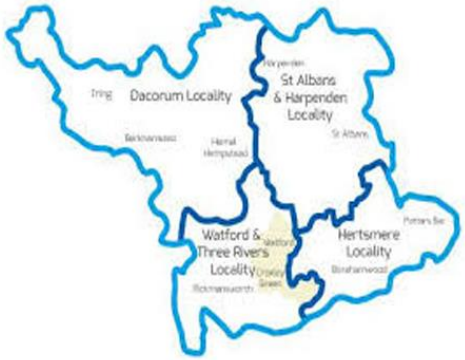


Herts Valley Integrated Diabetes Service (HIDS)

NHS
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust

HertsOne
GP Federation

We are HIDS!

(Herts Valley Integrated Diabetes Service)

Hertfordshire DIABETES Education

Our Vision - Integrated Diabetes Model

- Providing a joined up end to end pathway (enabling a smooth transition across services for patients) including single point of access
- Shorter waiting times for structure education and to see diabetes consultants and podiatry
- More support for primary care e.g. advice line
- Primary care up-skilling
- Psychiatry support as part of the diabetic pathway
- Outcomes bases contract

SPOC

West Hertfordshire Hospitals NHS
NHS Trust

Hertfordshire Community NHS
NHS Trust

REFERRAL FORM
INTEGRATED DIABETES SERVICE

Referrals must be submitted by e-RS -
e-RS Primary Care Menu Speciality: **Diabetic Medicine** Clinic Type: **All clinic types – send for triage**

Patient Enquiries:
Single Point of Contact (SPOC), Herts Valleys Integrated Diabetes Service, Potters Bar Hospital, Potters Bar, EN62RY
Tel: 01707 621152 **Email:** hct.hv.diabetes@nhs.net

Practice staff – please note that the telephone lines are extremely busy. If you have enquiries about receipt of referral/appointment dates please contact the service by e-mail hct.hv.diabetes@nhs.net

INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION
THIS COULD RESULT IN A DELAY IN PROCESSING YOUR REFERRAL

This form is to be used for all non-emergency referrals for people with Type 1 or Type 2 diabetes who are requiring an enhanced level of specialist diabetes management.

The following patients should be referred as indicated:

1. **EMERGENCY FOOT:** if systemically unwell WITH RED, HOT, SWOLLEN foot, spreading infection or signs of CRITICAL ISCHAEMIA, GANGRENE, requires admission to secondary care. Refer immediately to the Acute Medical Team On-Call.
2. **PREGNANT WITH DIABETES:** Refer **immediately** to diabetes midwife at Watford General Hospital on 07733 949119 or Diabetes Department at Watford General Hospital on 01923 217553 (Monday-Friday 09.00-16.00)
   N.B. For referral to other trusts please see Urgent Admissions Contact list

DATE OF REFERRAL:

Patient details

Patient Full Name: .....

NHS No: ..... Date of Birth: ..... / ..... / ..... Age: ..... Sex : .....

Address : ..... Postcode : .....

Preferred No: □ Home Tel No : ..... Patient consents to message being left Y □ / N □

Preferred No: □ Mobile Tel No: ..... Patient consents to message being left Y □ / N □

Ethnicity: ..... Language: .....

Tick if patient has a disability, requires information in an accessible format or requires additional support □

Please select all that apply and provide further information

□ Interpreter required – Language: .....

□ Cognitive Impairment :

□ Hearing Impairment :

□ Visual Impairment :

□ Mobility Impairment :

□ Learning Disability

Please advise any adjustments needed to support this patient: .....

Please advise if there is a relative/carer/friend who needs to be informed of any contacts/appointments

Name:..... Relationship to patient: ..... Tel no:.....

□ House Bound - home visit required (Not available for podiatry referrals)

Property access and relevant information for home visits:

Patient's GP details

Registered GP:.....

Referring GP/Practice Nurse: ..... Signature: .....

Practice: ..... Practice Code: .....

Practice Address: .....

Practice Telephone: ..... Practice e-mail: .....

Preferred no for virtual review:..... E-mail for correspondence: .....

CONSENT: This referral has been discussed with the patient and the patient consents to relevant information being shared with the service provider.

If not please provide further detail:

Enhanced clinical triage

REFERRAL DETAILS
DATE OF DIABETES DIAGNOSIS:
KNOWN DIABETES COMPLICATIONS
□ Peripheral vascular disease □ Peripheral Neuropathy □ Cardiac Event □ Nephropathy □ Retinopathy □ CVA/TIA

ADVICE AND GUIDANCE – if you request advice and guidance your patient will not be offered a face to face appointment
□ **Virtual review between GP and Consultant to discuss patient management** (eg oral therapy/renal/lipid management) *See Guidance*
Preferred method of contact: □ **GP Direct** Tel No: □ GP e-mail address:
If you are requesting advice and guidance by e-RS, telephone or e-mail please give a brief description of the issue you would like to discuss:
□ **Urgent Advice – for urgent clinical advice contact the Duty Diabetes Specialist Nurse on 07584 703989** This number is for urgent clinical advice only. Do not share with patients, or use to contact the service for admin queries.

Suggested Virtual Review cases:

- Clinical management discussions
- Second opinions in diabetes management or that relate to patient diabetes care
- Case reviews incl. non-engaged patients/serial DNAs therefore for specialist oversight +/- advice
- Medication
- Renal
- Lipids
- Hypertension

REASON FOR REFERRAL

□ DIETETICS

□ DESMOND (Type 2 DM education) for new patient confirmed diagnosis within the year) – *Desmond PIL*
□ Type 2 DM education for patients diagnosed for more than a year
□ DAFNE (Type 1 DM education)
□ Dietetic Advice

Please provide further information relating to your reason for referring if appropriate:

□ SPECIALIST REVIEW (face to face consultations)

□ Hyperglycaemia/High HbA1c
□ Insulin Initiation
□ Insulin Management
□ GLP-1 Initiation
□ Hyperglycaemia due to steroid therapy
□ Hypoglycaemia
□ Patient on Insulin Pump/ device management
□ Pre-pregnancy
□ Young Adult/Transition (16-25 years)
□ Diabetes Renal -Please refer to West Herts Diabetes Renal Pathway.
USS kidneys/autoimmune screen performed Y □ / N □

Please provide further information relating to your reason for referring if appropriate:

☐ **PODIATRY (See Guidance for assessing diabetic foot risk)**

URGENT FOOT: (If not requiring emergency admission, patient will be seen in the MDT foot clinic within 24 hours.)

☐ **Ulcer**
☐ **Acute Pain**
☐ **Infection not responding to standard treatment**
☐ **Unexplained foot swelling**

INCREASED / HIGH RISK FOOT (Tick all that apply)

☐ Neuropathy
☐ Absent pulses
☐ Foot deformity/discolouration
☐ Previous ulcer/amputation
☐ Callous

☐ **OTHER – please use this section to any enter further information:**

Please provide further information relating to your reason for referring if appropriate:

NICE diabetic foot risk categories: Please tick (see table 1 ☐ for clarification)

Low: ☐	**Moderate:** ☐	**High:** ☐	**Ulcerated:** ☐

COMMENT/ ADDITIONAL INFORMATION TO SUPPORT REFERRAL:

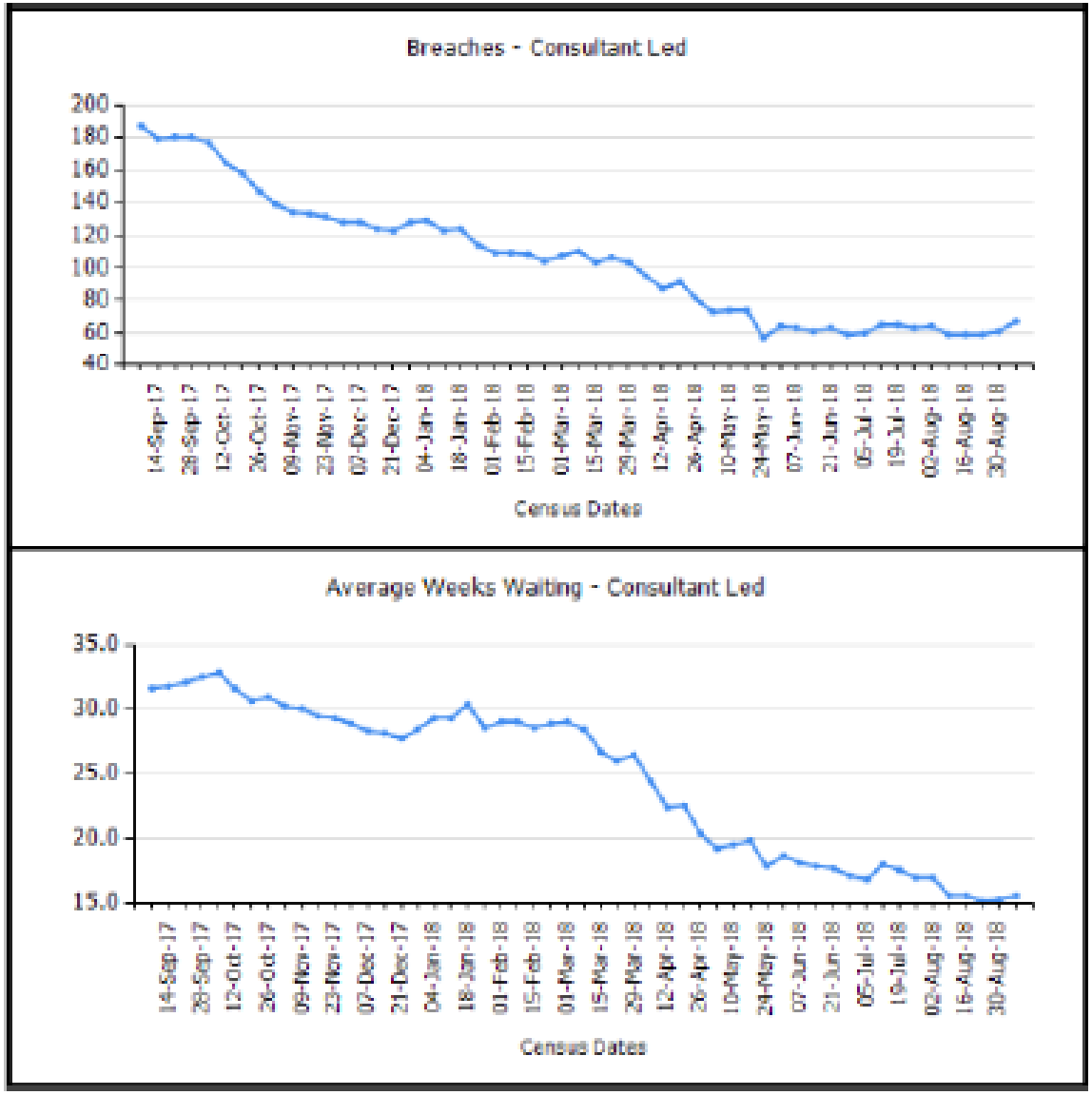
Would this patient benefit from a referral to the Wellbeing Service?

Table 1: NICE diabetic foot risk categories Assess the person's current risk of developing a diabetic foot problem or needing an amputation using the following risk stratification:	
Low Risk	*** no risk factors present except callus alone**
Medium Risk	***deformity or *neuropathy or *non-critical limb ischaemia**
High Risk	***previous ulceration or *previous amputation or *on renal replacement therapy or *neuropathy and non-critical limb ischaemia together or *neuropathy in combination with callus and/or deformity or *non-critical limb ichaemia in combination with callus and/or deformity**
Active diabetic foot problem	***ulceration or *spreading infection or *critical limb ischaemia or *gangrene or *suspicion of an acute Charcot arthropathy, or an unexplained hot, red, swollen foot with or without pain**

Insulin (including doses); Please complete this section if possible/relevant.				
Insulin	**Breakfast**	**Lunch**	**Evening**	**Pre Bed**

Investigations within the last 6 months	
Height (metric)	
Weight (kg) / BMI	
LFTs	
BP (mmHg)	
HbA1c IFCC (%/mmol/mol)	
HbA1c DCCT (%/mmol/mol)	
Total Cholesterol (mmol/L)	
HDL – chol (mmol/L)	
LDL – chol (mmol/L)	
TGs (mmol/L)	
eGFR (mL/min)	
Urine ACR (mg/mmol)	

Current Medication:
Problems – Active and Inactive
Allergies


Breaches - Consultant Led
200
180
160
140
120
100
80
60
40
14-Sep-17
28-Sep-17
12-Oct-17
26-Oct-17
09-Nov-17
23-Nov-17
07-Dec-17
21-Dec-17
04-Jan-18
18-Jan-18
01-Feb-18
15-Feb-18
01-Mar-18
15-Mar-18
29-Mar-18
12-Apr-18
26-Apr-18
10-May-18
24-May-18
07-Jun-18
21-Jun-18
05-Jul-18
19-Jul-18
02-Aug-18
16-Aug-18
30-Aug-18
Census Dates
Average Weeks Waiting - Consultant Led
35.0
30.0
25.0
20.0
15.0
14-Sep-17
28-Sep-17
12-Oct-17
26-Oct-17
09-Nov-17
23-Nov-17
07-Dec-17
21-Dec-17
04-Jan-18
18-Jan-18
01-Feb-18
15-Feb-18
01-Mar-18
15-Mar-18
29-Mar-18
12-Apr-18
26-Apr-18
10-May-18
24-May-18
07-Jun-18
21-Jun-18
05-Jul-18
19-Jul-18
02-Aug-18
16-Aug-18
30-Aug-18
Census Dates

GP Practice visits

- Questionnaire – to be circulated and completed prior to PV date and returned to HCT
- QoF data
- NDA data
- PH data
- EDEN Gap analysis data
- EDEN attendance data
- PDP

GPPV – suggested timetable

- Update regarding service and local initiatives (15 mins)
- Questionnaire review (30 mins)
- Case Review / case based Q&A CPD (45 mins) – 5 cases of each sub-speciality (e.g. renal/foot/oral meds/ANC/engagement/hyperglycaemia or insulin management)
- Feedback regarding particular patients in HIDS from the team / potential DSN and PN initiatives (cDSN lead) – (30 mins)
- Discussion re: QoF/NDA/Skills gap analysis (25 mins)
- Discussion re: PDP (5 mins)

New Services Offered

Clinics Offered

- Consultant Led MDT Clinics
- CDSN Follow up Clinics
- CDSN Home Visit
- Seamless Care with WHHT

Practice Support

- CDSN and Consultant Practice Visits.
- Virtual and Joint Clinics
- Telephone and email support for Surgeries.

Patient Education

- Group GLP-1 starts
- Learning disability Group education
- Starting insulin together groups
- Carbohydrate awareness Groups

HCP Education

- Nursing and care Homes Education
- Community and Practice Nurse Forums.
- Health Care Assistants Insulin administration Project.

Community DSN Team

Community Base for Referrals ; Potters Bar Community Hospital

4 localities aligned to Community Diabetes Specialist Nurses

Hertsmere

Watford

St Albans and Harpenden

Dacorum

Contact details available within HIDS document

Starting Insulin Together groups

- New 2 session education by DSN and Dietitian to equip patients with full understanding of using insulin to control type 2 diabetes
- Small groups run locally in Watford and Dacorum, now to roll out programme to all areas
- Good patient satisfaction and able to include carers
- Greater self management and engagement especially during titration phase

Learning Disability group education

- New course run in Watford and St Albans area for all types of diabetes in those patients who have a LD. Soon to run in Dacorum and Hertsmere.
- Small groups 6-10 patients attend a 4 week programme to learn more about their diabetes
- Set up with HPFT nurses and Practice Nurse
- Involvement and education of carers to help support patient with on going food, cooking, activity and lifestyle choices.
- Aim to improve engagement for their diabetes checks and understanding of how they can achieve better control

- Treatment targets
- Glycaemic control
- Insulin management (Foundation and Advanced)
- Footcare
- Type 1 Diabetes
- Diabetes in the Elderly
- Diet and Obesity
- Clinical Presentation
- eLearning modules: Pre-conception, hypoglycaemia

Key Contacts

- Integrated diabetes service clinical lead, Dr Thomas Galliford thomas.galliford@whht.nhs.uk
- HCT diabetes clinical lead and nurse consultant, Maggie Carroll maggie.carroll1@nhs.net
- HVCCG diabetes clinical lead, Dr Nicola Cowap nicola.cowap@nhs.net
- HVCCG senior commissioning manager, Pamela Shepherd p.shepherd@nhs.net
- Eden education, Dr Alka Patel alkapatel3@nhs.net
- Web-site, Dr Vidya Kanthi vidya.kanthi@nhs.net