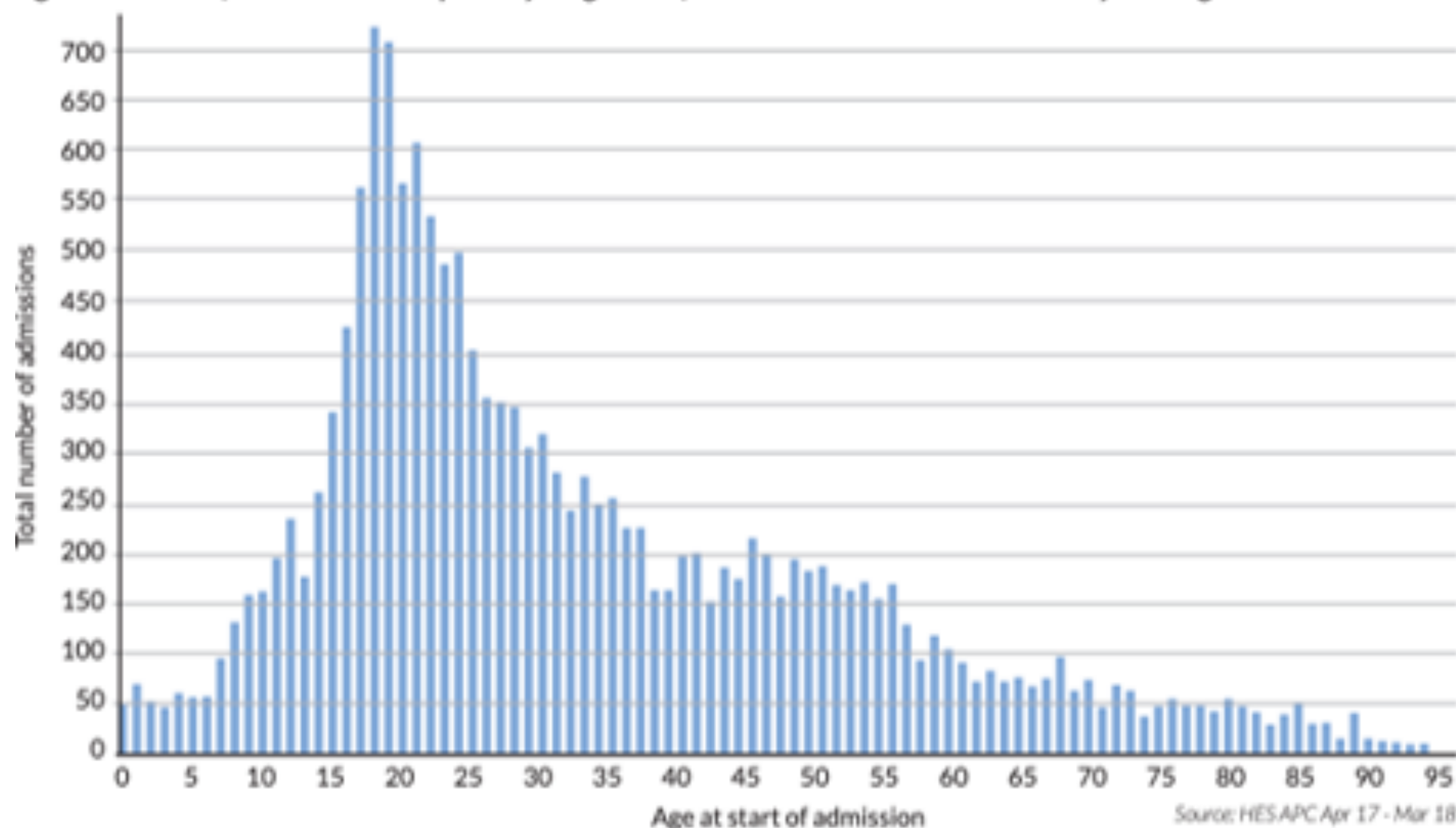
Getting It Right First Time

Diabetes

3 areas of focus

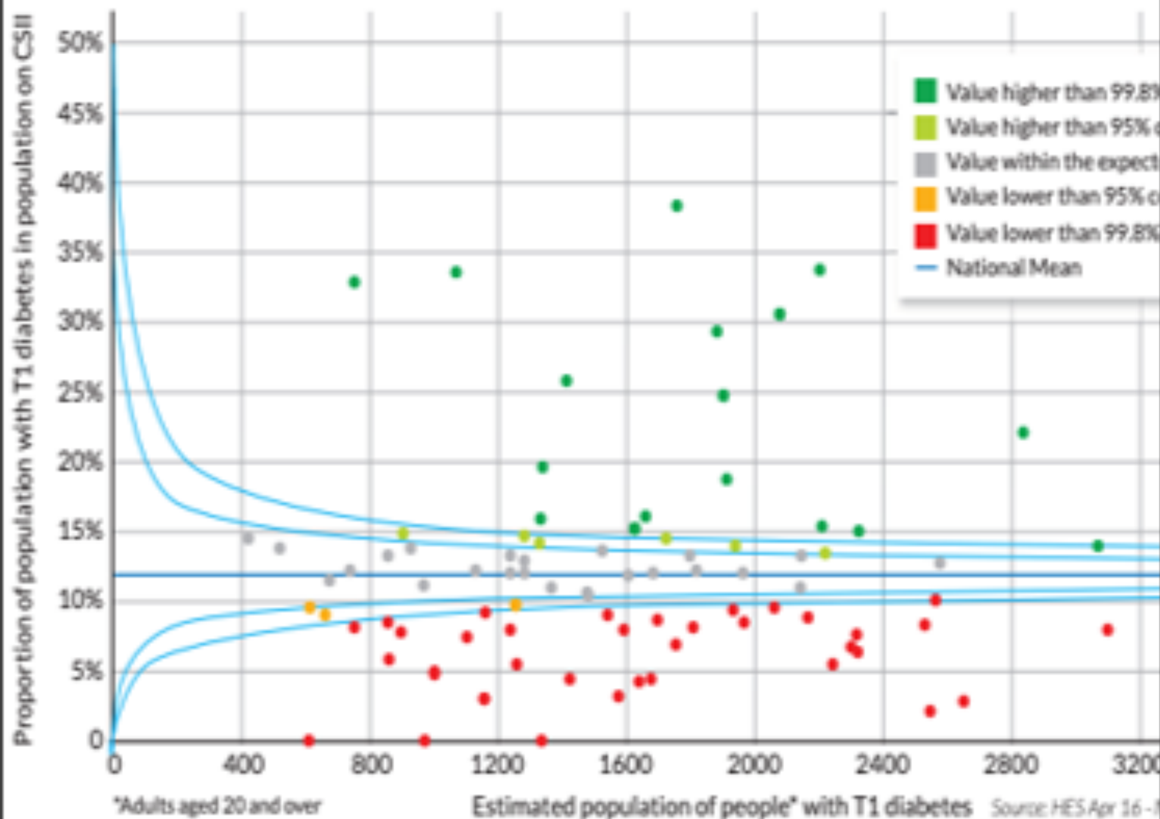
- Type 1 Diabetes care
- Inpatient care
- Foot care

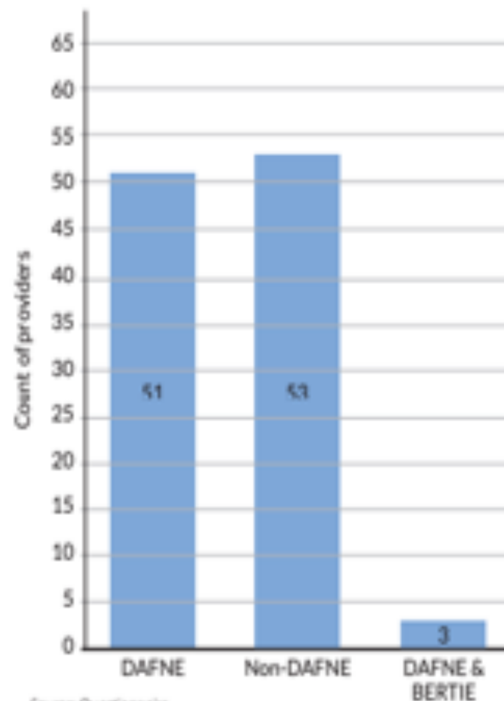
Type 1 Diabetes care

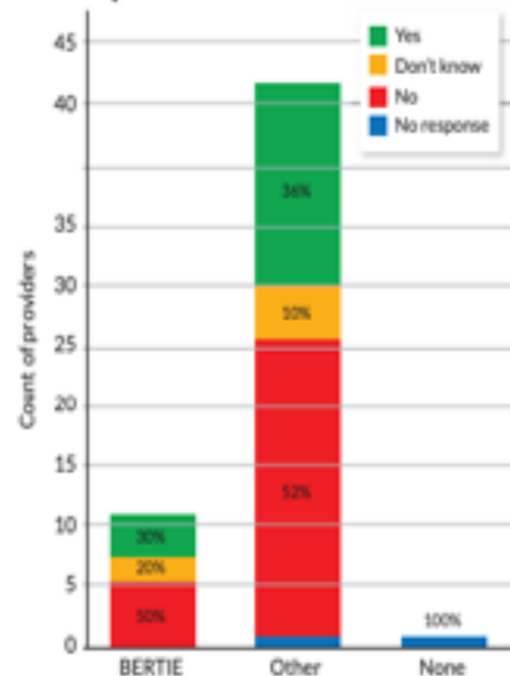


- Variation in awareness of numbers
- Variation in provision of transition services/ young adult services
- Access to technology

Technology and Education







Type 1 diabetes

Transition from paediatric to young adult services

1. All trusts providing type 1 diabetes care should have a dedicated transition service with a clear pathway between paediatric and 16-18 services, a named lead clinician for 16-18 patients, and a service for 19-25 year olds. These services should provide support for those on insulin pumps and new technologies, as well as ongoing psychological support.

Training and technology

2. Access to diabetes technology should be available to all people with type 1 diabetes who need it in their local area in line with the NHS Long Term Plan and NICE guidelines. Relevant staff should be trained to support patients using these technologies and given the time they need to complete this training, which should form part of their annual appraisal process.

Structured education

3. All people with type 1 diabetes should be offered appropriate training to manage their condition through a QISMET-accredited, quality controlled structured education programme.

Systems to allow data download from blood glucose monitoring devices

4. All trusts providing type 1 diabetes services should have a system, such as Diasend, to enable blood glucose data to be downloaded and presented in a meaningful way in all diabetes clinical areas – including paediatric, transitional, 16-18 and adult services as well as diabetes pregnancy services. Each department should have provision to offer virtual clinics to patients with type 1 diabetes. This should be supported by trust IT departments.

Inpatient care

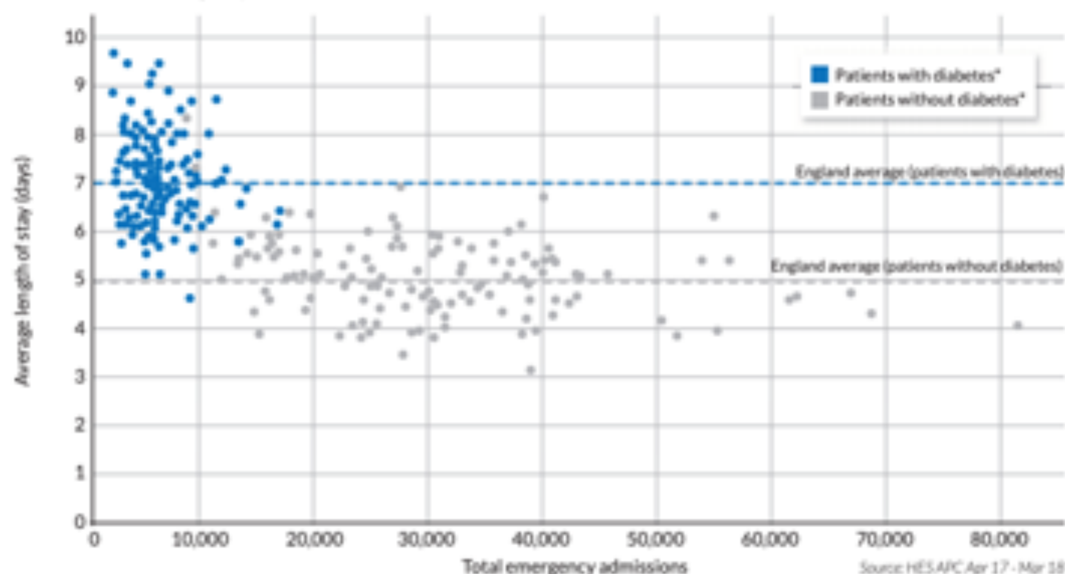


Figure 6: Difference in average length of stay between patients with and without diabetes (type 1 and type 2) admitted as an emergency*

*Excludes amputation and stroke admissions, includes admissions with LoS of 0 days

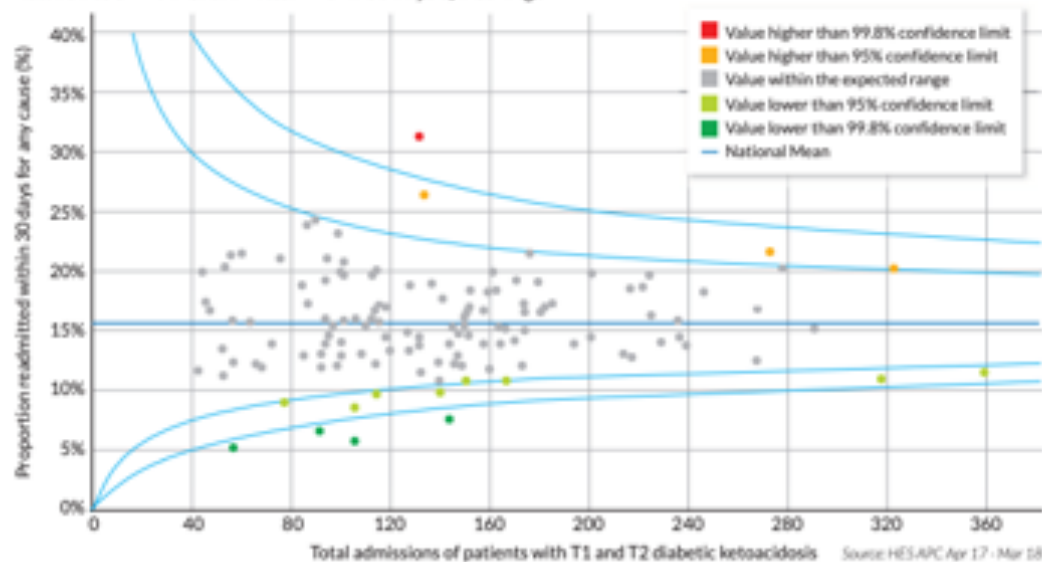
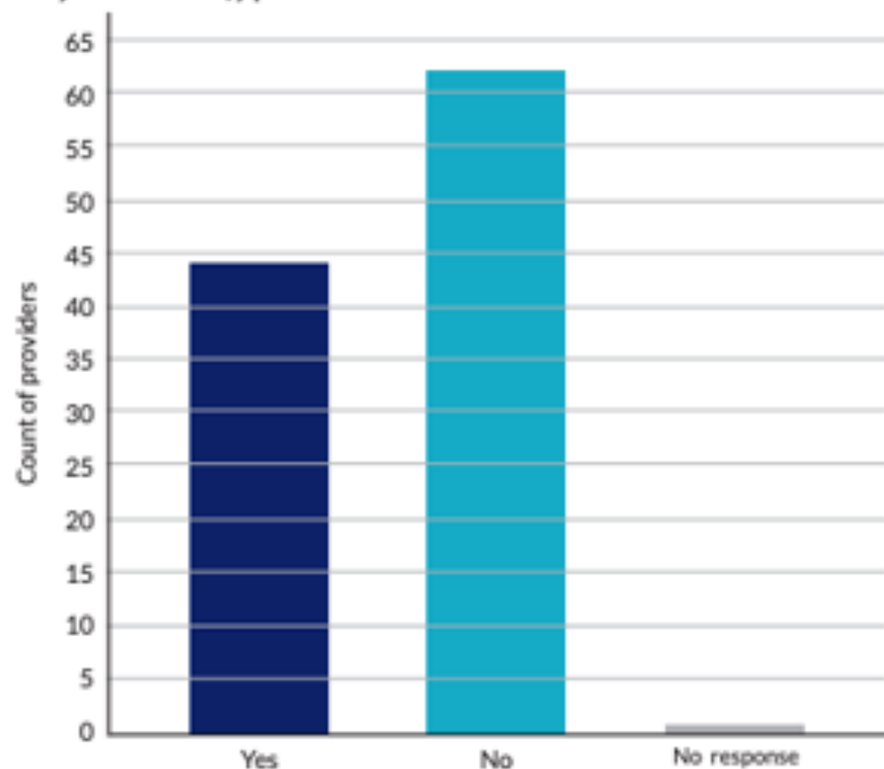


*Figure 8: Proportion of patients with diabetes admitted with diabetic ketoacidosis who are readmitted within 30 days of discharge**

*Excludes admissions of patients who are admitted in DKA > 3 times in the year

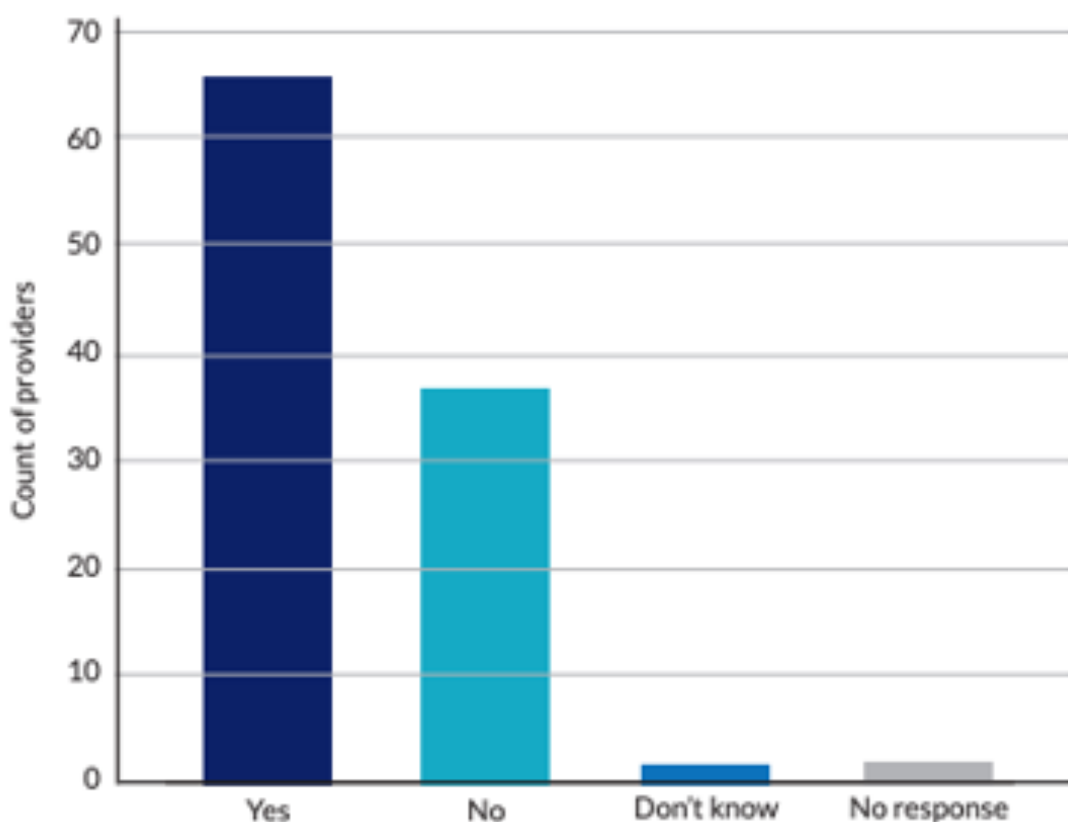
Figure 11: Count of providers by whether or not they have a method that they use to identify patients with diabetes on their admission to the trust



Source: Questionnaire

Note: 'No response' indicates providers who received the questionnaire but did not return an answer to this question.

Figure 16: Count of providers by whether or not the provider has a self-management policy in place for patients with diabetes



Source: Questionnaire

Inpatient Care

Dedicated multi-disciplinary inpatient diabetes teams (MDiTs)

5. All trusts must have a dedicated multi-disciplinary team of specialist diabetes inpatient practitioners as indicated in the NHS Long Term Plan. Trusts should work towards providing base level specialist diabetes cover at weekends where this does not exist.

6. The MDiT should meet regularly to discuss day-to-day errors and safety issues, and report to a quarterly trust-level diabetes safety board which reviews the overall quality of the inpatient service, with support from IT, based on incident reporting, local and national audits of patient harms, diabetes medication errors, length of stay and readmissions.

Identifying diabetes on admission and ensuring rapid referral

7. All trusts should have a robust system to identify all people with diabetes on admission to hospital, including emergencies and elective and non-elective surgery, and a triage system to identify those at risk and rapidly refer them to the diabetes team. This should be an electronic system, integrated with web-linked blood glucose meters which provide an alert system for staff when any out-of-range reading is recorded.

Reducing insulin errors

8. Training should be provided for every healthcare professional who dispenses, prescribes and/or administers insulin, appropriate to their level of responsibility, including an assessment of competency.

Improving care through perioperative pathways

9. All hospital trusts should have clear, audited perioperative pathways from pre-assessment through to discharge. These should be broadly in line with NCEPOD recommendations.

Footcare

South west: 10 steps to effective diabetic footcare services

1. Patient education at annual review
2. Regular community healthcare professional education
3. Adequate podiatry community staffing with rotation in to MDFT
4. Job planned MDFT weekly
5. Administrative support
6. Pathways and communication of plan of care to patient
7. Identification of diabetic inpatients and their foot checks
8. Orthotist an integral part of MDFT
9. Urgent vascular opinion available to foot clinic staff
10. Ulcer database and root cause analysis of all amputations

Diabetic footcare

Effective diabetic footcare services

11. All trusts should have a dedicated multi-disciplinary footcare service (MDFS) as stated in the NHS Long Term Plan and NICE NG19. The service should be well integrated with the community footcare protection service (FPS), and with hospital renal wards and dialysis units given the increased risk of amputation for diabetic patients in these areas. CCGs and STPs should ensure that community foot protection teams are trained to carry out foot screening and that the community service is structured to deliver the standards recommended in NG19.

Vascular networks

12. Everyone with a diabetic footcare emergency requiring admission should be assessed the same day by the MDFS. If the MDFS identifies vascular impairment, they should have same day access to a vascular opinion, according to NICE NG19, whether the hospital is a vascular service hub or a spoke. If the MDFS is not present, the patient must still be assessed same day, which may require transfer to the vascular service.

Ensuring access to vascular services in spoke hospitals

In response to the apparent variation we found, we have identified a number of potential solutions which could overcome challenges in accessing a vascular opinion in spoke hospitals. These include:

- Holding multi-disciplinary diabetes footcare clinics ideally twice a week.
- Ensuring a vascular surgeon is on site whenever there is a multi-disciplinary footcare clinic.
- Developing closer relationships between diabetes and vascular services, with a key role for nurses to act as a liaison between teams.
- A member of the vascular team reviewing every patient admitted with an acute footcare problem within 24 hours of admission.
- A service level agreement or standard governing how hubs will provide cover to support spokes when needed.
- Governance over every hub and spoke link to ensure that the service is being delivered as specified, with auditing and national benchmarking of outcomes for people with diabetes managed in the vascular service.
- Closer working and outreach with primary care and community-based teams (including podiatrists), ensuring links to MDFTs.

Other recommendations:

Data and coding

13. Local commissioners should build in clear contractual requirements for trusts to collect and submit data to the Diabetes Audit, including data on type 1 patients aged 19-25, the National Diabetes Inpatient Audit and the Diabetes Footcare Audit. Trusts should work to improve the quality and consistency of clinical coding.

Procurement and medicines optimisation

14. GIRFT and partner organisations should work together to assess the financial and clinical case for novel appro the procurement of insulin pumps, blood glucose testing strips, oral anti-diabetic agents and diabetes footwear, w reduce costs and support increased uptake of continuous glucose monitoring and closed loop technology. This s done in a way that maintains reasonable choice for people living with diabetes.

Reducing the impact of litigation

15. Reduce litigation costs by applying the GIRFT Programme's five-point plan.

Report available on:

https://www.gettingitrightfirsttime.co.uk/medical-specialties/diabetes/