



INFORMATION FOR NURSES

An RCN guide to the National Service Framework for Diabetes



Royal College
of Nursing



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Acknowledgements

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Foreword

Helping someone to come to terms with their diagnosis, to move quickly on to learning how to take responsibility for managing their diabetes and caring for themselves is a complex process. The contribution of nurses working in both primary and secondary care to this process must not be underestimated. Key attributes for the nurse – and any health care professional involved in diabetes care – include good interpersonal skills, an ability to educate and facilitate learning in others and the sensitivity to give information in a way and at a pace that the person living with diabetes can really relate to. It also requires a high level of self-awareness about when and how to facilitate, coach, direct, lead, influence and negotiate with the patient, taking into account the patient's needs and priorities at that time. Partnership and collaboration is the basis of a therapeutic relationship and this takes time to develop for both the patient and the nurse.

Nurses can, and do, make a real difference to people's lives. They do this within the context of the clinical team. Nurses co-ordinate care for the patient, signposting them to appropriate services and resources or referring them to other specialists or agencies. More nurses are involved in the diagnosis of the patient, establishing treatment, agreeing the plan of care, arranging follow-up and reviewing and monitoring progress, deciding on referral to other health care professionals. In future, many more nurses will be able to prescribe medications within the framework of supplementary prescribing. This improves the patient's experience by making sure that they receive timely and appropriate care.

The RCN Diabetes Nursing Forum has produced this excellent guide for nurses. I am very proud to have been asked to write the foreword. The Diabetes National Service Framework standards and delivery strategy provide a framework to facilitate local improvements in the way that diabetes services are organised and provided, ensuring that the standards of care apply to all groups of people. This guide will help you to interpret the standards and see ways of making improvements in your own clinical practice. Nurses in leadership positions should ensure that they are at the heart of local decisions being made about diabetes service improvement and about enabling frontline nurses to strengthen their contribution to the care of people living with diabetes.

Sarah Mullally

Chief Nursing Officer for England

Introduction

The National Service Framework (NSF) for Diabetes is the sixth Framework to be introduced by the Government. By setting national standards for England, the Framework aims to improve health care and make it consistent across the country. While giving most of the responsibility to primary care trusts (PCTs), it also emphasises the need for closer co-operation between primary care and specialist services. The 12 standards for diabetes care were announced in December 2001, and the delivery strategy was published in January 2003. This guide summarises the standards, offers practical tips on achieving them and outlines the delivery strategy.

Elsewhere in the UK

Wales will use the same standards as England but is developing its own delivery strategy. Wales will also use the NICE Guidelines. The Scottish Executive Health Department published the Scottish Diabetes Framework in 2002. Different priorities have been set, but the overall content is similar to the English Service Framework. The plan for Northern Ireland follows the Scottish approach.

Wales:

www.wales.nhs.uk/sites/documents/334/diabetes-standards-wales.pdf

Scotland:

www.scotland.gov.uk/library5/health.sdf-00.asp

Northern Ireland:

www.diabetes.org.uk/n.ireland/execsummary.doc

The delivery strategy

The diabetes Framework sets only two specific targets:

1. **eye screening:** primary care trusts will ensure that systematic eye screening and treatment programmes are in place so that by 2006, 80 per cent of people with diabetes will be offered screening, rising to 100 per cent by 2007.
2. **registers:** GP practice-based registers of patients with coronary heart disease and diabetes will be updated by 2006 to ensure systematic, effective treatment, call and recall.

The other recommendations are less prescriptive. Nevertheless, health care providers are expected to set their own local priorities with the aim of making progress across all 12 standards over the next 10 years. Clearly, the standards cannot all be achieved at the same time and the Framework suggests prioritising work with patients with poor blood glucose control and the newly diagnosed.

The key themes of the delivery strategy are:

- ◆ leadership and accountability
- ◆ involving and empowering patients
- ◆ audit and information technology
- ◆ workforce planning.

Leadership and accountability

A national clinical director for diabetes has been appointed, and each PCT will identify local clinical leads (a doctor, nurse or allied health professional) and leaders from among people with diabetes. There will be clear lines of accountability for service provision.

Involving and empowering patients

The Framework promotes a partnership approach to care. Patients should hold their own personal diabetes record, containing an agreed care plan along with a record of treatment and test results. Patient representatives will become increasingly involved in local service planning.

Audit and information technology

National datasets will facilitate standardised care delivery and information sharing as well as producing audit information for local and national use.

Workforce planning

Each diabetes network will carry out a workforce skills profile and work with their local Workforce Development Confederation to provide the appropriate training and education.

The standards

Standard 1

Preventing Type 2 diabetes

This standard aims to reduce the number of people who develop diabetes. It is primarily concerned with increasing public awareness of diabetes and providing specific targeted support and information for people who are at high risk of developing the disease. It also promotes healthy living for the population as a whole: 'Prevention is always better than cure. Where there is no cure, prevention is better still.'

- ◆ Take every opportunity to promote healthy living, especially to 'hard-to-reach' groups and those at particular risk of developing diabetes. Wherever possible, encourage those who are better placed than nurses – teachers, fitness instructors, those involved in Surestart programmes, pharmacists and people with diabetes – to spread the message too, and give them the information they need in order to do so.
- ◆ Provide 'healthy lifestyle' and diabetes education for staff in mental health, learning disabilities, prison, elderly care, and school settings. For example, in schools run educational sessions and support government initiatives like making fruit available for pupils during school breaks. Specialist diabetes nurses can help with this, or ask Diabetes UK, health promotion units or appropriate commercial companies for information you can then pass on.
- ◆ Run 'healthy lifestyle' groups to provide information on, for example, diet and exercise. Some groups organise supermarket tours so people with diabetes can learn about shopping for healthy foods. Contact your local PCT to find out about existing local initiatives.
- ◆ Make sure visits or talks to, for example, schools, prisons or patient participation groups include discussion of prevention strategies.
- ◆ Think about organising a 'Diabetes Awareness Day' – set up a stand in a local shopping centre, or have an open day in a doctor's surgery or diabetes centre. Invite health professionals and drugs reps and use local radio and TV to publicise the event. Try to involve all relevant health professionals and social services.
- ◆ In some areas, council-run leisure centres work with GPs to provide low-cost exercise programmes for people with diabetes. Evidence shows that regular exercise can improve patients' blood glucose levels. Contact your local leisure centre – if they don't already offer this service, you may be able to persuade them to do so.

- ◆ Support local leisure centres that offer designated time for older or overweight people, or people from ethnic minorities.
- ◆ Provide information on local slimming classes.
- ◆ Discuss pharmaceutical and/or surgical intervention with obese patients.

Standard 2

Identifying people with diabetes

Standard 2 aims to identify people who don't know they have diabetes, so that early intervention and education can reduce the risk of diabetic complications. Current evidence is unclear as to which screening test should be offered to which group. The UK National Screening Committee plans to publish targeted screening advice in 2005. In the meantime, consider the following actions.

- ◆ The NHS Information Authority is currently working on a detailed dataset which nurses will be able to use to flag up individuals for screening for Type 2 diabetes. See: www.nhsia.nhs.uk/phsmi/datasets/pages/diabetes.asp.
- ◆ Categories for screening include those with heart disease and stroke, the elderly, those with a first degree relative with diabetes, those with a BMI of 30+ or waist circumference greater than 88cm (female) or 102cm (male), and overweight children or young people seen by school nurses.
- ◆ Provide follow-up and regular screening for people previously found to have impaired glucose tolerance.
- ◆ Provide follow-up and regular screening for women with a history of gestational diabetes.
- ◆ Screen hospital inpatients for glycosuria.
- ◆ Use fasting plasma glucose as a screening test.
- ◆ Consider urinalysis plus fasting plasma glucose (if positive) for some groups, such as new residents of care homes.
- ◆ Display posters advertising the symptoms of diabetes.
- ◆ Educate primary care and community staff, especially those working with older or black and minority ethnic groups, to promote awareness of symptoms of diabetes. Identify and contact existing groups and offer them formal and informal education about diabetes – for example, you could offer to give a talk at a community lunch club. You could also use Surestart programmes or, for example, local radio.
- ◆ Consider screening overweight children and young people as they may be at risk of developing Type 2 diabetes.

Standard 3

Empowering people with diabetes

This standard encourages people with diabetes (and their carers) to be partners in decision-making. It aims to give them more personal control over their day-to-day diabetic management, ensuring the best possible quality of life. Providing patient-held records and offering patient education are key to this standard. As one patient put it: ‘Dentists may see you once or twice a year, but they don’t brush your teeth for you.’

- ◆ Listen to your patients with diabetes and make an effort to get to know them.
- ◆ Take every opportunity to enhance your empowerment skills through training and/or counselling.
- ◆ Where appropriate, do what you can to involve parents and carers in decisions about treatment and in everyday care.
- ◆ Involve people with diabetes in clinical decision-making.
- ◆ Refer patients to self-help groups such as the Expert Patient Programme. The NHS Plan (2000) highlighted the need to develop services designed around patients’ needs. The Expert Patient Programme is an excellent way of getting patients involved in their own care. Your PCT will tell you if there is a programme in your area.
- ◆ Identify psychological problems and refer people for psychological support as appropriate.
- ◆ Provide patient-held records.
- ◆ Effective self-management calls for a thorough understanding of the condition. Provide group or one-to-one education for patients.
- ◆ Supply up-to-date written information, for example, NICE guidelines and Diabetes UK publications, for patients and carers. This must be culturally and age appropriate. For patients with literacy problems, or those who cannot read or write in English, you may need to offer visual information – for example, videos – or ethnic language versions of printed documents.
- ◆ Pass on useful website addresses such as Diabetes UK (www.diabetes.org.uk) and any local diabetes websites.
- ◆ Establish structured education programmes. Structured group programmes enable patients to learn from each other and offer mutual support. It also means that patients will be given the same information, and that the effectiveness of the programme can be evaluated. Some paediatric teams, for example in Newcastle, are running age-banded clinics using age appropriate tools and supplementing this with individual one-to-one education.

Standard 4

Clinical care of adults with diabetes

This standard aims to optimise quality of life for people with diabetes and to reduce their risk of long-term diabetic complications. A team approach is likely to provide the best outcomes. Achieving this standard relies on establishing and implementing guidelines and protocols, and on the continuing education of all health professionals involved in the diagnosis and care of people with diabetes.

- ◆ Ensure that the person with diabetes knows what care to expect from the time of diagnosis onwards and that they understand why this care is being given, for example, how it is likely to affect their condition.
- ◆ Patients need regular call and recall for review of their condition, and ongoing education and support.
- ◆ Identify and follow up patients who fail to attend hospital and clinic appointments.
- ◆ Provide appropriate care for the housebound and people in residential or custodial settings. Lines of responsibility may not always be clear, and you should speak to GPs, practice nurses and district nurses to find out what is going on in your area.
- ◆ Refer people with specific problems to relevant specialist care.

- ◆ Use national guidelines, for example, NICE, to underpin care to optimise control of blood glucose, blood pressure and other risk factors. The Guidelines contain specific information on these topics. See Useful websites (page 13) for information on the guidelines in Wales, Scotland and Northern Ireland.
- ◆ Make special provision for people at risk of being disadvantaged or excluded, for example ethnic minority groups and older people.

Standards 5 and 6

Clinical care of children and young people

These standards aim to meet the special needs of children and young people, ultimately enabling them to manage their diabetes effectively. Children, young people and their families should receive high quality care and support, and there should be a smooth transition from paediatric to adult diabetes services. Although the majority of care for children and young people is provided by the secondary care multidisciplinary paediatric team, school nurses, health visitors, practice nurses and GPs also have an essential part to play.

The standards recognise that while children and young people usually develop Type 1 diabetes, an increasing number are

being diagnosed with Type 2. The possibility of MODY (maturity onset diabetes of the young) and other rare genetic disorders should not be ignored.

Children

- ◆ Make sure you understand the special needs of children and young people with diabetes: see the RCN publication *Children and young people's nursing: a philosophy of care* (RCN Publication Code 002 012).
- ◆ Make sure parents and carers can access support from the multidisciplinary paediatric team, including paediatric diabetes specialist nurses. Input from school nurses, health visitors and practice nurses is essential. Effective communication systems must be in place.
- ◆ Provide appropriate educational resources for children from diagnosis onwards. As well as written information, look out for computer packages and videos. Children will need more and different information as they grow older.
- ◆ Involve parents in the day-to-day management of their child's diabetes.
- ◆ Encourage links with local and national support groups.
- ◆ Educate all carers, including school staff and social services, about the diabetes care requirements of this special group.

Young people

- ◆ Recognise the special needs of this age group at what is already a time of enormous change. See the RCN publication *Caring for young people* (RCN Publication Code 001 824).
- ◆ Pay special attention to the arrangements for the transfer of young people from paediatric to adult diabetes services. Joining an adult service can be a culture shock, and some young people may stop attending their appointments. A staged transition period is essential. Some units offer structured handovers where nurses from both services meet the young person together to explain the arrangements.
- ◆ Consider a separate transition or young persons' clinic, to cover the post-school leaving period. Young persons' clinics should cover all those attending adult services up to the age of 25.
- ◆ Consider holding clinics outside normal working hours, for example early in the evening or on Saturday mornings. Young people may be more willing to attend if they don't have to take time off from work or study (which sets them apart from their peers).
- ◆ Arrange special events focusing on areas of interest to young people and where their diabetes could cause problems, such as sport and nutrition.

- ◆ Identify those young people with complex emotional needs and offer referral to a psychologist.
- ◆ Set up a 24-hour telephone advice service to deal with out-of-hours problems.
- ◆ Identify those young people who are not attending hospital or clinic appointments and follow-up non-attendance.
- ◆ Make sure all carers, including health care professionals, school staff, social services and leaders of voluntary youth organisations have a thorough grounding in the specific needs of young people with diabetes.

Standard 7

Diabetic emergencies

This standard aims to ensure that acute diabetes-related complications are recognised promptly and treated by appropriately trained health care professionals. Educating patients and the general public will form a key part of the work needed to achieve this standard.

- ◆ All nurses need up-to-date knowledge of diabetic ketoacidosis, hyperosmolar non-ketotic coma (HONK) and hypoglycaemia management. Look for appropriate courses and information, either written or online. Non-specialist

nurses may find information intended for patients particularly useful.

- ◆ Patients should be taught how to manage their blood glucose when they are unwell, and about how to treat and prevent hypoglycaemia. This knowledge should be assessed regularly.
- ◆ Follow your local protocol for managing diabetic emergencies in the community or during a hospital admission.
- ◆ Consider setting up a telephone hotline or encourage patients to contact the Novo Nordisk careline (0845 600 5055).

Standard 8

Caring for people in hospital

This standard aims to ensure consistently good quality care for people with diabetes admitted to hospital for whatever reason. This will be achieved by educating hospital staff and through the support of a specialist diabetes team.

- ◆ Highlight healthy food options on menus and offer health snacks, particularly at bedtime.
- ◆ Don't take over! Wherever possible, patients should continue to be involved in decision-making.
- ◆ Use an in-patient stay as an opportunity to assess and update the

patient's diabetes knowledge.

- ◆ Teamwork is vital – there should be good liaison between the ward nurse, practice nurse, district nurse or diabetes specialist nurse. This will ensure more effective care and that the advice offered to patients is consistent.
- ◆ Policies and procedures should be published on the hospital intranet site.
- ◆ Work with designated diabetes specialist nurses to provide patient support and staff training.
- ◆ Make sure all diabetes patients and ward staff are aware of the Diabetes UK publication, *What care to expect*. Contact Diabetes UK for hard copies or refer patients to the Diabetes UK website at www.diabetes.org.uk. Look out for printed information aimed specifically at children and young people.

Standard 9

Diabetes and pregnancy

This standard aims to ensure that women with pre-existing diabetes or who develop diabetes in pregnancy have a positive experience of pregnancy and childbirth and have healthy babies. This can be achieved by identifying and treating

patients who are at risk of developing diabetes during their pregnancy and providing high quality pre-conception and antenatal care, particularly meticulous blood glucose control. Follow your local protocol for screening pregnant women (the National Screening Committee is currently developing guidance).

- ◆ Make sure all young female patients are aware of the need for planned pregnancy with optimal glycaemic control before conceiving.
- ◆ Refer patients to their local diabetes pregnancy clinic early on in the pregnancy. Ensuring correct glycaemic throughout will optimise the patient's chances of a healthy pregnancy and uncomplicated delivery.
- ◆ Type 2 patients should stop taking oral hypoglycaemic agents before becoming pregnant. This calls for a proactive approach on the part of the nurse, who may need to offer advice before being asked.

Standards 10, 11 and 12

Detecting and managing complications

These standards aim to minimise the impact of diabetic complications through early detection and effective management. This requires integrated service provision

and clear referral criteria, and may involve the development of highly specialised secondary care services.

- ◆ Use the national diabetes dataset as the basis for a systematic review of patients' heart, eyes, feet and kidneys.
- ◆ Refer high-risk patients and people who are already experiencing complications for specialist care.
- ◆ Educate and empower people with diabetes to reduce their risk of complications, using all the ideas outlined above.
- ◆ Involve other services as appropriate, for example, social services.

Next steps

Clearly, it will not be possible to tackle all these service developments at the same time. Start by identifying those measures that will make the most difference, and/or those that are easiest to achieve. Ask your local primary care organisation what's happening in your area and how you can get involved. They should also be able to tell you who your local diabetes leads are. Help establish local priorities by taking part in your local baseline assessment. You can also establish and/or update diabetes registers in your area. If you need further training, find out what's on offer. Finally, make a point of reminding all patients with diabetes of the importance of retinal screening.

Further reading

Department of Health (2001) *National Service Framework for Diabetes: standards*. London: DH

Department of Health (2002) *National Service Framework for Diabetes: delivery strategy*. London: DH

(Both publications can be downloaded from www.doh.gov.uk/nsf/diabetes.htm. They are also available free of charge to NHS professionals from the NHS Responseline on 08701 555 455.)

Directory of Diabetes Care – contact 0800 585088 for a free copy (plus £2.50 p&p)

National Institute for Clinical Excellence (NICE) publications are available from www.nice.org.uk or free of charge to NHS professionals from the NHS Responseline on 08701 555 455.

Already published:

- ◆ Rosiglitazone for Type 2 diabetes
- ◆ Pioglitazone for Type 2 diabetes
- ◆ Orlistat for the treatment of obesity in adults
- ◆ Sibutramine for the treatment of obesity in adults
- ◆ Surgery to aid weight reduction in morbid obesity

- ◆ Management of Type 2 diabetes:
 - ◆ Screening and early management of retinopathy
 - ◆ Prevention and early management of renal disease
 - ◆ Management of blood glucose
 - ◆ Management of blood pressure and lipids
- ◆ Long-acting insulin analogues – insulin glargine

◆ Insulin pump therapy

Forthcoming:

- ◆ Patient education models
- ◆ Footcare in Type 2 diabetes
- ◆ Management of Type 1 diabetes in adults
- ◆ Management of Type 1 diabetes in children

Scottish Human Services Trust (2002) *Partners in change: diabetes report – living with diabetes and opportunities for getting involved: experiences of people who have diabetes*. Edinburgh: SHS www.shstrust.org.uk

Scottish Human Services Trust (2002) *Partners in change: Diabetes summary. Hearing the voices of people in Scotland who have diabetes*. Edinburgh: SHS www.shstrust.org.uk

Useful websites

Datasets: the NHS Information Authority's diabetes datasets are available at www.nhsia.nhs.uk/phsmi/datasets

Diabetes National Service Framework
Zone: the National Electronic Library for
Health's Framework Zone is available at
www.nelh.nhs.uk/nsf/diabetes

Diabetes UK is establishing a good
practice database for sharing information
and ideas. Go to www.diabetes.org.uk
Quality indicators in diabetes services: see
www.quids.org.uk

Resumé – the RCN Diabetes Nursing
Forum online newsletter, can be found at
www.rcn.org.uk in the RCN Newsletter
Plus section

Scottish Diabetes Group – Set up by the
Scottish Executive Health Department to
support and monitor the implementation
of the Scottish Diabetes Framework.
Information on the group and list of
publications and events can be found at
www.diabetesinscotland.org

Scottish Intercollegiate Guidelines
Network (SIGN): www.sign.ac.uk



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