successfully with patients and their carers to ensure understanding of the dietary implications of the medical condition
- Communicate relevant dietary and lifestyle advice effectively, to the level of understanding of the patient (and their carer where necessary)
- Utilise counselling, motivational and negotiating skills to facilitate behaviour change
- Communicate therapeutic dietary advice and treatment recommendations to a variety of health and social service professionals and make referrals to those professionals as required

- Manage own case load unsupervised and maintain accurate patient records in accordance to Trust/professional policy/standards
- The service will be flexible in delivery, providing face-to-face advice as well as telephone and Internet based advice on matters relating to diet and nutrition. The service will respond to strategic developments and government initiatives concerning diet and nutrition.
- The Dietetics service will provide advice to patients on an individual and/or group basis.

D) Service Development

- Conduct audits to facilitate improvements in service delivery
- Ensure service developments include patient and public involvement

3.3 Population covered

The service will operate across Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood). The service will be provided for all patients registered with a GP Practices within one of the Mid Nottinghamshire Primary Care Networks (i.e. Ashfield North

PCN, Ashfield South PCN, Mansfield North PCN, Newark PCN, Rosewood PC or Sherwood PCN)

If the patient has no registered GP, then residence within Mansfield, Ashfield and Newark & Sherwood Districts shall be acceptable admission criteria.

3.4 Any acceptance and exclusion criteria and thresholds

Services are provided from birth until end of life, this includes prenatal and preconception care. Services are provided for patients with any disease / condition that are referred into service.

Referrals are accepted from any registered primary or community Health Care Professional for clinical dietetics.

Self-referrals are accepted for type 2 diabetes education (TIIDE and KAREN programmes).

An eligible patient is any patient identified as having a nutritional need, who has a GP within Mansfield & Ashfield and Newark & Sherwood area or in a surrounding area that has a separate agreement.

Following assessment and the provision of advice a written report will be provided to the referrer, containing any recommendations for future management and monitoring.

Follow up appointments with the Nutrition and Dietetics Department will be determined according to clinical need / care pathway.

Health visitors, family support workers, and any other relevant referral source can also refer to group education classes within the community. When a patient self-refers permission should be obtained to contact their GP prior to attending a Group.

The service cannot discriminate on any grounds.

The service will operate Monday to Friday, with core hours from 8.30am to 4.30pm However hours should be flexible and should be adapted to meet demand, for example in delivering the service outside these hours and weekends where appropriate.

Exclusion criteria:

Patients who self-refer for therapeutic advice and patients who have specific condition that we do not have expertise or SLA for e.g. renal end stage 3, Parental feeding at home, complex Mental Health/ Learning Disability needs.

3.5 Interdependence with other services/providers

The service is an important aspect of healthcare provision in Central Nottinghamshire (Mansfield & Ashfield and Newark & Sherwood Clinical Commissioning Groups) and must work in partnership with other services to define and share information on local needs to create a dynamic local model of provision The provider will notify the patients referrer and/or general practitioner (GP) of their involvement and provide an update of progress and inform the patient that this is happening .The outcomes of all referrals will be reported to the referrer Safeguarding - The service must ensure that policies and procedures relating to safeguarding are adhered to and that staff have undertaken training appropriate for their role. All staff working with children and young people will have undertaken an enhanced Disclosure and Barring Service (DBS) check (previously known as CRB check).

The service requires referrals and engagement from other healthcare professionals, including health visitors and district nurses. The service also provides a Community Nutrition Service through an additional specification.

The service works with other services to provide certain aspects of the Service e.g. (TIIDE, KAREN (diabetes structured education)

Applicable local standards

All dietitians will have Degree in Nutrition and or Dietetics and will be registered with the Health and Care Professionals Council (HCPC) All dietitians will maintain registration and adherence to the HCPC standards of Continuous Professional Development.

The Provider's Premises are located at:

Services are provided from:

- Kings Mill Hospital (KMH);
- Mansfield Community Hospital (MCH);
- Ashfield Health Village (AHV);
- Newark Hospital (NH);
- Sherwood Children's Centre (formally Bilsthorpe, Blidworth , Clipstone and Rainworth Sure Start);
- John Eastwood Hospice;
- Beaumont House;
- Millbrook Unit;
- various Community Clinics (currently Meden Medical Centre, AHV, Rainworth Health Centre, Mansfield Woodhouse Health Centre, Ollerton Health Centre Surgery, Oak Tree lane Health Centre, Hawtonville Clinic Mansfield Community Hospital)

Services are also provided in non-NHS establishments e.g. church halls, schools, children's centres, leisure centres and community centres. The majority of these are in the former Mansfield & Ashfield CCG area.

Service	Community Dietetics South Nottinghamshire
Service specification number	DT02

National / Local Context and Evidence Base

Obesity and overweight are conditions in which weight gain in the form of fat has reached a point of affecting health. Obesity is known to lead to both chronic and severe medical problems. Several conditions are associated with overweight and obesity including Type 2 diabetes, hypertension, coronary heart disease, stoke, metabolic syndrome, osteoarthritis and cancer. Obesity is associated with premature death and increases the risk of a number of diseases including the two major killers – cardiovascular disease and cancer. It is estimated that on average obesity reduced life expectancy by between 2 and 13 years the excess mortality being greater the more severe the obesity. The greatest burden of disease arises from obesity-related morbidity.

For several years, there has been an increase in the focus on the importance of the prevention and treatment of diet related illnesses and there is a considerable body of research to link diet with physical well-being. Evidence shows that the modern epidemics of obesity, CHD and Type 2 diabetes are the result of a more sedentary lifestyle with no adjustment to energy intake to compensate and a combination of dietary change with a moderate increase in activity is likely to be more successful. People with learning disability or mental health problems would generally benefit from lifestyle changes. They are known to be at a health disadvantage, dying, on average, fifteen years before their peers (Department of Health (2006)).

Evidence to support this can be found in a number of documents namely:

- Department of Health, National Service Frameworks (NSF): The NSF for Coronary Heart Disease (2000), The NSF for Older People (2001), The NSF for Diabetes (2001 and 2002), the NSF for Children, Young People and Maternity Services (2004), The NSF for Long Term Conditions (2009), The NSF for Renal Services (2006)
- Choosing Health: making healthy choices easier (DH 2004)
- Scottish Intercollegiate Guidelines Network (SIGN) Management of Obesity Guidelines 2010
- Public Health England 2013 local Health Priorities
- National Institute of Clinical Excellence (NICE) 2007 – Obesity: Guidance on the prevention, identification, assessment and management of obesity in children and adults
- NICE 2011 Preventing Type 2 Diabetes – population and community interventions
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- NICE 2013 Managing overweight and obesity among children and young people lifestyle weight management services
- NICE 2008 CG 63 Diabetes in Pregnancy
- NICE 2010 CG 87 Type 2 Diabetes Newer agents
- Health Weight, Healthy Lives: A cross government strategy for England and Guidance for local areas (2008)
- DH “Our Health, Our Care, Our Say” (2006)
- National Audit Office (2008) Tackling Obesity in England, London, The Stationary Office Healthy Weight
- Healthy Nottinghamshire Strategy – local guidance aiming to tackle local prevalence of obesity in children and adults and is the delivery plan for the Local Area Agreement obesity indicators
- NICE guidance: Improving nutrition of pregnant and breastfeeding mothers and children in low income households (2008)
- DH, Standards for Better Health (2004)
- NICE (2006) Management of overweight and obesity in adults and children, Clinical guideline 43 London
- NICE – Nutrition Support in Adults (2006) Clinical Guidelines 32 NICE 2004 Type 1 Diabetes diagnosis and management in children, young people and adults
- NICE Care Pathways – Chronic Kidney Disease, COPD, Coeliac Disease, Constipation in Young Children, Crohns Disease, Diabetes, Diet, Eating Disorders, Food Allergy, Familial Hypercholesterolaemia, IBS in adults, Nutrition Support in adults, Obesity, Rehabilitation after critical illness, Ulcerative Colitis

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

- Offer all appropriately referred patients evidence based dietary self-management advice following assessment of dietary need
- Facilitate achievement of agreed patient goals (where applicable)
- Promotion of the use of evidence based dietary guidelines to contribute to improved health of individuals and specific population groups
- Deliver face-to-face training sessions to health professionals
- Provide telephone advice (for patient-related support) to health professionals

3.1 Aims and Objectives of Service

Aims:

- To provide a comprehensive, therapeutic dietetic service to adults and children of all age ranges across South Nottinghamshire Place Based Partnership (PBP) (Rushcliffe, Nottingham North and East, Nottingham West) in order to improve clinical outcomes, to contribute to the prevention of disease, complications and reduction of hospital admissions.
- To be a specialist Nutritional and Dietetic resource for other health professionals and service providers across South Nottinghamshire PBP.
- To promote good nutrition and contribute to preventing the incidence of nutrition related ill health across South Nottinghamshire PBP.

Objectives:

The objectives of the service are:

- To provide patient centred therapeutic dietary advice for the dietary management of specific medical conditions for both adults and children
- To provide training and support for health professionals to give first line dietary advice to patients
- To provide structured telephone advice to patients and health care professionals
- To support the strategic development of food and nutrition initiatives to meet Government and NHS targets

3.2 Service Description / Care Pathway

All aspects of this service specification must be fully complied with. If any aspect is not achieved this constitutes non-compliance and must be discussed with Commissioners at the earliest opportunity for a way forward to be agreed.

The main functions of the Community Nutrition and Dietetic Service are clinical work, training of other health professionals, resource development, consultancy and professional advice.

The service provides:

- Therapeutic clinical dietetic services

(a) Primary and community care clinical dietetic service for adults and children

(b) Dietetic input for primary care support to nursing registered care homes

- Training of other professionals
- Resource development
- Consultancy and professional advice
- Service development

Therapeutic Clinical Dietetic Services

The service is required to provide Registered Dieticians to assess patients' dietary needs and provide appropriate dietary counselling, therapeutic dietary advice and lifestyle advice to patients and carers. Consultations take place in community health centre based dietetic clinics, within general practices, via structured telephone advice or domiciliary visits (where appropriate).

(a) Primary and community care clinical dietetic service

The service is required to provide:

- Community dietetic clinics for one to one consultations for therapeutic dietetic referrals
- Structured therapeutic advice and support for patients by telephone
- Telephone support for health professionals in relation to individual patient care
- Community paediatric dietetic support for complex paediatric dietary problems e.g. multiple food allergies, malnutrition, failure to thrive
- Domiciliary visits for adult housebound patients with complex nutritional problems and their carers; this includes patients with permanent physical disabilities, degenerative illnesses and those requiring palliative care
- Input to multi-disciplinary meetings discussing patient care plans
- Group dietary education or health promotion sessions when identified as appropriate
- Assessment and advice on nutritional needs and management of individuals who are capable of consuming oral diet and fluids, following receipt of written referral. When sip feeds are used this will be in accordance with the Nottinghamshire guidelines

(b) Dietetic input for primary care support to nursing registered care homes

The service is required to:

- Assess and advise on the nutritional needs and management of individuals who are capable of consuming oral diet and fluids, following receipt of a written referral. When sip feeds are used, this will be in accordance with Nottinghamshire guidelines
- Consult with general practitioners with regard to appropriate prescription of nutritional supplements
- Monitor the nutritional progress of referred residents in nursing registered care homes through domiciliary review visits and telephone support
- Provide supporting written information to facilitate nutritional care, screening and planning e.g. therapeutic diets, validated nutrition screening tool, menu planning guidance
- Respond to safeguarding investigations as required

- Provide input to education and training of professional groups

Training of other professionals

The service is required to:

- Educate front line professionals to give dietary and lifestyle modification advice to their patients
- Develop, plan and deliver training sessions on diet and nutrition related topics, incorporating the provision of relevant educational materials and evaluation
- Continually develop training programmes to meet the needs of professional groups and participate in course reviews as required
- Participate in the training programmes of other health professionals and students e.g. shadowing opportunities, tutorials, lectures, workshops and seminars

Resource development

- The service will develop and provide literature for first line advice for use by GP practices and community health professionals and will liaise with local resource libraries to ensure the most appropriate and up to date literature i.e. booklets, leaflets regarding aspects of nutrition are available for use by GP practices, community health professionals, hospital professionals and patients of all ages.

Consultancy and professional advice

The service is required to:

- Adopt and ensure effective communication strategies with patients in the understanding of their medical conditions
- Communicate successfully with patients and their carers to ensure understanding of the dietary implications of the medical condition
- Communicate relevant dietary and lifestyle advice effectively, to the level of understanding of the patient (and their carer where necessary)
- Utilise counselling, motivational and negotiating skills to facilitate behaviour change
- Communicate therapeutic dietary advice and treatment recommendations to a variety of health and social care professionals and make referrals to those professionals as required
- Manage own case load unsupervised and maintain accurate patient records in accordance to Trust/professional policy/standards
- The service will be flexible in delivery, providing face-to-face advice as well as telephone and internet based advice on matters relating to diet and nutrition. The service will respond to strategic developments and government initiatives concerning diet and nutrition
- The dietetics service will provide advice to patients on an individual and/or group basis

Service development

The service is required to:

- Conduct audits to improve service delivery
- Ensure service developments include patient and public involvement

Discharge criteria:

Patients are discharged from the service when:

- Agreed goals are met (where appropriate)
- The patient is assessed to be competent to self manage dietary needs
- Remaining dietary needs can be adequately managed by referrer with professional support

- The patient has demonstrated poor attendance or compliance with interventions

Discharge Procedure (Care Transfer)

Upon discharge patients are provided with written therapeutic dietary information suitable for their condition along with a summary of dietary goals agreed. A letter is sent to the referrer providing information on the outcome of the service's interventions along with key points for follow up within primary care.

Transition from Children's to Adult Services:

The service will work in partnership with Children's and Adult commissioners, the Nottinghamshire Integrated Community Children and Young People's Healthcare (ICCYPH) Service and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring support specific to this service specification to ensure seamless continuity of care during transition from children's to adult services.

Proactive planning and care pathways will be developed in line with local and regional transition guidance and the Together for Short Lives transition care pathway (http:/www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework that can be adapted locally to plan services specifically for teenagers and young adults with life threatening, life limiting or complex medical conditions. The pathway sets out six standards that should be developed as a minimum, with the aim of achieving equality for all young people and families, wherever they live.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young adults during and following transition
- Use of Nottingham ICCYPH Programme Families' Statement of Expectations as guiding principals
- Continuation of the personalisation approaches and systems used by they young person/adult
- Statutory duty to contribute to and provide services to young people/adults within Education Health and Care Plans (EHCP) up to age 25 in line with SEND legislation (http://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014)
- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions (http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx)
- Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Networks. Further work is being undertaken locally regarding this document and therefore should not be seen as definitive guidance.

3.3 Population Covered

The service covers any patient registered with a GP Practice in South Nottinghamshire PBP.

3.4 Any Acceptance and Exclusion Criteria

Acceptance:

Adults and children registered with a GP practice within South Nottinghamshire PBP can access services. Referrals must be made by GPs, health and social care professionals and meet the inclusion criteria for the specified service.

Referrals for children with special needs who are under the care of the Children's Development Centre (CDC) are sent directly to the CDC at NUH Campus.

Exclusion Criteria:

Prior to dietetic referral patients should receive first line dietary advice from a member of the Primary Health Care Team and/or community health team. Literature, telephone advice and training sessions will be available from the service to support this work.

Patients can be referred on to the following services if more appropriate:

- Patients with type 2 diabetes are referred to a structured education programme

Patients are excluded if a referral to the following services would be more appropriate

- Eating disorder services

Patients are excluded if they do not meet the referral criteria.

3.5 Interdependencies with other Services

- Nottinghamshire County Council/Public Health Teams
- NUH including outreach Home Enteral Feeding Service
- Diabetes structured education programmes
- GP's and practice nurses
- Community diabetes nursing service
- Community health professionals
- Primary and Community Care Providers

Relevant networks and screening programmes

- Greater Nottingham Diabetes Network
- CVD Network
- Strategic Child Obesity Group
- Food Initiatives Group/Network
- National Child Measurement Programme

The service will be provided in several community locations and nursing/care homes throughout South Nottinghamshire Placed Based Partnership.