NHS
Southern Derbyshire
Clinical Commissioning Group

Derbyshire Community Health Services NHS
NHS Foundation Trust

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HEALTHCARE

Derby Teaching Hospitals NHS
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JoinedUpCare
in the South of Derbyshire

Southern Derbyshire and Derby City Integrated Diabetes Service Model

Version 4.1

24/09/2015

Project Lead: Nick Whitehead

Contents

PREVENTION, RISK IDENTIFICATION & MANAGEMENT

Based on NICE guidance PH35 & PH38 – Preventing type 2 diabetes: risk identification and interventions for individuals at high risk; and population and community-level interventions – and NHSE / PHE pre-diabetes prevention programme

1. Awareness raising in high risk groups and communities
    - South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups
    - adults with conditions that increase the risk of type 2 diabetes
    - vulnerable groups whose risk may be increased or where risk awareness and / or access to services may be poor including people with several mental health illness, learning disabilities, physical or sensory disabilities

2. Risk assessment for high risk groups in community settings and primary care
    - adults aged 40 and above, except pregnant women
    - people aged 25–39 of South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups, except pregnant women
    - adults with conditions that increase the risk of type 2 diabetes
    - Stage one: validated self-assessment tool or computer-based tool using primary care records
    - Stage two: blood glucose testing for those with high risk score

3. Intervention based on risk score
    - Brief interventions to reduce risk
    - Referral to lifestyle-change programme including education, physical activity, weight loss / management and dietary advice.

4. Reassessment of risk
    - Annual, three or five-year reassessment depending on risk score

5. Prescribing
    - Follow local prescribing guidelines

What is already in place?	• NHS Health Checks include diabetes risk assessment for 40-74 year olds – 5 yearly cycle (LA commissioned). • Lifestyle / weight management programmes for those with BMI >30 (City & County); BMI ≥ 28 with co-morbidities or BMI ≥ 25 with very high waist circumference (County only). • Health referral programme inclusion criteria diagnosed 'pre-diabetes' (County only) • Opportunistic risk assessment and management within primary care including referral to lifestyle services and prescribing. No method of identifying how widespread or systematic this is across practices or target population groups.
How would the new service differ?	• Targeted awareness raising programme for high risk groups and communities • Systematic risk assessment of high-risk groups who are not including in the NHS Health Check programme (adults aged 25-39 in high risk BME groups, adults

	aged 75 and over) through community services and primary care working with individuals and community groups • Develop lifestyle programmes to ensure provision is in line with evidence from pre-diabetes prevention programmes. Consider pre and post intervention HBA1C testing as part of lifestyle programmes • City only: Lifestyle service inclusion criteria to include individuals with raised HBA1C where BMI <30 **Identification of those with pre diabetes** The specialist team will also work with primary care to identify those at risk of diabetes and screen them for diabetes. Those with normal glucose will be signposted to lifestyle advice if needed through public health initiative. Those found to have pre-diabetes will be offered a single intervention group session, and peer supported follow up, which has been shown to improve glucose tolerance, and so prevent or at least delay the onset of diabetes.
Resource/Staffing Gaps?	**City:** • No additional resources available within LA to commission awareness raising and systematic risk assessment activity. • Lifestyle service currently has a 6 week waiting list
	County: • No additional resources available within LA to commission awareness raising and systematic risk assessment activity. • Decommissioning of Diabetes Education programme

Work stream Lead:	**Rachel Sokal**
Provider Delivery Lead:	**Public Health / General Practice**
Supported By:	**DSN with Community Team**

SELF-MANAGEMENT AND EMPOWERMENT

- Care Planning
- Education
- Online Resources
- Peer Networks
- Use of Tele-health
- Smart Phone Apps
- Flo
- Support from local practice
- Individual Target Setting

What is already in place?	**Care Planning/target setting** **CITY** We are moving towards care planning through target setting, 85% patients attending integrated care have a target set. Integrated care has target setting templates- clinicians are asked to set and review these at every consultation. Users are encouraged to be involved in shared decision making, and specialist clinicians have been trained in motivational interviewing to support this. **COUNTY** Traditional consultations – no formalised target setting or care planning **Education** **CITY** • User are signposted to lifestyle programmes undertaken by Public Health (see above) and t other providers such as Weightwatchers. As part of the Community Engagement Project, links were established with Derby City Public Health and representatives from walking groups were attending structured education sessions, but this resource was withdrawn last year. • Education is undertaken 1:1 at all times by all providers, and through group sessions at specific time points • Pre- diabetes intervention sessions are undertaken as a group session. These are evidence based to improve glucose tolerance • Type 1: DAFNE commissioned via Acute Trust for users with Type 1 diabetes > 1 year on basal bolus • Type 2: 1. Newly diagnosed DAY ICH subcontracted DCHS education team to deliver. 2. Currently Interim contract is delivering an equivalent in house, but would like to work with DCHS but would like to support their new educators more to ensure a quality service. 3. Basal Bolus Groups are undertaken as part of the current contract. i.e. are not separately commissioned. 4. First Diabetes and InterCare have also provided group sessions for those on maximum oral hypoglycaemic agents, GLP starts and for young women. **COUNTY** • 1:1 in Acute Trust • DAFNE for Type 1 – via Acute Trust • DAY – newly diagnosed Type 2 diabetes commissioned via Public Health • Sporadic delivery of basal bolus groups via the Acute Trust

	<u>On-line resources</u> **CITY** • The InterCare website contained resources for users and links to on-line resources. With the decommissioning of the service, the website was closed down **CITY and COUNTY** • There are resources for preconception care available through the PROCEED website. • Users are signposted to on-line resources to support their education as part of group or 1:1 education eg Diabetes UK resources, DAFNE website. • Sites are available and used to download sensors and meters to share information with health professionals and support self-management eg Diasend **<u>Peer Networks</u>** **CITY** • Were established through First Diabetes and InterCare. The First Diabetes was particularly proactive in initiating walking groups, but with current uncertainties the groups no longer meet. • There is a Derby City Diabetes UK group **COUNTY** • Diabetes UK group in Ashbourne **<u>Telehealth and Smart Phone apps</u>** **CITY and COUNTY** • SKYPE consultations are available at royal derby and London Road Community Hospital • Uploading profiles manually or through programs such as Diasend • Signposting users to apps that facilitate self-management eg Carbs and Cal, Bolus calculators and software to record glucose readings. • Many meters have technologies to assist with self-management, but short term cost implications mean some practices are reluctant to support these. • We are not using Flo **<u>Support from local practices</u>** **CITY** Relationships were established between clinicians working in practices and the specialist team through satellite visits, These were re-enforced through education courses at basic and higher level. This meant that there was consistency of information given and signposting. Working from a single record facilitated this too as it allowed each clinician to be aware of the others' actions and also rapid communication which each other. This resulted in shared responsibilities between primary care and the specialist team with the user being part of the process being supported in self-management at all stages.

	COUNTY A traditional often unidirectional referral system from primary to secondary care with primary care supporting advice given by secondary care. Communication is hampered as it requires letters or unsuccessful attempts at phoning each other. There is a division of responsibility with users either being under primary care who provide all support or the specialist team, in which case routine support from primary care such as the annual review is frequently not undertaken. This makes it harder to support self-management as users can become lost between two systems and there is inconsistency of information given.
How would the new service differ?	**CITY and COUNTY** • There should be no differentiation between City and County as exists at present; instead, all resources made available through one integrated service where all users have equal opportunity to access quality resources to support self-management. • The psychological literacy of consultations should be improved through training for all clinicians, so facilitate care planning and shared decision making. • We should build on what is already available. For example, there should be more Groups sessions reflecting challenges at stages of the user journey other than initial diagnosis could be developed eg more prevention groups, preconception awareness, sessions for those on maximum oral hypoglycaemic agents, sessions for transition and young adults etc. • The range of self-management tools above would be tailored to the individual's needs throughout their journey with diabetes. • These could be listed on the service website, with a link to them from System one. Eligibility and referral route and provider information can be included as appropriate.
Resource/Staffing Gaps?	**CITY and COUNTY** The success of an integrated self-management programme is not about additional staffing but smarter working, in particular working as one team. Currently the differences in commissioning between the city and County are making this challenging and driving variation in provision. The specific gaps are listed below. While additional group working is desirable, this would replace 1:1 consultations and therefore will not require additional resources. City: • No commissioning for Type 2 diabetes structured education • Differences in lifestyle intervention initiatives between city and county County: • No targeted screening or commissioned interventions for pre-diabetes • Differences in lifestyle intervention initiatives between city and county

	• Traditional delivery model impedes cross boundary working to maximise supporting self–management opportunities.

Work stream Lead:	**Paru King**
Provider Delivery Lead:	**General Practice / DCHS/Acute Trust/public Health/ 3rd Sector**
Supported By:	**DSN**

LOCAL TO PATIENT - PRIMARY CARE / GP PRACTICE

- Care Planning & Goal Setting
- Use of standardised Diabetes template across every practice linked to the 9 Care Processes
- Annual Reviews
- Supporting Patient Self-Management
- Diabetes Care Coordination (Care Coordinator new function)
- Prevention of complications
- Initial Education
- Ongoing patient education
- Ongoing patient support
- Support and information for relatives and carers
- Peer Educators
- Pre-Conception Awareness and Advice
- HBA1C Management
- Renal low level management
- Foot Care low risk
- Weight Management
- Appropriate referring to other parts of the pathway
- The day to day management and annual review of patients with Type 2 diabetes.
- The day to day management and annual review of older patients with Type 1 diabetes.
- Smoking cessation.
- Blood pressure management.
- CV management.
- Microalbuminuria management.
- Glucose management.
- Initial management of Erectile Dysfunction and referral into existing pathway.
- Initial management of neuropathic pain and referral into existing pathway.
- Screening for other complications.
- Retinal Screening Referrals.
- House Bound and Care Home Annual Reviews.
- Peer support for Staff
- Screening for Mental Health issues
- Referrals to IAPT and Psychological Intervention.

What is already in place and how would the new service differ?	• Care planning and Goal setting - This will be done in varying degrees at different practices. This is because to put on an HbA1c target that is auditable you have to use a Read code and this is not part of the System 1

	diabetic template, so means extra work. • Use of standardised templates - Most practices are using the template that will record information for QoF, but some practices will also have adapted these to record other information as well. • Annual reviews - Practices call patients in for an annual review, as it is needed to get the patients in for QoF. Unfortunately not all pts attend for them. • Supporting patient self-management - Done by GP's and practice nurses. • Diabetes care coordination - Done by GP's and practice Nurse • Prevention of complications + screening for other complications - Done by GP's and practice nurses at the annual review and interim reviews. • Initial education - Done by GP's, Practice nurses because of the time it takes for patients to get on the Diabetes and You courses. • Ongoing patient education - Done by GP's, practice nurses. We were able to book pts to see dieticians, carb counting courses but not sure how much of this is still available. • Ongoing patent support - By GP's and practice nurse via appointments or telephone consultations • Support and information for relatives and carers - By GP's and practice nurses. They can also attend the DAY and other courses. • Peer educators / Peer support for staff - Done between GP's and nurses in individual practices. Some education groups are available but they are run by pharmaceutical companies and staff usually have to attend in their own time. Also DSN's when asked will support nurses in their clinics. • Pre conception awareness and advice - Done by GP's and practice nurses, but this will vary from practice to practice. • HbA1c management + glucose management - Done by GP's and practice nurses, but not all practices start injectable therapies. Some are also unsure about when to use other types of oral treatments. • Renal low level management + microalbuminuria management - Done by GP' and practice nurses. Foot care low risk - GP's , practice nurses and HCA's • Referrals to podiatry have to be faxed or posted. • Weight management - Referred to Live Well, some practices will do this 'in house' • Appropriate referring to other parts of the pathway - Done by GP's and practice nurses. • Day to day management of Type 2 pts - See ongoing pt education/support. Pts are called back as needed eg weekly, monthly, 2-6 monthly depending on their HbA1c or other factors that we are trying to improve. • Day to day management of Type 1 pts - See ongoing pt education /support and see above • Blood pressure management = reducing CVD risk - By

	GP's and practice nurses. • Initial management of Erectile dysfunction and when to refer - By GP's and practice nurses. • Initial management of neuropathic pain and referral - GP's and practice nurses. • Retinal screening referrals - Done via sending an email with the information attached. • Housebound and Care home annual reviews - In some practices this is done by GP's or practice nurses will do home visits, in others it is done by telephone consultations. Some practices will not send their practice nurses out because when the DN's stopped doing this, the practice was not provided with additional support to take this on. • Screening for mental health issues - depression questions and use of PHQ9 • Referrals to IAPT and psychological interventions - Done by GP's
Resource/Staffing Gaps?	• Care planning and Goal setting - The diabetic template with this READ code, so we can add the target figure, but is also easily printable off to give to the pt. • Use of standardised templates - A new template that records all the 9 care processes, QoF and goal setting , depression, Erectile dysfunction etc. Who would keep this updated promptly with any changes • Annual reviews - Call /recall system • Supporting patient self-management - Appointment timings, Telephone consultations, Motivational interviewing. • Diabetes care coordination – Support by expanded Care Coordinator role within Practices. • Prevention of complications + screening for other complications – Improved Education • Initial education - More frequent courses that can be directly booked by practice. • Ongoing patient education - Need to have these additional courses available that we can refer pts to. Being able to send pts to group sessions saves time. • Ongoing patent support - By GP's and practice nurse via appointments or telephone consultations with DSN support • Support and information for relatives and carers - They actually need to be able to access dieticians and other courses themselves. Also they need psychological support that we could refer them to. • Peer educators / Peer support for staff - Needs to be a more structured service, using nurses in practice, but enabling them to free up time for them to support another nurse or attend another nurses clinic. • Pre conception awareness and advice – Better education and local advice • HbA1c management + glucose management - Education and support especially into the newer therapies and when to use them.

	• Renal low level management + microalbuminuria management - With support and education more could be done by practice nurses. • Foot care low risk - Education especially for HCA's as more of them are now doing the annual foot checks. - Why can't a Podiatry referral be done via a task on System 1? • Weight management - Pts to have more psychological support –CBT • Appropriate referring to other parts of the pathway - Education – to reduce inappropriate referrals. • Day to day management of Type 2 pts – No change • Day to day management of Type 1 pts - See ongoing pt education /support and see above • Blood pressure management = reducing CVD risk - With support and education more could be done by Practice nurse. • Initial management of erectile dysfunction and when to refer - With education and support, more could be done by practice nurses. It would also be useful if nurses with the appropriate training could refer these pts themselves. Have ED as part of the template. • Initial management of neuropathic pain and referral - With education and support more could be done by practice nurses and it would be useful for it to be part of the template eg using one of the scoring charts that helps to distinguish between neuropathic and other types of pain. • Retinal screening referrals - Why can't this be done via a task on System 1 • Housebound and Care home annual reviews – Closer working with Community teams / District Nurses • Screening for mental health issues - Should be on the diabetic template • Referrals to IAPT and psychological interventions - More services for CBT need to be available for nurses to refer their pts to.

Work stream Lead:	**Marion King – *with Support from Ann Warren, Kyran Farrell and Gillian Davidson***
Provider Delivery Lead:	**General Practice**
Supported By:	**DSN with Community Team** **Secondary Care Advice and Support**

SPECIALIST COMMUNITY MDT - LOCAL TO PATIENT

- Care Planning & Goal Setting - City not county
- Use of standardised Diabetes template - City not county
- Type 1 Management Both- City integrated care, County Consultant lead clinics
- Multi-Speciality Support for Diabetic Patients Both City integrated care, County – via Consultant led clinics

- Education – DAFNE, D&Y, Other programmes as set down by Education Work stream
- Intensive Lifestyle Advice and Support Both see above
- IAPT Referrals via GP – Acute Trust employ a psychologist to support people with diabetes with complex problems
- Renal Medium level management Both City integrated care, County – via Consultant led clinics
- Retinal Screening Pathway – Joined up working City – joint responsibility of primary care and specialist team – those attending integrated care specialist clinics have one stop shop for retinal screening. County – Primary Care responsibility
- Drop in Sessions- all patients currently attending the specialist clinics have open access as clinicians work in the Trust and in the community
- Dietetics - Specialist Weight Management Both City integrated care, County – via Consultant led clinics and dietitian monthly session at St Owalds and Swadlincote
- Primary care Support City only through integrated care.
- Additional glucose management Both City integrated care, County – via Consultant led clinics
- Carbohydrate counting and general dietetic advice. Both City integrated care, County – via Consultant led clinics
- Psychological Interventions for the patients, but also for partners/carers. See above – carers/ partners via Primary Care
- Reviews of adults with Type 1 diabetes. See above "Type 1 management
- Insulin pumps. Initiation in Acute Trust as it is commissioned through Trust, follow up in City integrated care or Trust pump clinic, County – via Consultant led pump clinics
- Pre conception care In integrated care through commissioning of PROCEED
- Neuropathic pain not managed in Primary care Both City integrated care, County – via Consultant led clinics

What is already in place?	**City:** Integrated Care Core Care For the majority, who have Type 2 diabetes, core care is undertaken in the primary care setting, with care seamlessly escalated to and de-escalated from the specialist team across organisational boundaries as needed. The terms "escalation" and "de-escalation" reflect the fact that the whole team of clinicians is responsible for the care of people with diabetes either directly or indirectly through raising standards of care through the support and training outlined below. In addition, the terms reflects the lack of financial (payment by results) or technological (multiple patient records) thresholds that have to be crossed, as might be understood by the traditional terms "refer" and "discharge". Supporting Primary care Practice support is designed to improve standards of care and reduced variation. A nurse specialist and consultant provide satellite support to the practices tailored in accordance to their needs. This ranges from supporting clinics in surgeries to case based discussion. In addition educational courses are provided for all practices, which included sessions on improving the psychological literacy of consultations through the promotion of motivational interviewing techniques, the promotion of shared decision making and care planning as well as sessions on complications of diabetes and glucose management. Visits

	to practices are mutually beneficial as it also allowed members of the specialist team to gain an understanding of some of the pressures of working in primary care and the visits were also invaluable for building relationships and partnership working. <u>Education for people with diabetes</u> Fragmentation of commissioning of educational initiatives means delivering equitable education of type 2 diabetes is challenging. Through subcontracting arrangements the different educational resources are brought together to provide equitable access to structured education for Type 1 and 2 diabetes at diagnosis and other points of the users' journey see above for details. <u>Specialist Care</u> When targets were not being met or there was a need for specialist team support, care is escalated to the multidisciplinary team where the user can choose to be seen iin one of the 4 community based clinics or at the Acute Trust of. A single record meant the user sees the right clinicians to meet their needs or access the most appropriate educational initiative. They are also able to have other aspects of their care such as retinal screening at the same time as seeing the diabetes clinicians. To promote shared decision making, mutually agreed targets such as HbA1c or weight were set in consultations and recorded on templates that were visible to the primary care team. When targets are achieved, care is de-escalated back to the primary care team. The user is given a contact number for the service or clinician so that if support or advice is needed in the future, they are able to directly access the specialist team and retain continuity of care. The de-escalation allows the service to maintain sufficient capacity to see users urgently if needed but does not leave patients and colleagues feeling isolated and unsupported. Clinical pathways are extended beyond the financial limits of integrated care so that the user journey can be continued seamlessly in and out of secondary care services. For example when a woman attending the integrated care preconception service becomes pregnant, her care is transferred to the antenatal clinic. While this service is financially outside integrated care, the same clinicians worked in integrated care and the antenatal clinic, maintaining continuity of care for the user. Postnatally, she is transferred back to integrated care and if appropriate her care is de-escalated to Primary care. In addition to these core principles, there were a number of initiatives to meet the needs of specific groups: <u>Type 1 diabetes</u> A focus group of users with Type 1 diabetes described the importance of seeing clinicians who understood the principles of intensive glucose management such as carbohydrate counting and basal rate testing for those on pumps. Most felt that the primary care team did not have

	these skills and that it was important to maintain contact with the specialist team, not so much for routine review, but to support them at times of crisis. As the skills of the primary care team improved, many were comfortable to attend primary care for their annual review but have a telephone consultation from the specialist team to support any care planning issues that arise from their review. With the technological advances in the management of Type 1 diabetes, these users are offered a Consultant appointment every 2-3 years as an opportunity to review their medication, and discuss new technologies such as advances in glucose meters and pumps. When a preference is expressed for traditional care, the annual reviews are undertaken by the specialist team. <u>Hard to reach groups</u> Practising in community based settings gives clinicians the opportunity to develop other partnerships to improve care for those that are traditionally hard to reach. For example, by working with the community matrons, who also use SystmOne, housebound users can be supported at a distance. Derby has a large South Asian Community and we have worked across organisational boundaries to bring service together to meet their needs through a Community Engagement Project. For example bilingual educators and interpreters support the delivery of structures education, and public health colleagues attended these sessions to promote their lifestyle initiatives, in particular local walking groups. The dietitian leading the project established links in religious and community venues to deliver healthy eating and cooking sessions in hindu temples, gurdwaras and pakistani community centres. In addition she supported the local community pharmacists who were undertaking diabetes awareness events where a risk calculator is used to discuss individual risk. The dietitian and pharmacist can then discuss lifestyle changes at an individual level. **Clinical Governance** All these measures were supported by a single clinical governance structure. A multidisciplinary clinical board of managers, administrators, primary and secondary care clinicians and users met monthly to address issues of clinical governance such as: • Staff competencies and mandatory training (supported by annual appraisal). • Plan Do Study Act cycles, case reviews and audits to drive efficiencies to continuously improve quality and look for new opportunities for service development. • Discuss safety issues. • Review pathways. Review agreed outcomes including user experience.
	County: Traditional Acute Trust centred consultant lead clinics with a satellite service in Ripley. There is DSN and

	dietician input into Swanlincote and St Oswalds – but without consultant support. As all patients see a consultant there is duplication of appointments and capacity is a problem. Discharge is difficult because of variation in experience and skills in primary care. The service struggles to respond to user needs, and there is no joint working with primary care clinicians who struggle to communicate with the specialist team. This means that sometimes there is no choice but to admit patients unnecessarily. All components of the service are provided but access is via the Consultant lead clinics. See secondary care below
How would the new service differ?	**City / County:** A single integrated service for diabetes where there is no distinction between the City and County. This service should build on the success of the city model and integrate services that are not currently included in particular foot care. The service should include the key enablers of integrated care including a single joint record, alignment of finances as well as clinical integration and a single governance structure. The aim is to have seamless pathways centred around the user and based within the community whereby care can be escalated to the specialist team and de-escalated back to the primary care team as needed. There will be an emphasis on prevention of diabetes and its complications supported through motivating and supporting users to undertake lifestyle and other self-management strategies and supporting shared decision making and making them partners in their care. Specifically, the service will include several areas: **Routine care and self-management** Initial support for those found to have Type 2 diabetes, will be by the primary care team supported by structured education as agreed by the education work stream. For the majority, a Primary Care Team diabetes care coordinator (DCC) , practice nurse or GP depending on the presence of comorbidities will signpost them to additional pathways such as lifestyle intervention and smoking cessation supported by public health. Those with Type 1 diabetes will have a member of the specialist team as their DCC, and will be empowered through 1:1 support and the DAFNE (Dose Adjustment for Normal Eating) course. The aim from the start is to move away from a didactic service centred around crisis management to one where the user and professionals work to achieve common goals. Health professionals will be trained in motivational interviewing to ensure that "every contact counts" and maximise user engagement through using a consultation style that facilitates engagement. Users will be empowered to self-manage through group and

	1:1 support as discussed above. These initiatives give users the tools to participate in shared decision making, target setting and care planning which are fundamental to improving outcomes. For the majority, the primary care team will also be responsible for ensuring the 15 care processes are undertaken and all involved in the care of the user will have responsibility to ensure that the 9 key care processes are undertaken annually, although for those with type 1 diabetes there will be ongoing support by the specialist DCC. For those with multiple comorbidities the DCC will ensure communication is maintained with other agencies involved in their care, and if needed through the use of the Community and other support teams as outlined below. **Primary Care support and professional education** There is significant variation in expertise in primary care, particularly within the county where diabetes services have been delivered using a traditional rather than integrated model. The specialist diabetes team will undertake satellite visits tailored to the individual practice needs and educational courses as agreed by the education work stream to support primary. **Integrated Multidisciplinary Specialist services in the community** A multidisciplinary team of doctors, nurses, dieticians, podiatrists and psychologists will support specialist services in the community. Specialist services will be coordinated through hubs in the 4 localities where care can be undertaken through one stop appointments when other services such as retinal screening are needed. Care could be undertaken at other community based venues such as GP practices if single professional input is needed. The Primary Hub (eg London Road Community Hospital) would be the single point of contact. Referrals from primary care and other stakeholders will be undertaken electronically and reviewed by a member of the specialist team so the user sees the right clinician to meet their needs and avoids the duplication that occurs in a traditional service. The aim of the hub based model is to take the service closer to the user but also to offer choice whilst retaining expertise. Care will be 'escalated to' and 'de-escalated to and from' the specialist team to generate and maintain sufficient capacity to see users in a timely manner (and eliminate PBR Tariff). The majority of the specialist team also undertake sessions within the Acute Trust so that when care is escalated to a service outside integrated care (e.g. from preconception to antenatal care), there is a seamless transfer of care without loss of continuity of clinician. This will also work in reverse to facilitate the rapid and effective follow up of inpatients to reduce readmissions.

	The emphasis will be in expertise rather than location, and for particular subspecialty problems such as support with pumps a limited range of locations will be offered to ensure that users see clinicians with the appropriate skills. Target setting and care planning with shared decision making will help to maximise user engagement and achievement of targets. The clinician seen will be their primary point of contact **Foot pathway** Foot care will be integrated throughout the pathway see below **Preconception Care** The specialist team will support primary care and others in contact with women with diabetes of childbearing age to discuss pregnancy plans at every opportunity and document & advice on contraception use ie raise preconception awareness. When a woman is actively planning pregnancy then support by the specialist team is needed in accordance with NICE. This is currently commissioned and delivered as the PROCEED model which currently covers Southern Derbyshire. **Psychological support** Psychological support is of paramount importance at all stages of diabetes. In addition to optimising the quality of consultations to maximise user engagement as described above, the specialist team have counselling skills to support the bereavement process that can occur following the diagnosis of diabetes. Clinicians will be vigilant to the need for additional support, not just after diagnosis, but also later when adverse life circumstances impacts on users' ability to engage with diabetes self-management. If there is concern, the DCC will screen the user for depression using a validated questionnaire, and signpost them to the IAPT pathways. There is an increased incidence of psychological problems such as eating disorders, particularly amongst young people with Type 1 diabetes, and these users will be signposted to the appropriate specialist resources. Some may have chronic complex psychological problems, and diabetes may be intrinsically part of the problem. For these people, dedicated psychological support from psychologists with an interest in diabetes will be provided as part of the service. These diabetes specialist psychologists could also have a role in training the team in techniques such as motivational interviewing and mindfulness. **Clinical Governance** The service will be supported by a single clinical governance structure.

Resource/Staffing Gaps?	**City/County:** There will be a single service so there should be no differentiation between City and County. A gap is the contracting vehicle. Generally the proposed model is about integrating existing resources so additional resources are minimal. The current psychology provision is inadequate and additional recruitment may be needed. It is likely 1WTE Band 3 administrative support will also be needed. As we go towards care planning – a band 4 or 5 clinician could be used to support the process.

Work stream Lead:	**Paru King and Rick Meredith**
Provider Delivery Lead:	**General Practice / Community Provider**
Supported By:	**Secondary Care**

FOOT CARE

- **Care Planning & Goal Setting**

  Community podiatry service provides foot care for diabetics in both city and county following referral within a number of sites. Podiatrists from DCHS support the MDT Foot clinic at Royal Derby Hospital.

  Currently following referral to the podiatry service a diabetic patient receives a comprehensive foot care assessment which will determine a risk category for the patient. On the basis of the identified risk a care plan is formulated. As a result of the assessment, clinical findings and other clinical issues being raised by the patient at the time of assessment care plan is formulated. For the pathway development the group need to focus on ability to share records and prevent service duplication which frustrates the patient.
  Full electronic record should allow us to share the care/ goal setting across all colleagues supporting a patient along the care pathway.

  Changes in sites of care to meet community MDT will require some workforce realignments.

- **Embedded within the community MDT**

  Diabetic foot care is already provided within community within both city and county.

  Community podiatry already provides clinical podiatry care to a range of patients following referral by a health professional, GP or self-referral. Diabetics attend podiatry services at a number of locations across Derby city and Southern Derbyshire. Currently there are no clinical sessions provided within community which are solely for diabetic patients. One half day a week at Ripley hospital for diabetic patients.

  Once sites for community MDT are decided the community podiatry service will need to determine how its manpower/ skill mix is realigned to make best use of resources for the developing pathway and support the pilot sites.

- **Foot Care increased risk and high risk**

  These patients are seen in both city and county for treatment, support and advice when referred to the podiatry service. As part of the new pathway some of these patients.

- **Drop in Sessions**

  No diabetic foot care drop in sessions are currently provided within city or community, however increased risk/ high risk/ ulcerated diabetic patients can contact either their local clinic or the MDT foot clinic at RDH if they have any problems requiring care.

  Group need to look at ability for drop in within Swadlincote/ S Derbyshire locality and the Burton Hospitals provision and its links within the developing pathway.

- **Advice and Support to Patients**
  No specific designated face to face advice and support is given on diabetic foot care for patients. Generally patient will contact the local service for advice on an ad hoc basis. RDH MDT Foot clinic provides some advice and support to its patients.

  NB DAY courses used to have an attending Podiatrist but this stopped several years ago. Need to ensure that whoever delivers DAY is trained to an appropriate level to deliver the foot care element.

  The podiatry service does have some simple leaflets which offer foot care advice to patients following the initial assessment. There are different leaflets for each level of risk. Where patients are IT users they are asked to link into

  Is this something that the care coordinators identified within the service model could initially manage and refer to specific identified clinicians along the pathway if this did not create any significant delay.

- **Diabetes screening**
  - Diabetes UK Risk indicator

  In both City and County diabetic patients referred to the podiatry service and who are retained by the service are given an annual diabetic foot risk assessment as per NICE and Diabetes UK. Where an individual patient presents with significant clinical changes further diabetic foot risk assessments may be undertaken. All assessments are recorded on TPP S1.

- **Primary care Support**

  Some support offered to individual GP Practices, district nurses, practice nurses, nursing homes and some specific groups where high incidences of diabetes. No formal package of support in Primary care at present. Pathway needs to encourage the development of improved networks for diabetic foot care education in Primary care.

  Some Diabetic foot care screening training for GP's and Practice Nurses was offered in the City but this has since been decommissioned.

- **Foot Care Facilities as close to patients as possible**

There are 8 sites of care in Derby city, 9 sites in county within SDCCG catchment. TPP S1 allows patients the flexibility of attendance at any site should it require. Important to note that most facilities operate 5 days per week but there is possibility at some sites for 7 day service.

Community MDT needs to be positioned at facilities to provide equitable access whether you live in Swadlincote, Derby or Alfreton. Process for escalation and de-escalation of care is critical to determine scope and level of services provided within the MDT.

- Podiatry support into RDH Foot clinic
- Podiatry provider should have an appropriate skill mix providing care to diabetic patients
- Choice and access offered to the patients not restricted to their GP locality

- **Podiatry support into RDH Foot clinic**

  Not in the CCG specification.

- **Podiatry provider should have an appropriate skill mix providing care to diabetic patients**

  Podiatry service has podiatry assistants, community specialist podiatrists and highly specialist podiatrists providing care to patients across the diabetes care pathway. Each role has clear competencies with clear guidance on when and where escalation or de-escalation of care is required.

- **Choice and access offered to the patients not restricted to their GP locality**

  As previously indicated currently podiatry service offers care across a significant geographical spread from a number of sites within SDCCG catchment. Good patient education and knowledgeable care coordinators could ensure care was accessible and electronic patient management systems ensure patient record is available at all sites.

  Currently MDT Foot Clinic and DCHS community podiatry service operate different patient management systems. Need a move towards one shared patient management system. (Information / technology work stream)

FOOT CARE PATHWAY

Low Risk

- Annual screening by “suitably trained professional”
- Supported by Education at practice level e.g. Level 1 or satellite visits
- Included in structured education for users
- Green low risk leaflets for patients with contact numbers for access

Medium Risk

- Assessment by member of a podiatrist team
- Self-management advice e.g. footwear and self of feet
- Amber leaflet to support self-management and contact numbers for advice/ care if acute problem

High risk- no active foot problem

- Assessment by member of a podiatrist who is a member of the Foot Protection team frequency depending on risk
- Specific measures to prevent foot ulceration e.g. footwear/ orthotics
- Self-management e.g. regular inspection of feet
- Red foot leaflet – with contact numbers for advice or if develops acute foot problem

Management of acute foot problem

- Education of practice staff – target GPs as well as practice nurses – urgent referral to MDT foot clinic
- Encourage practice team to educate all people in contact with patients with an acute problem e.g. receptionists should understand that foot problems need urgent same day appointment
- Aim to escalate into and deescalate acute foot problems from the specialist MDT foot team to community based specialist podiatry in integrated care

In patients

- Foot risk chart for all people with diabetes
- Urgent referral to foot team if evidence of acute problem (Not in spec)

What is already in place?	**City:** Community podiatry service provides a general podiatry service from 8 sites in Derby city. This is not just diabetic patients and therefore facilities and staffing support a wider caseload. Current facilities are purpose built and the service also has a number of decontamination facilities. Admin support is also provided in the city**. MDT foot clinic at DHFT**
	County: Community podiatry service provides a general service from 9 sites in County. This is not just diabetic patients and therefore facilities and staffing support a wider caseload. Current facilities are purpose built and the service also has a number of decontamination facilities. Admin support is also provided by DCHS sites and services teams.
How would the new service differ?	**City:** To provide a specialist community hub for diabetic foot care patients, some who are currently seen at Royal Derby Hospital alongside a group of high risk foot care patients who are currently treated in community at sites already identified as moderate and high risk. Community Podiatry service needs to: • reorganise/ reschedule staffing • Equipping proposed Podiatry rooms • Decontamination facilities • Admin
	County: To provide a specialist community hub for diabetic foot care patients, some who are currently seen at Royal Derby Hospital alongside a group of high risk foot care patients who are currently treated in community at sites already identified as moderate and high risk. Community Podiatry service needs to:

	• reorganise/ reschedule staffing • Equipping proposed Podiatry rooms • Decontamination facilities • Admin
Resource/Staffing Gaps?	**City:** Rescheduling of staff teams to provide care at additional hub sites will leave gaps in cover for the remainder of our case load at other sites. Equipment costs Decontamination and decontamination staff costs Admin
	County: Rescheduling of staff teams to provide care at additional hub sites will leave gaps in cover for the remainder of our case load at other sites. Equipment costs Decontamination and decontamination staff costs Admin

Work stream Lead:	**Duncan Bucklow with support from Fran Game**
Provider Delivery Lead:	**DCHS / General Practice**
Supported By:	**Secondary Care**

SPECIALIST - SECONDARY CARE

- Care Planning & Goal Setting
- Support Initiation of Insulin in Primary Care
- Initiation of Insulin that cannot be initiated in Primary Care
- Insulin Pumps
- Antenatal
- Urgent and Emergency Care:
  - Foot Care High and Very High Risk
  - MDT Foot Clinic
  - Renal
- Inpatient Care
- Diagnostic support
- Newly diagnosed Type 1 diabetics
- Reviews, management and support of children and young adults with Type 1 diabetes
- Other Pathway Interactions
  - Management of eye complications
  - Management of neurovascular complications such as gastroparesis
  - Bariatrics

What is already in place?	**City: Care Planning and Goal setting** Templates used in integrated care, but individualised targets are part of any consultation **Insulin Support** Not undertaken in Acute Trust – undertaken in integrated

	care either in primary care or by DSN/dietitian led integrated care clinics **Pumps** Started and annual follow up in Consultant lead clinic – but glucose support often undertaken by same team members in integrated care **Antenatal** • Acute Trust MDT clinic physically in Maternity involving midwife, obstetrician, sonographers, anaesthetists, paediatricians as well as diabetes team. • Preconception and postnatal care undertaken in integrated care with Consultant Diabetologist and Obstetrician support **High risk foot** • Acute foot problems seen in MDT foot clinic which may include vascular surgery input. • Stable but high risk patients are managed by foot protection team in the community **Renal** • Stable renal patients are managed by consultants in integrated care or in primary care • There is a joint renal and diabetes clinic. • The renal team follow up those approaching dialysis and joint clinics exists for those on established haemodialysis. **Inpatients** Consultant led care – DSNs support diabetes management of inpatients generally. **Diagnostic support** Not Acute Trust activity – Consultant sees patients in integrated care **Newly diagnosed Type 1** Seen either in trust or community by DSN depending on availability as patient needs to be seen the same day **Children and Young adults** Acute Trust consultant led clinics – transition clinics are undertaken jointly with the paediatric diabetes team. **Eye complications** Opthalmology led clinics **Neutological complications eg gastroparesis** Consultant diabetologist in integrated care- but may need to be seen in Acute Trust for supporting investigations eg endoscopy **Bariatrics**

	Tier 3 Bariatrics is part of Acute Trust activity. Patients requiring Tier 2 support are signposted to Livewell.
	County: Care Planning and Goal setting Not formalised but individualised targets are part of any consultation **Insulin Support** Consultant led clinics with DSN support **Pumps** Started and annual follow up in Consultant lead clinic with support from DSN and dietitian **Antenatal** • Acute Trust MDT clinic physically in Maternity involving midwife, obstetrician, sonographers, anaesthetists, paediatricians as well as diabetes team. • Preconception and postnatal care undertaken in integrated care with Consultant Diabetologist and Obstetrician support. PROCEED is available for County as well as City patients. **High risk foot** • Acute foot problems seen in MDT foot clinic which may include vascular surgery input. • Stable but high risk patients are managed by foot protection team in the community **Renal** • Stable renal patients are managed in consultant led clinics • There is a joint renal and diabetes clinic. • The renal team follow up those approaching dialysis and joint clinics exists for those on established haemodialysis. **Inpatients** Consultant led care – DSNs support diabetes management of inpatients generally. **Diagnostic support** Consultant clinics **Newly diagnosed Type 1** Seen either in Acute Trust **Children and Young adults** Acute Trust consultant led clinics – transition clinics are undertaken jointly with the paediatric diabetes team. **Eye complications** Opthalmology led clinics **Neurological complications eg gastroparesis**

	Consultant clinic **Bariatrics** Tier 3 Bariatrics is part of Acute Trust activity. Patients requiring Tier 2 support are signposted to Live life better**.**
How would the new service differ?	**City & County:** There should be no difference in the services available for patients living in the City or County. Core care should be based in primary care with the majority of specialist care in integrated care delivered in community based clinics as described above. There are a number of services that require multidisciplinary working across specialities or are separately commissioned or involve small numbers of patients that will require to be contractually outside integrated care and delivered through the Acute Trust. These services are: 1. Inpatients/Emergency Care 2. Renal (under renal team) 3. Antenatal (not preconception or postnatal care) 4. Acute Foot problems 5. Initiation of pumps 6. Ophthalmology 7. Paediatrics and transition 8. Tier 3 Bariatrics
Resource/Staffing Gaps?	**City & County:** These services are already being provided, so additional resources are not needed. It is envisaged that staff and work would transfer from the hospital based to community venues in the County.

Work stream Lead:	**Paru King**
Provider Delivery Lead:	**DtHFT**
Supported By:	**DCHS**

CROSS CUTTING THEMES

- Organisational integration
- Mentorship
- Hard to reach groups, ethnic minorities. Learning disability, housebound
- User involvement
- Clinical Governance arrangements
- Emphasise flexibility- “it is about expertise, not location”

EDUCATION

To be shaped by the Education model being developed by the Education Work stream

What is already in place?	**City:**
	County:

How would the new service differ?	**City:**
	County:
Resource/Staffing Gaps?	**City:**
	County:

Work stream Lead:	**Karen Gale / Marion King**
Provider Delivery Lead:	**Primary Care**
Supported By:	**DCHS / DSNs / DtHFT**

PSYCHOLOGICAL SUPPORT

Present situation

It is understood that, at the present time, there is only a very small amount of specialist clinical psychology input to the service and this is provided by a highly experienced Consultant Clinical Psychologist who is employed directly by RDH to provide one session per week to the service. This service has been highly valued by both staff and patients but would require being built upon to meet the increasing needs and demands of the patient group going forward. All patients also have potential access to the Increasing Access to Psychological Therapies (IAPT) services which are provided under an Any Qualified Provider Arrangement (AQP). However, this service is only for "common mental health problems" (anxiety and depression), which may be suitable for a small cohort of patients but is unlikely to meet the psychological needs of many patients with diabetes, given the range and complexity of psychological and medical problems that present to patients and their families. Specialist Mental Health Services are also provided by Derbyshire Healthcare NHS Foundation Trust, but in many cases a patient with diabetes would not present with psychological problems that would meet the access threshold for this service.

Emotional and Psychological Support for those living with Diabetes
Clearly, addressing the emotional and psychological needs of people living with diabetes is vital in order to ensure that they are best able to self-manage and maintain long term physical health. Psychological support should enable them to take full advantage of the comprehensive range of services that are on offer and thereby maximise positive outcomes within a range of economic, medial, social and psychological parameters.
The Southern Derbyshire and Derby City Integrated Diabetes Service Clinical Model that has been developed recognised that psychological support should be at all stages of the model from pre-diabetes through to highly specialist care. The following proposal aims to suggest how this could be provided, utilising existing resources and also by putting additional resources in place in order to meet the brief.
Consideration is given to psychological support to patients, staff and improving psychological literacy and staff education

Patient pathway

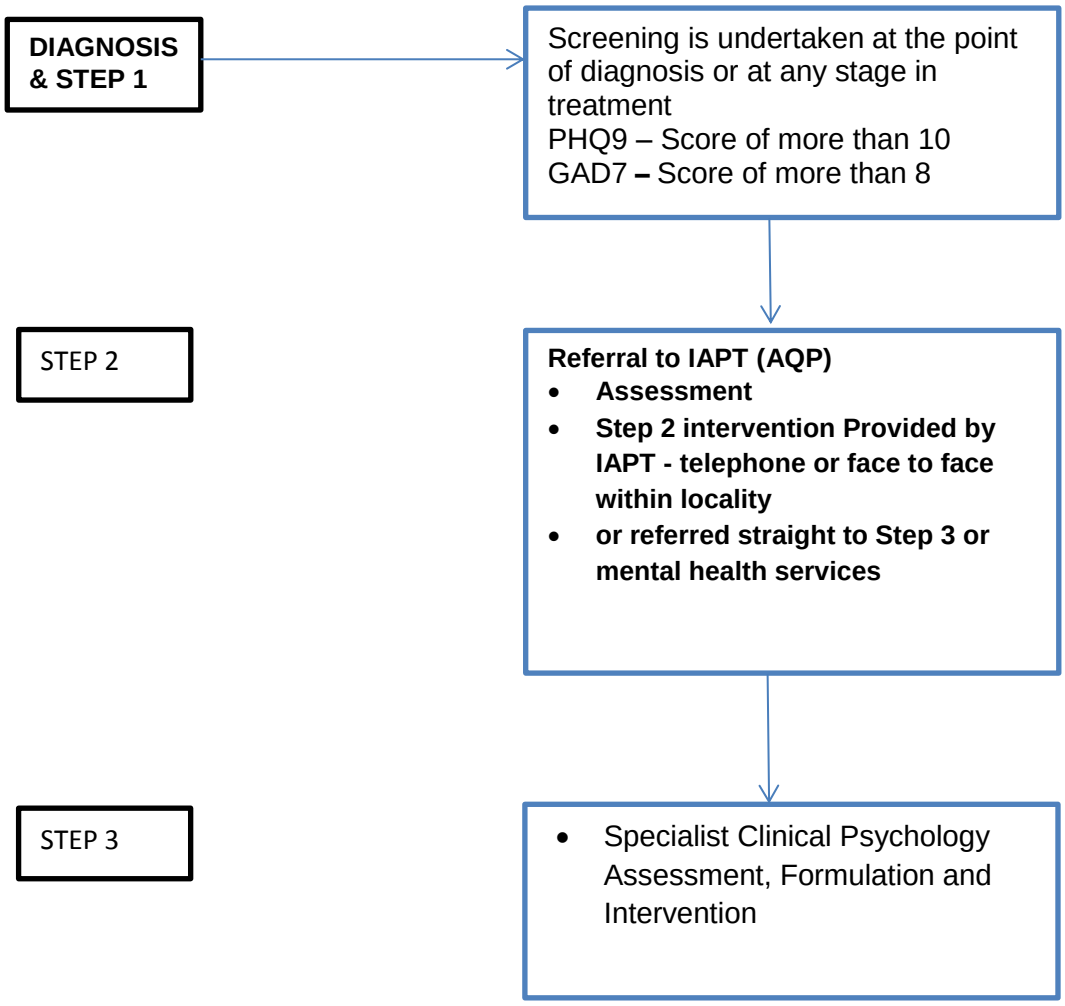
This proposal broadly follows the "pyramid model"(1) and promotes a stepped model of care. The model also takes into account a number of specific elements that were stated within the previous service's specification. They are as follows:

"Psychological support
The Contractor shall ensure that:

- Robust partnerships are in place to provide specialised Psychological support services.
- At the point of diagnosis patients' psychological needs are screened and supported on an on-going basis according to need.
- Where risks indicate the patient is screened for depression.
- Specialised psychological support is integrated at every stage of the pathway."

Proposed Psychological Care Pathway

It is important to note that although this model is proposed, IAPT is a service that is provided by Any Qualified Provider. This model has been put together in conjunction with the IAPT service delivered by Derbyshire Healthcare NHS Foundation Trust (DHcFT) and makes a number of assumptions that can be provided at each of the steps of the model. These assumptions may not be the same for other providers. The following paragraphs outline what possible interventions could be at each step of the model.



Diagnosis and Screening – Step 1

At any appropriate point following diagnosis, all patients could be asked to complete the PHQ9 and GAD7 by a member of the DH diabetes service (e.g. specialist nurse or doctor). These are both self-report measures that are used by IAPT services in order to assess and

access treatment for common mental health problems (anxiety and depression). If a score is achieved above a given threshold (10 or more for PHQ9, 8 or more for GAD7) a referral should be made to the IAPT service. Under AQP arrangements patients can refer themselves but it may be helpful to facilitate this if the referral could be made by the clinician who asks the patients to complete the questionnaire. This should clearly indicate that this is a referral for a patient with diabetes in order for figures to be collated to enable measurement against performance targets. If patients do not reach the threshold score, this information should be recorded within the clinical record for future reference if required. It is important to note responses to question 9 of the PHQ9 which directly refers to suicidal ideation in order to ensure that responses to this question are effectively addressed.

Assessment & IAPT - Step 2

An assessment would be undertaken by the IAPT service. This may be by telephone or face to face and would aim to locate the client in the correct step of the model (2, 3 or 4). A typical intervention at step 2 would be four to six sessions either face to face or over the telephone (this would be cognitive behavioural therapy and may also include psycho education and self-help components). In addition, self-monitoring and behavioural activation exercises for those with depression may be amongst the interventions utilised.

Specialist Clinical Psychology – Step 3

This would be a dedicated service to patients with diabetes provided by a Clinical Psychologist with specialist expertise in Health Psychology and long term conditions, and experience of working with people who have diabetes. As well as an agreed referral pathway from the stepped care model, additional referral pathways may be needed in order to meet the needs of the clients with more complex psychological issues that may not have presented at other parts of the pathway.

As a stepped model of care, it is envisaged that the most complex referrals may come from the “secondary care” diabetes services. However, as a hub and spoke model of delivery, a comprehensive psychological service would also provide input into each of the “community” MDT’s. The clinical psychologist would undertake psychological assessments, formulations and interventions with a range of complex presentations which may include the following;

- Severe and complex mental health presentations secondary to primary diabetes diagnosis
- Engaging with those having self-defeating behaviours who have not been able to engage with treatment interventions, resulting in a deterioration in their physical health
- Working alongside patients to provide psychological resilience in order to facilitate their self-management
- Issues relating to eating – who may not meet the remit for other specialist services
- Patients requiring longer-term interventions or alternative therapeutic approaches (behavioural couple work, family interventions, alternative therapies to CBT etc…)
- Providing group based therapy and intervention programmes

Clinical Psychology and the role with staff

In addition to direct patient focussed work, it would be envisaged that an invaluable contribution could be made in respect of providing a range of other services including:

- Liaison with other steps of the Psychological Care Pathway
- Advice and consultancy to a range of staff within the diabetes service
- Contributing to MDT meetings

- Providing Reflective practice groups
- Working with other professionals to evaluate and audit psychological interventions and support

This work would need to be considered within the overall workload and remit of the post and could be subject to negotiation.

Improving Psychological Literacy and staff education

There may also be a role in respect of contributing to staff teaching and education, but this may depend more broadly on the education and training strategy within the wider service. For example, if the service were to utilise a specific programme to support patients (e.g. DESMOND) it would be important that any psychological approaches complimented this model. It is also unclear at this stage if the service will adopt a national programme of staff education (again, the clinical psychologist could input into staff education by, for example, teaching on recognised approaches such as motivational Interviewing and mindfulness, but these do need to be incorporated into the wider ethos of the service).

Psychological Support – form to follow function…

The scale and amount of specialist Clinical Psychology input required depends significantly on the final model that is accepted.

There is an assumption that the costs of IAPT will be met through the existing arrangements for the provision of this service.

In order to meet the requirements of the role it is envisaged that a clinical psychologist at Band 8A of Agenda for Change would be required.

Depending upon the final agreed service model, it might be anticipated that a full-time 8A Clinical Psychologist would provide 20 (1 hour) face to face clinical sessions per week (2 new and 18 follow-up) with an assumption that an average intervention would be for 12 sessions. This is based on 40 weeks and therefore a total of 800 contacts per annum. Clearly, a proportion of time would then be available to provide the range of functions additional to direct clinical face–to-face contact with patients.

This contact time would, of course, vary depending on how the Clinical Psychologist wished to be utilised by the team.

At this stage, the model has suggested that there will be community based multi-disciplinary teams (spokes to the hub). In order to truly embed psychological support in the spokes, it could be anticipated that a minimum of half a day of an 8A Clinical psychologist should be made available to provide a clinic at each of these sites; this may be in addition to their contribution to the MDT and staff support.

It is important that the provision is sufficient to have the correct impact. As an absolute minimum this should be a 1.0 WTE Band 8A Clinical Psychologist, although more may be required in order to be able to operate at an effective level within both the hub and “spokes” as indicated in the model.

Work stream Lead:	**Graham Wilkes**
Provider Delivery Lead:	**DHcFT**

Supported By:	All

IT

- Single IT for all referral and assessment process
- Shared / Consistent Templates
- Patient Shares across the system and all providers
- Consistent reporting against outcomes and KPIs

LOCAL DIABETES CARE DELIVERY CENTRES

The following locations have been identified as local diabetes care centres, pending resources analysis of if facilities can be expanded to accommodate to house an integrated diabetes team.

1. London Road Community Hospital

	Current	Required
Room Availability		
Podiatry Capacity	Nothing provided.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	None	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

2. Swadlinote Health Centre

	Current	Required
Room Availability		
Podiatry Capacity	2 Podiatry rooms (bookable third room on some days of the week) Decontamination shared with Dental.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	4-6 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide	Service can be flexible within current or any new funding.

	sessions just for Diabetic patients although we are starting to do interim Diabetic debridement clinics. Need to consider RDH pathway and Burton hospital pathway for this hub.	
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

3. Ripley

	Current	Required
Room Availability		
Podiatry Capacity	3 Podiatry rooms and Decontamination room No availability for additional sessions need to reorganise.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	Existing Diabetes foot care sessions provided on a Thursday am to support GP/Consultant led Diabetes Out-patient clinic.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

4. St Oswald's – Ashbourne

	Current	Required
Room Availability		
Podiatry Capacity	2 Podiatry rooms and Decontamination room Some flexibility in sessions available.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	2-4 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.

DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

5. Alvaston - Coleman Street

	Current	Required
Room Availability		
Podiatry Capacity	2 Podiatry rooms and a pre-op room which we utilise as often as available Decontamination shared with Dental.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	4-6 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients, at this site we also provide pre-op and nail surgery sessions which tie up some of the room availability.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

6. Belper

	Current	Required
Room Availability		
Podiatry Capacity	3 rooms and a bookable room with some availability. Decontamination suite.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	4-6 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening	Yes / No	

Available		
Education Delivery		

7. Heanor

	Current	Required
Room Availability		
Podiatry Capacity	Currently 2 rooms and decontamination. From 2017 moving to Heanor Hospital(early indication of limited space rooms/capacity).	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	3-4 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

8. Alfreton

	Current	Required
Room Availability		
Podiatry Capacity	2 rooms and shared Decontamination facilities.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	3-4 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

9. Sinfin or Willington

	Current	Required
Room Availability		
Podiatry Capacity	Sinfin 1 room Not involved at Willington.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	2 sessions per day provided currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

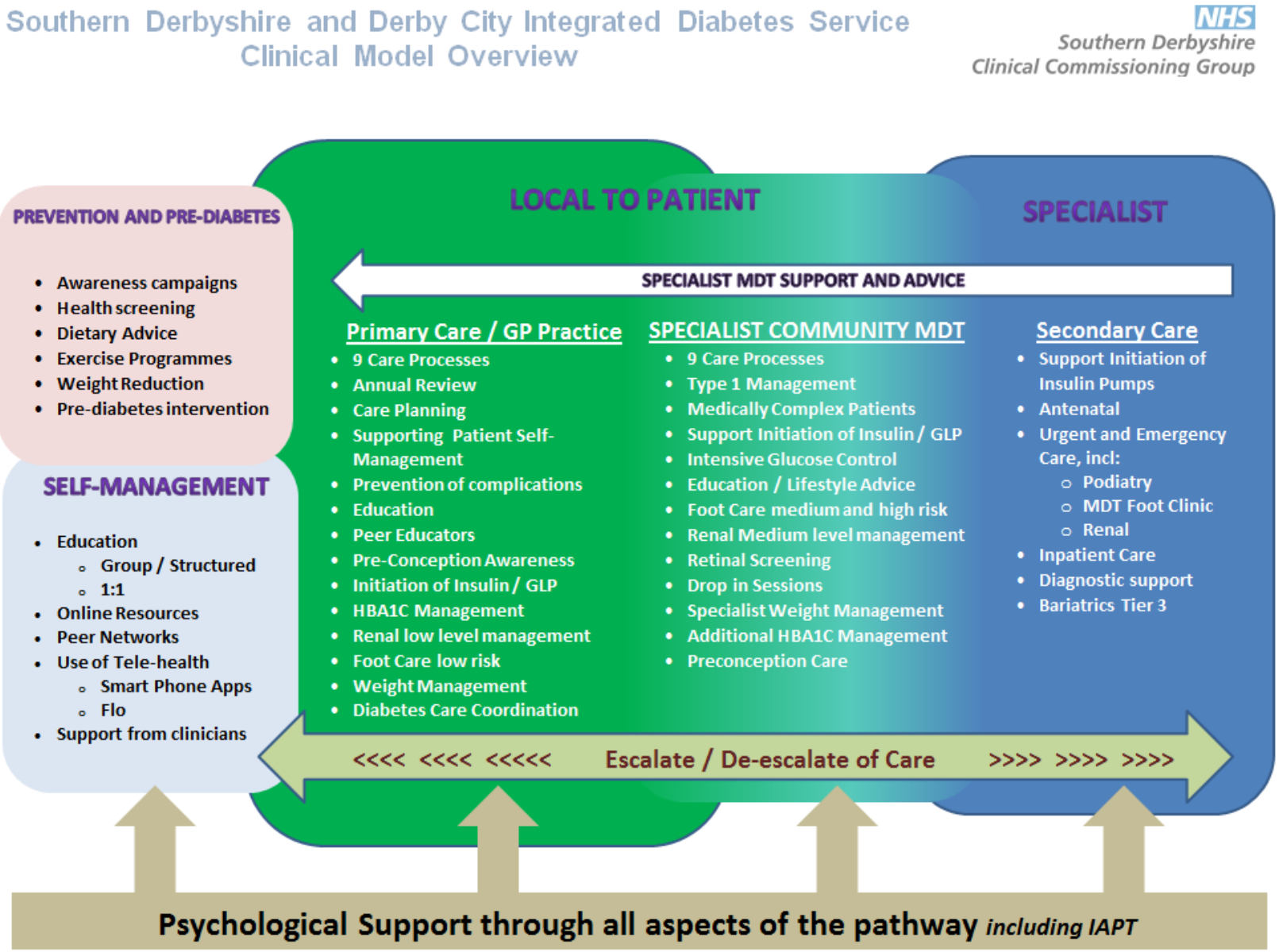
10. Chaddesden – Revive Centre

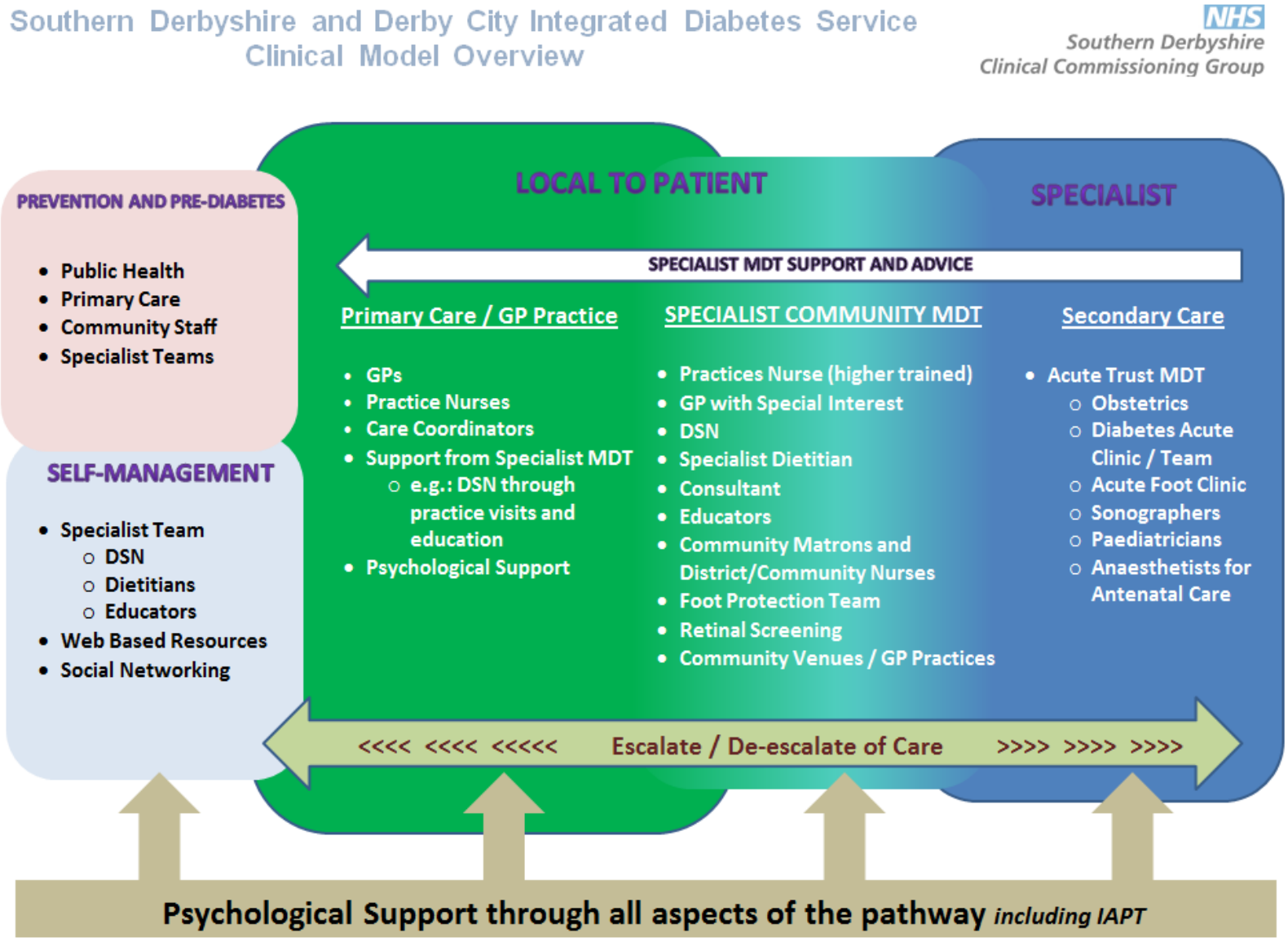
	Current	Required
Room Availability		
Podiatry Capacity	Monday 1 room and 2 rooms for the rest of the week.	Depends on patient numbers-number of days wanted At least 5 day cover potentially required.
Podiatry Sessions	2 sessions on a Monday and 3-4 sessions rest of the we currently for mixed case load(not just Diabetes) We currently do not provide sessions just for Diabetic patients.	Service can be flexible within current or any new funding.
DSN Capacity		
DSN Sessions		
Dietitian Capacity		
Dietitian Sessions		
Retinal Screening Available	Yes / No	
Education Delivery		

Potential Gap:

Wirksworth Area - Podiatry have one room at Hannage Brook Medical Centre.

MODEL OVERVIEWS




Southern Derbyshire and Derby City Integrated Diabetes Service
Clinical Model Overview
NHS
Southern Derbyshire
Clinical Commissioning Group
PREVENTION AND PRE-DIABETES
Public Health
Primary Care
Community Staff
Specialist Teams
SELF-MANAGEMENT
Specialist Team
DSN
Dietitians
Educators
Web Based Resources
Social Networking
LOCAL TO PATIENT
SPECIALIST
SPECIALIST MDT SUPPORT AND ADVICE
Primary Care / GP Practice
GPs
Practice Nurses
Care Coordinators
Support from Specialist MDT
e.g.: DSN through practice visits and education
Psychological Support
SPECIALIST COMMUNITY MDT
Practices Nurse (higher trained)
GP with Special Interest
DSN
Specialist Dietitian
Consultant
Educators
Community Matrons and District/Community Nurses
Foot Protection Team
Retinal Screening
Community Venues / GP Practices
Secondary Care
Acute Trust MDT
Obstetrics
Diabetes Acute Clinic / Team
Acute Foot Clinic
Sonographers
Paediatricians
Anaesthetists for Antenatal Care
<<<< <<<< <<<<< Escalate / De-escalate of Care >>>> >>>> >>>>
Psychological Support through all aspects of the pathway including IAPT