Blackburn with Darwen Community Diabetes Service Referral Criteria

Referrals accepted into the Blackburn with Darwen Community Diabetes Service from any Blackburn with Darwen GP or Blackburn with Darwen secondary care consultant for patient's resident and registered with a Blackburn with Darwen GP:

1. Patients with Type 2 diabetes and an HbA1c of greater than 8.5% recorded on 2 consecutive occasions 3 months apart.
2. Patients with Type 2 diabetes with control greater than 8.5% and on 2 or more oral hyperglycaemic therapies
3. Patients with Type 2 diabetes requiring insulin initiation/GPL1 assessment and initiation
4. Patients with Type 2 diabetes for intensive weight management by specialist dietician
5. Patients with Type 2 diabetes requiring specialist community diabetic podiatry services excluding level 1 annual assessments undertaken by GP practice
6. Patients with Type 1 diabetes whom are well managed
7. Patients with Type 2 diabetes requiring basal bolus insulin regime
8. Patients with Type 1& 2 diabetes requiring X-pert standard and X-pert Insulin education.

Referrals accepted for Structured X-Pert Education Programme from any healthcare professional or via patient self referral

Exclusion criteria to the Community Diabetes Service:

1. Patients under the age of 18
2. Pregnancy or pre conceptual advice
3. Suspected Type 1 Diabetes
4. MODY and uncommon types of diabetes
5. Structured education for Type 1 diabetics DAFNE
6. Insulin pump therapy

Discharge criteria to GP practice

1. Attainment of individual HbA1c target as per NICE between 6.5% and 7.5% and stable for 3 month period
2. Attainment of individual optimal target for HbA1c and stable for 3 month period
3. Failure to improve diabetes clinical indicators over 4 separate tests (Hba1c) at 10-12 weekly intervals.

Referral to Secondary Care from Community Diabetes Service

1. Pre conceptual advice
2. Patients on complex treatment regimes and failing to achieve target HbA1c
3. Patients presenting with acute 'Hot Foot' or unresolved foot ulceration
4. Patients with persistent unexplained hypoglycaemia and unresolved hypoglycaemia unawareness
5. Deteriorating complications of Diabetes requiring specialist secondary care intervention

NHS Blackburn with Darwen

DIABETES SERVICE MODEL LEVELS OF CARE

NHS East Lancashire

Level 0 – Diabetes Prevention/Targeted Screening
General health education, including healthy schools, obesity strategies and public health. Encourage self care, NHS health checks.

Level 1 – Standard Diabetes Care
Standard care that all patients regardless of diabetes type, complications or place of care should expect to receive from their key health professionals.

- Annual review to screen for complications i.e retinal screening and foot assessment
- Education/advice to support self management
- Follow up of uncomplicated type 2 patients on diet only or monotherapy/dual/triple combination tablet therapy in line with NICE and NSF guidelines
- Long term conditions register and record maintenance
- Information exchange to support patient management across pathway
- Referral to structured patient education
- Referral to dietician
- Referral for psychological support
- Personalised care plan in collaboration with patient to support self care
- Undertake comprehensive cardiovascular risk assessment including blood pressure
- Offer patients a medicines use review as part of their annual diabetes review
- Clinical audit to ensure appropriateness of referrals to level 2
- Educate patients on blood glucose monitoring
- Offer patient choice of intervention or support when problem or need arises

Level 2 – Enhanced diabetes care (includes all elements in level 1)

- Support and follow up for patients with more complex needs for type 1 and type 2 diabetes e.g quarterly or as required
- Encourage and support patients to self manage their conditions using care planning and motivational interviewing techniques during consultations
- Establish appropriate basal or bd mixed insulin regimes or alternative 3rd line therapies treatments as required by NICE guidance
- Initiation of exenatide/liraglutide and other new therapies when indicated
- Educate patients on correct use of appropriate equipment and devices including injection technique and patterns of blood glucose monitoring
- Manage well-controlled type 1 diabetics basal bolus insulin
- Recognise and refer to level 3 poorly controlled type 1 and type 2 diabetes and refer appropriately to more specialist services
- Enable joint virtual clinics within practices to enable type 1 and more complex type 2 patients to be reviewed by the consultant led service and newer treatments to be available to patients promptly
- Accept referrals back from level 3 with management plan; some of which may have suboptimal control e.g elderly patients

Level 3 – Consultant led diabetes care (rapid input for short period then discharge-few exceptions e.g. pump patients)

- Intensive intervention and initiation (including all elements of level 1 and 2)
- Suspected Type 1 Diabetes at any age
- New diabetes in persons aged under 35 years
- Young adults aged under 25 years with any type of diabetes
- Uncommon types of diabetes e.g. secondary to pancreatic disease, MODY
- Patients requiring initiation of basal bolus insulin regimes
- Patients with poorly controlled diabetes
- Patients with multiple co-morbidities
- Patients on complex treatment regimes – uncontrolled on any triple combination therapies
- Patients with employment issues – e.g. HGV drivers
- Problematic hypoglycaemia
- Autonomic neuropathy
- Painful peripheral neuropathy
- Morbid obesity (BMI >40) if suboptimal glycaemic control
- DAFNE type 1 structured education
- Insulin pump therapy
- Planning pregnancy
- Pregnancy with diabetes
- Patient defined need

Note: Patients under consultant led diabetes care can be under shared care of consultant with

CARE PLANNING TAKES PLACE WITHIN ALL LEVELS – ACCREDITED AND APPROPRIATE STRUCTURED EDUCATION TAKES PLACE ACROSS ALL LEVELS

THESE MODELS ARE DESIGNED FOR USE BY THOSE TRAINED AND COMPETENT IN DIABETES CARE

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