Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
COMMUNITY - DIABETES MANAGEMENT

(For the Clinical Waiting Priorities and Management of Referrals for Patients in Scarborough & Ryedale Community Diabetes Service)

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Author/Lead **Job Title**	Elizabeth Harrison, Non-Medical Prescribing Lead Sarah Middleton, Diabetes Specialist Nurse Carol Wilson, Community Matron
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Jan 2024*	*New SOP. Approved at Community CNG meeting (5 January 2024).*

Contents

1. INTRODUCTION

The document is intended to support staff with triaging and management of referrals received int the Diabetes Management Service.

2. SCOPE

To provide guidance and information for diabetes specialist nurses to triage and manage referrals received.

3. DUTIES AND RESPONSIBILITIES

Registered diabetes specialist nurses will determine the clinical waiting list priorities and management of referrals.

4. PROCEDURES

All referrals received are registered on SystmOne by the administration team and triaged by a diabetes specialist nurse. These patients will be referrals from the Acute Trust to continue ongoing support with patients discharged from their services. From Community Hospitals following a rehabilitation stay and support after stepdown from the acute Trust or a step up from Primary Care.

Patients will be referred from Primary Care in support of complex diabetes. Patients that require additional input with their diabetes, which may include initiating Insulin or other injectable therapies. The service will also take referrals from both Acute and Primary care to arrange structured education. This comes in two forms, for Type 1 Diabetes and Type 2 Diabetes. Patients will have to meet criteria for this education pathway. (This is addressed within this SOP).

The Ambulance Service will also refer patients in who have experienced a severe Hypoglycaemic episode, that required assistance.

5. SCOPE OF SERVICE

The service will deliver interventions to individuals and to groups as part of a multidisciplinary team approach.

The service accepts referrals for the Diabetes Management service of adults (25 years +) (16-24 years are supported within the Acute Trust under Consultant Led Care)

5.1. The service is expected to provide:

- Injectable Therapy initiation for those patients where the service is not provided within their own practice setting. This will be identified at point of triage if the Primary Care setting cannot offer this service, then support will be given.
- Insulin review and dose titration for complex patients including presence of long-term complications and co-morbidities.
- Patient education regarding self-monitoring of blood glucose and associated self-titration of medication.
- Patient advice on the management of diabetes during inter-current illness.
- Education into residential and nursing home
- Case notes reviews (face-to-face or via SystmOne).

- Education sessions for Community Nurses.
- Yorkshire Ambulance Service - Severe Hypoglycaemic Episode follow-up this is required to support patients who have required 3rd party assistance with a severe hypoglycaemic episode. This may mean the patient was unconscious and required immediate treatment.
- Acute Trust referral due to a discharge from hospital following an episode of DKA (diabetes ketoacidosis)
- Palliative Care for Type 1 Diabetes patients- that may require an adjustment or change to their insulin regime or support in CGM (continuous glucose monitoring)
- The service also delivers structured education programmes for type 1 & 2 diabetes.

6. EXCEPTIONS

6.1. Patients managed under Primary care

- Prevention type 2 diabetes
- Early detection of those at risk
- Diagnosis and categorisation of diabetes
- Ongoing management of people aged 25 and above with stable type 1 and type 2 diabetes.
- Initial management of type 2 diabetes
- Annual complications screening and care planning
- Retinal screening referral
- Insulin / GLP 1 initiation where this can be initiated in Primary Care.
- Recognition and management of early diabetic complications
- Identification and appropriate referral of diabetic emergencies
- Blood glucose monitoring advice and guidance
- pre pregnancy counselling
- Managing diabetes and intercurrent illness
- Management of early neuropathy and nephropathy
- Initiation of LIBRE
- Ongoing support with Libre
- Under the age of 24yr

6.2. Patients seen by the Hospital Diabetes Specialist Nurse Team

- Advanced neuropathy / autonomic neuropathy
- Advanced renal
- Pregnancy
- Insulin pump
- Acute onset of unstable symptoms
- All patients under 24yrs

7. PRIORITIES / WAITING TIMES

- **Urgent -** if the referral is deemed urgent following triage by the diabetic specialist practitioner, the diabetic practitioner will contact and assess the patient within 3 working days. This will be initially telephone contact and followed up with a face to face depending on urgency following the initial assessment. If this is deemed an acute situation, then the nurse will advise for acute follow up with A&E 999 or 111. If the urgency is downgraded to routine, it will then follow the routine pathway.

- **Routine -** Following triage by the diabetic specialist practitioner if the referral is deemed non-urgent. Patients that are deemed as non-urgent will be added to the routine Waiting list and will be scheduled within 8-12 weeks from Triage and at this point added to the relevant

caseload. A letter will be sent to the patient explaining the waiting list if their condition becomes more unstable or deemed a more urgent concern. They must go back to their GP and ask for the original referral to be escalated. This will then be triaged again and placed according to level of urgency.

- **Follow ups**- these will be agreed with the patients dependent on support required. All stable patients to be transferred back to primary care. This may only be a one-off appointment or a lengthier process depending on support needed.

7.1. Decision Making Guidance

Priority **Urgent - Seen in 3 working days**	➢ Recent discharge from hospital new to insulin ➢ Recent discharge from hospital Diabetic ketoacidosis ➢ Yorkshire Ambulance Service referrals for *severe hypoglycaemia- required third party intervention and unconscious. ➢ Palliative Care for Type 1 Diabetes patients- that may require an adjustment or change to their insulin regime or support in CGM (continuous glucose monitoring) ➢ Newly diagnosed type 1 diabetes / secondary diabetes from Primary Care (already able to administering insulin) ➢ Steroid and other medications affecting blood glucose control. ➢ Palliative Care- last few weeks of life T2DM ➢ Complex patients with other health issues, that required input around insulin. ➢ District Nurse patients that require support initially seen or discussed at DARL (Diabetes Assessment Review Learning). To refer on if require more intervention administration. * Patient referred as urgent may be downgraded after the initial triage and consultation.
Routine- added to waiting list and aim for 8- 12 weeks to be assessed.	➢ Type 1 structured education – (DAFNE) ➢ Type 2 structured education ➢ Libre initiation for assessment in complex patient/long term issues with blood glucose monitoring. ➢ Sick day rules ➢ Hypo-unawareness -high risk situations occupational risks ➢ dysphagia type 2 diabetes unable to take oral medication. ➢ Patients with pancreatitis – support ➢ Consideration for complex insulin regimens ➢ Advice regarding chemotherapy –optimisation of blood glucose prior to commencing insulin or adjustment of established regime. ➢ Patients with chronic Hba1c that require review of diabetes medication and education. ➢ One to one education, if patient does not meet the criteria for group education. ➢ Pre-operative optimising blood glucose control- insulin treated. ➢ Carbohydrate Counting

7.2. Rationale for Priorities / Waiting Times

WAITING LIST FOR ROUTINE_REFERRALS

All patients considered to be **routine** in the referral criteria can be added to the diabetes waiting list.

Type 1 Routine Waiting List

Type 2 Routine Waiting List

These waiting lists will be reviewed twice weekly to ensure there is movement and patients are being assessed and added to an appropriate clinic space. Initially a telephone conversation, to assess the issues and then to add in a Face to Face if this is deemed necessary.

7.3. Referrals Changed from One to Another Group Once Triaged by the DSN (Diabetes Specialist Nurse)

- Oncology patients receiving chemotherapy may be prioritised as high risk (2). The patient will be triaged against the priorities/ waiting times guidance as above which may result in them being prioritised as a higher risk.

- Hypo-unawareness - Patients requiring priority such as drivers and responsible for dependents.

- There will be an explanation if the referral is stepped down. The clinical risk and condition will be discussed with the referring physician/HCP.

- A referral may be escalated as a developing issue with a patient- this may be brought off the waiting list and added to a caseload for appropriate review as considered from the referral criteria.

7.4. Priority High Risk Patients

Patients who are high risk- the diabetes specialist nurse will arrange the appointment in the appropriate clinic this may be virtual. If unable find an appointment within the time necessary.

To be aware that this is not an acute service and so any urgent or immediate concerns need to be referred to the GP, 111/ A&E, 999.

8. APPOINTMENTS

- Virtual/clinic/group appointments should be made for all patients that are able to attend.
- Housebound patients should be given either a telephone appointment or domiciliary visit which will be decided on clinical judgement. The diabetes team should liaise with other health professionals that are visiting the patient to enhance reviews and to see if they are able to do part of the monitoring, which may enable less domiciliary visits.
- Nursing home or residential home patients that cannot come to clinic, care should be given the option of telephone, virtual appointments, or face to face.

9. DID NOT ATTEND / CANCELLED APPOINTMENTS (Follow DNA SOP)

Unable to contact - telephone appointments -

- If booked appointment, follow DNA SOP.
- If unbooked appointment – check telephone number with GP surgery. Liaise with other health professionals involved in their care to establish best way to contact. Consider arranging booked appointment and if unable discharge letter to GP and discharge.

10. PATIENTS ADMITTED TO ACUTE HOSPITALS

York and Scarborough Teaching Hospitals NHS Foundation Trust if inpatient diabetes care is indicated - the acute specialist diabetes nurses should be emailed with details of the patient and why they require a community diabetes referral.

Hull University Teaching Hospitals NHS Trust If inpatient diabetes care is indicated the acute diabetes specialist nurses should be emailed with details of the patient and why they require a community diabetes referral. The patient should then be discharged, and the patients GP and consultant (if referred by consultant) informed.

Any patient from our caseloads, that is admitted to the acute Trust, will be discharged if there is potential for changes with diabetes management in the community and re-referred once their period of acute care is completed. As the referral and patients' needs may have changed since the admission into hospital.

11. PATIENTS ADMITTED ON TO A COMMUNITY WARD

These patients record of care is on the community hospital System 1 record, therefore should not have an open referral on Community Specialist Systmone Diabetes caseload. The patient will require re-referring if diabetes support is needed on the patients discharge.

APPENDIX 1 – DIABETES

Type 2 diabetes – Diabetes management referrals for type 2 diabetes advice should be referred to structured education unless they meet the exclusion criteria below. If referral is made, they should be discharged from the dietitian and referrer informed.

Exclusion Criteria –

- Check suitability for group – social history or medical problems that would make it inappropriate for face to face.
- Have any cognition or learning disabilities.
- Pregnant
- Diagnosis type 2 diabetes but complex insulin regimen e.g., basal bolus
- Cannot speak English.
- Palliative
- Severe sight or hearing impairment.
- Complex cases – other conditions requiring dietary manipulation where there would be conflicting advice. Some may be suitable for structured education after 1:1 dietary advice with a dietitian explaining the differences and how they can still follow the programme.

Carers can attend type 2 diabetes structured education on behalf or with someone who is unable to do it themselves.

References and Policies

Evaluation of a diabetes referral pathway for the management of hypoglycaemia following emergency contact with the ambulance service to a diabetes specialist nurse team A Walker1, C James, M Bannister3, E Jobes4.

NHS-rightcare-pathway-diabetes

NICE guidelines for Type 2 diabetes in adults; management. Published Dec 2015 updated June 2022
Overview | Type 2 diabetes in adults: management | Guidance | NICE

NICE guidelines for Type 1 diabetes in adults: diagnosis and management
Overview | Type 1 diabetes in adults: diagnosis and management | Guidance | NICE