Health and care experience profile #2

What are the characteristics of this health and care experience profile?

A person of South Asian ethnicity with diabetes.

Rationale

This Profile:

- Illustrates a condition that requires the person to interact with many kinds of services and support – including primary, community and specialist care.
- Provides the opportunity to explore the experiences of people from South Asian ethnic groups, who have an increased risk of developing type 2 diabetes,[1] and serious complications associated with diabetes.[2]
- Provides the opportunity to explore both integration between the different health services involved and integration with other relevant services and organisations including community support, social prescribing and/or social care.
- Reflects key broad commitments of the NHS Long Term Plan – better care for major health conditions and stronger action on health inequalities.[3]

What kind of care should this Profile be able to expect?

> "Each person with diabetes is constantly managing their condition. They need an NHS focused on supporting their self-management – by delivering care and support centered and coordinated around their needs." – Diabetes UK[4]

People living with diabetes need input from services across a wide range of provider sectors. This includes generalist, community-based and specialist care.

[1] NICE (2018) Promoting health and preventing premature mortality in Black, Asian and other minority ethnic groups [QS167]

[2] Diabetes UK & South Asian Health Foundation (2009) Recommendations on research priorities for British South Asians

[3] NHS England (2019) NHS Long Term Plan

[4] Diabetes UK (2014) Improving the delivery of adult diabetes care through integration

NICE guidance covering the management of type 1 diabetes[5], type 2 diabetes[6], diabetes in pregnancy[7] and prevention and management of diabetic foot problems[8] outlines the need for:

- Care being provided by a range of professionals with skills in diabetes care working together in a coordinated approach.
- Individualised care that is tailored to the person's needs and circumstances.
- Annual review of a jointly agreed care plan.
- Annual eye screening for complications of diabetes.
- Individualised and culturally appropriate dietary advice from professionals with appropriate specialist knowledge.
- Appropriate structured education on how to manage diabetes.
- Advice on and use of smoking cessation services, if needed.
- Prompt referral to psychological support from specialists, if needed.
- Regular assessments and integrated care across all settings to prevent and manage diabetic foot problems.
- For older adults with type 2 diabetes, particular consideration of their broader health and social care needs.

Best practice guidance for commissioning diabetes services[9], produced by Diabetes UK, Department of Health, and the NHS Diabetes team (amongst other partners), supports the clinical guidelines and highlights that people living with diabetes receive input from a wide range of health and care professionals, and that the fragmented delivery of this care results in both system inefficiencies and poor experiences for service users. Patient experience of their care, including moving between different parts of the system, is noted as an outcome that should be measured.

[5] NICE (2016) Type 1 diabetes in adults: diagnosis and management [NG17]

[6] NICE (2019) Type 2 diabetes in adults: management [NG28]

[7] NICE (2015) Diabetes in pregnancy: management from preconception to the postnatal period [NG3]

[8] NICE (2019) Diabetic foot problems: prevention and management [NG19]

[9] Diabetes UK, NHS Diabetes, Department of Health and partners (2013) Best practice for commissioning diabetes services: an integrated care framework

What kind of care should this Profile receive in Cambridgeshire and Peterborough?

The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) (Draft) Long Term Plan[10] set out the needs for patients with diabetes. A new strategy was developed specifically addressing health inequalities in areas with the worst outcomes and greatest deprivation. This is a draft version as the final version has been delayed due to the Covid pandemic.

Local pathways and processes for people with diabetes

There are no local system wide clinical processes or pathways for people with diabetes. Each Primary Care Network (PCN) is responsible for their own systems. Our local research has shown that from the three PCNs who replied, they do not differentiate between different ethnicities for diabetes care.

[10] Cambridgeshire and Peterborough STP (2019) Confidential draft Cambridgeshire and Peterborough Long Term Plan, 29 November 2019

Local Services provided for diabetic patients

Integrated Lifestyle Services

Cambridgeshire County Council and Peterborough City Council's new Integrated Lifestyle Services contract started on 1 October 2020 under the brand name 'Healthy You'[11] and is provided by Everyone Health. The service provides weight management, stop smoking service, health trainers and falls prevention. Language interpreters are available via Cinta.

A new service using Diabetes Specialist Health Trainers will provide support to patients newly diagnosed with type 2 Diabetes to help them make sustainable change. This will be available after the Covid pandemic.

There are South Asian languages on offer to this health and care experience profile, and different languages available for the online services.

See Appendix 3 for the referral process to Healthy You diabetes health trainers and Appendix 4 for the Everyone Health Integrated services pathways.

Diabetic eye care

Annual eye screening for diabetics is provided by the East Anglia eye screening programme.[12] Once people have been referred to the programme by their GP, the service is responsible for carrying out all aspects of screening, including grading and referring to hospital eye services as required.

The process after screening shows:

- Up to three accredited healthcare professionals will access pictures.
- Aim to review images quickly and send the result to the patient within ten days.
- If a further review is needed, the patient will be referred to the hospital eye service.

[11] Everyone Health (2021) Healthy You - The new name for Healthy Lifestyle Services in Cambridgeshire and Peterborough

[12] East Anglia Diabetic Eye Screening Programme (2021) Diabetic Eye Screening

The local eye screening programme follows the national guidelines. On their website they say:

> "Once there is or has been a definite diagnosis of diabetes, excluding gestational diabetes, the patient should be screened for diabetic retinopathy annually for life.
>
> For those patients who had steroid induced diabetes whose diabetes is now 'resolved' the decision about screening should be made on a case-by-case basis. If there is any doubt, the patient should continue to be offered screening."

All patients aged 12 and over with a diagnosis of diabetes should take part in the diabetic eye screening programme. Patients who have had bariatric surgery or no longer show the symptoms of diabetes still need to attend for screening. Recent national guidance has confirmed this position.[13]

Podiatry services

NHS podiatry in Cambridgeshire and Peterborough[14] is accessible to those that meet certain criteria through Cambridgeshire and Peterborough Foundation Trust.

Advanced Podiatry Services (APS)

The APS service helps to provide diabetic foot care service for Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).[15]

The APS clinicians are advanced podiatrists and have highly specialist knowledge and skills in assessing, diagnosing, and treating diabetic foot pathology.

They provide:

1. Community/ Primary care: wound clinics and Total Contact Casting clinics, weekly consultant led diabetic foot clinic.
2. Hospital in-patient care: Multidisciplinary foot ward rounds
3. Hospital out-patient: monthly Multidisciplinary foot clinic and casting sessions (while primarily under care of orthopedics)

[13] Gov.uk (2020) NHS diabetic eye screening (DES) programme

[14] CPFT (2021) Podiatry Service

[15] Cambridgeshire and Peterborough Clinical Commissioning Group (2019), Advanced Podiatry Service - Who we are and what we do, January 2019

Diabetes Outreach Team (DOT)

DOT[16] is a team of specialist nurses, dieticians, and a care technician, led by diabetes consultants, who provide a diabetes advisory service for patients. This service is based at Cambridge University Hospitals NHS Foundation Trust (CUH). Their role is to support the needs of patients admitted with diabetes to improve patient experience and outcomes.

CUH say, "One in six patients admitted to hospital has diabetes. Of these 9 out of 10 are not admitted because of their diabetes. However, they experience longer length of stay, higher complication and mortality rates. Medication errors and glucose control issues can contribute to these outcomes. Many patients also experience a sense of loss of control over their diabetes when admitted."

North West Anglia Foundation Trust

Hinchingbrooke and Peterborough City hospitals run weekly consultant outpatient clinics for patients with type 1 and type 2 diabetes,[17] as well as five nurse led clinics a week and two specialist diabetes dietician clinics.

There are a dedicated team of inpatient specialist nurses supporting patients with diabetes in hospital and aim to screen all patients with diabetes for foot problems.

Patient education programmes and campaigns

NHS Diabetes Prevention Programme[18]

This is a free community-based behaviour change programme that helps those at risk of developing type 2 diabetes reduce their chances of getting the disease.

The programme is currently accessible via either telephone or video consultation. There is also an app available. Face to face support options are currently paused due to the Covid-19 pandemic. Other language options available include Punjabi, Urdu, and Hindi.

In discussions with some local diabetes professionals, they told us they would welcome the National Diabetes Prevention programme (NDPP) to prioritise provision of information in both different languages and easy read versions. Other formats such as YouTube videos could also prevent barriers in knowledge due to poor literacy within the South Asian community.

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[16] Cambridge University Hospitals NHS Foundation Trust (2021) Diabetes Outreach Team (DOT)

[17] North West Anglia Foundation Trust (2021) Diabetes and Endocrinology

[18] Cambridgeshire and Peterborough CCG (2020) Healthier You Diabetes Prevention Programme

In a recent trial by GP practices in Ely North and South Primary Care Networks (PCNs) area, newly diagnosed patients were texted with details of the education programme. This increased uptake in the programme; however, ethnicity data is not available. This could be improved in the future targeting specific high-risk groups via Eclipse system in primary care and offering translated services.

Patients can **self-refer** themselves to the programme by registering on the provider's website https://preventing-diabetes.co.uk/self-referral/. Patients will need their NHS number, latest HbA1c or FPG reading including the date (within last 24 months) and their GP surgery name.

DESMOND

The national Diabetes Education and Self-management for Ongoing and Newly Diagnosed (DESMOND)[19]

The STP team have said patient education locally has been successful with white English-speaking cohorts. However, it has been less successful in engaging people from South Asian communities.

The STP team identified that to help address this, courses should be offered to patients at diagnosis with more comprehensive languages and accessible formats.

They also recognise other barriers, for example, employment is more likely to be low paid and a shift pattern style, therefore courses need to be offered outside office hours. These could be via a digital platform such as YouTube videos.

BMI Can Do It campaign[20]

People of Cambridgeshire and Peterborough are being encouraged to eat well, sleep well, and move more as part of a healthy living campaign launched by Cambridgeshire and Peterborough CCG in 2020.

The campaign sets out a range of healthy living challenges for people to undertake individually, amongst groups of friends or work colleagues. They aim to get people to eat less, move more and sleep better. They are easy to follow and do not require any specialist equipment or gym membership and are suitable for everyone, from those starting out on the healthy living journey to those already undertaking regular exercise.

People can sign up as individuals or in groups through a website and are encouraged to share their progress via social media.

[19] DESMOND (2020) https://www.desmond.nhs.uk/centre-posts/cambridgeshire-and-peterborough

[20] Cambridgeshire and Peterborough CCG (2020) www.bmicandoit.co.uk

Work in progress and future projects to ensure integrated care

Diabetes care draft pathways

The STP has developed a draft diabetes care pathway which they have shared with us – see Appendix 1.

Cambridgeshire and Peterborough STP have written a draft diabetes care pathway (with Olli Hart, Clinical Lead for Person Centred Care, Sloan Medical Centre, Sheffield) to guide health professionals to services for diabetic patients. This includes peer support groups, apps, and social prescribers within the community.

This is on hold due to the Covid pandemic but is awaiting approval.

Cambridgeshire and Peterborough CCG have produced a guide to support primary care services in prioritising the management of diabetes care during the COVID-19 response – see Appendix 2.

A draft "spoke and wheel" diagram showing integrated services throughout the Cambridgeshire and Peterborough area has also been produced – see that diagram below – reproduced with permission.

Following recommendations in the draft Long Term Plan, PCNs in Cambridgeshire and Peterborough are making changes to systems and processes to ensure better integrated services for all people with diabetes.

This is done through the South and the North Alliances, which are part of the local health and care system governance structure. These are place-based alliances, which oversee and drive delivery of health care priorities in partnership with leaders from the 21 primary care networks.

The PCNs use a software package called Eclipse to identify and track the care of patients with diabetes. Eclipse allows practices to upload their data weekly, allowing an up-to-date view of patients' progress against the three treatment targets (3TTs) and nine care processes identified by NICE and Diabetes UK as markers of improved long-term care of patients with diabetes.

As of November 2020, 81 of the 84 GP Practices in Cambridgeshire and Peterborough CCG were using Eclipse. This system helps identify ethnicity to help target people from South Asian communities.

South Alliance PCNs

In January 2020, two PCNs with high diabetes prevalence and deprivation for STP-wide work focused on improving the 3TTs set by NICE; these are: blood glucose, blood pressure and cholesterol levels. Ely North and Ely South, the two PCNs, now have the highest performance against the 3TTs across the STP.

Through the Integrated Neighbourhood Programme, Ely South have developed new approaches for patients with type 1 and type 2 diabetes. Patients are invited to have a review of their health and care needs with their GP practice and develop a joint plan to help them manage their diabetes themselves.

Patients are linked into other local support networks within the local community which may help with their wider health and wellbeing through Social Prescribers. This may include peer support groups, exercise groups, carer hubs, benefits/money advice and social activities.

In addition, over the Summer of 2020, Ely South, Ely North and Cambridge City 4 PCNs collaborated with the Cambridge University Hospital NHS FT Diabetes Outreach Team to review patients with type 1 Diabetes who were not accessing specialist community care or who had uncontrolled diabetes, using the nine care processes.

Virtual Clinic Review (VCR) meetings are now held weekly to ensure patients have been jointly reviewed and have a personalised care plan.

North Alliance PCNs

The North Alliance are developing improvements within different areas of clinical care for diabetes.

- Developing a single point of contact and triage for all referrals to the North Alliance diabetes specialists.
- Developing an integrated referral form for North West Anglia Foundation Trust (NWAngliaFT) Endocrinology and Cambridgeshire and Peterborough Foundation Trust (CPFT).
- Ensuring that triage and other relevant documentation from NWAngliaFT and CPFT teams can be clearly seen by GP services and vice versa – this is requiring various IT and Information governance process.
- Primary care staff within the North Alliance area are able to book and access a virtual clinic review with a multi-disciplinary team (MDT) to better understand the wide range of community and specialist services available to patients.

Digital Diabetes

Kaleidoscope Health and Care and Edge Health were commissioned by the STP in February 2020 to provide project support for the development of 'digital first' type 2 diabetes pathways in primary care.

Both clinicians and some people with diabetes have said the provision of an app to access information and care services would be a helpful tool.

Five 'Early Adopter' PCNs are working with patients to identify the current barriers and challenges and to seek ways to mitigate these. This would include looking at literacy, different languages, and cultural differences.

Referral forms

The diabetes team at the STP are developing a 'Single Point of Access' so GPs can refer patients to systemwide specialist diabetes care services as opposed to needing to identify which service offers which element of diabetes care. They have identified that some services have duplications that are unhelpful to GPs.

The STP want to simplify the referral process and share the skills and resource of the specialist diabetes community teams by enabling the integrated team to ascertain who is best to care for the patient when the referral is received.

Currently, if the GP refers to a service and it is not appropriate for the service to care for the patient, the referral is rejected and sent back to the GP to resend to the correct organisation. The STP have been actively working on this for six months and are now awaiting final approval on the single point of access process.

Clinical Support Tool

To improve integrated services for people with diabetes, the STP diabetes and Obesity team are developing a Clinical Support Tool within SystmOne - a clinical software system that is used by many GP surgeries.

This would guide a primary care clinician to see all things diabetes at one point. It shows where GPs can refer patients to, how to send for structure education, and how to request the support of the special diabetes team for a VCR (Virtual Clinic review) or a practice review session for the clinical team.

The STP are continuing to build this and hope to re-launch its use in early 2021. It is live on the system now.

What does the evidence tell us about experiences of integrated care for this Profile in Cambridgeshire and Peterborough?

There is limited local insight that focuses on the experiences of integrated care for people living with diabetes; even less insight relates specifically to people from South Asian ethnic groups.

Primary care clinicians and hospital trusts code patients as Pakistani, Bangladeshi etc rather than South Asian. And patients do not recognise themselves as 'South Asian' because each group within this ethnicity has different distinct racial, cultural, and other traits.

What people have told us

Through general feedback at engagement events and Diabetes UK South Asian peer support groups we heard from South Asian people who had diabetes.

- People want better information that is relevant to them. Self-care education and peer support groups should be offered at accessible times as often working patterns of this Profile are not 9 to 5. Older South Asians can sometimes have more limited literacy. Education in different formats such as YouTube videos would be beneficial.
- People wanted joined up and coordinated appointments.
- An accessible resource available in different languages and easy read format showing "How to" and listing local services would benefit patients , including those from a South Asian background that may not speak English as their first language. For example, our evidence has shown that some patients were not aware how to access a sharps bin for their injectables.
- Our evidence shows that after diagnosis (and after attending educational courses), people would like regular dietary updates. For example, a patient had been diagnosed 10 years ago, and had not had up to date nutritional information which has changed over time.
- Some senior/65+ older South Asian people have told us they would like a carer to be able to come with them to diabetes health training courses.
- South Asian diabetics are concerned about the COVID-19 pandemic and high death numbers within their group. It has affected their mental health. There should be more mental health information and strategies available for this health and care experience profile.

People said:

> *"I am a carer for my elderly father who is diabetic. Appointments are all over the place and I work fulltime, making it difficult to ensure he gets to the appointments. Could patients have a birthday MOT and have all the GP checks at one time? This would be efficient for us and the NHS system."*
>
> *"I am a new mother and am really worried about the news coverage about the high death rates within my community. It is affecting my mental health."*

"Treatment was fairly swift but since do not always see anyone, it is initially a consultation over the telephone."

DESMOND courses "You only get a few weeks; it would be good if you could access when needed".

What would you do?

Healthwatch Cambridgeshire and Healthwatch Peterborough's 2019 "What would you do" [21] report was written to help the local STP develop its Long Term Plan. The report fed back the views of more than 800 local people via a survey and focus groups undertaken in March and April 2019.

83 people living with other unspecified long-term conditions told the local Health watch about their experiences, nine were identified as having diabetes. Ethnicity data was not collected for this project; however, our research has shown there is no difference between diabetes care for any group or ethnicity.

The report identified that people with diabetes were not offered further access to health and care support after diagnosis.

The report said, "This implies a lack of information or support in the early stages which could make the difference to how well people manage what are increasingly common conditions. All the people whose condition started in the last three years said they were not offered further access to health and care support after diagnosis."

What primary care staff and the CCG have told us

- GPs would like clear referral criteria to prevent referrals bouncing back to their GP, therefore delaying care.
- The STP support the view that integrated information technology can mean all providers in a pathway are able to access a patient's data. As well as the obvious efficiency and convenience, it means that referrals can be triaged to the right healthcare professionals and that 'at risk' patients can be identified more quickly.

The CCG asked Cambridgeshire and Peterborough PCNs on our behalf whether they had a separate pathway for diabetes care for people in the South Asian population groups. Three responded saying they did not have a separate process or pathway.

One PCN responded to say:

[21] Healthwatch Cambridgeshire and Healthwatch Peterborough (2019) What would you do? Local people's ideas and experiences to help improve the NHS

> "There is actually a big gap in delivering care to Asian community within the context of general practice. As diabetes is so prevalent among Asian patients, I feel we are not equipped to deliver a knowledgeable advice on lifestyle and diet to our ethnic minorities unless doctor/nurse have the same background."
>
> "I'd like to propose to have a workshop for healthcare professionals involved in diabetes care to be able to gain that background knowledge so our advice is specific and relevant to Asian cuisine and traditions."

CCG have told us they are working with CPFT Dietetic colleagues and the Training Hub to create a short video/educational material for clinicians regarding dietary advice and to see if they can also create one specifically for Asian dietary changes.

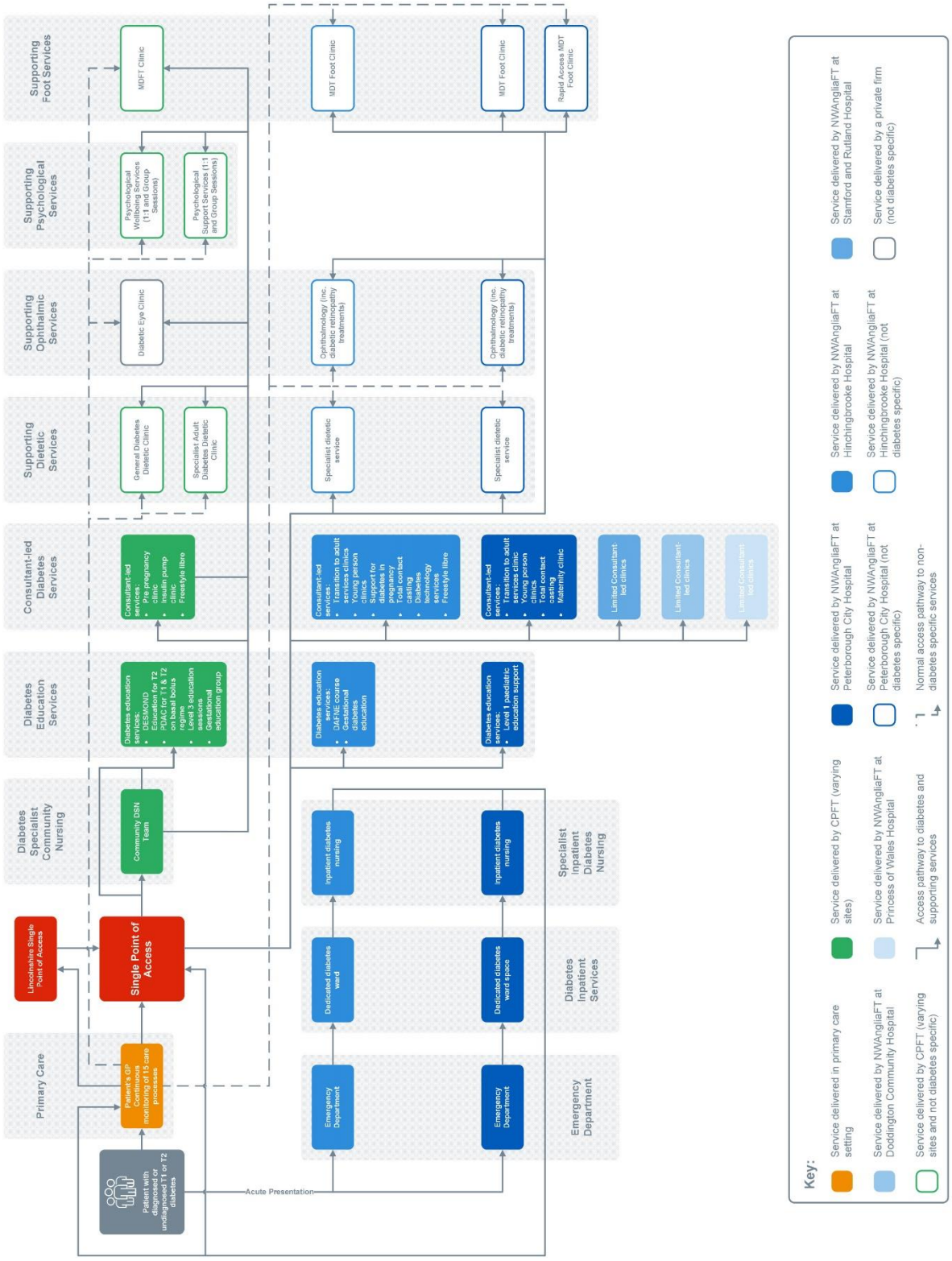
Other local evidence gathered

- Diabetes UK have a local peer support group for South Asians that meets fortnightly at 5pm on Zoom. This gives opportunity to discuss what works for them in practical ways such as recipes and local services. An additional group for Ely area will start 10 February 2021.
- We have found that older South Asian population are more likely to eat a traditional diet and less likely to speak English. Whereas the younger age groups choose mostly a Westernised diet and are more likely to speak English. This shows that diabetes information will need different approaches to be effective.
- Diabetic patients are concerned that they are not getting automatic appointments for annual checks due to the Covid pandemic. Our research has shown when several patients from this ethnic group took the initiative to directly book check-ups with their GP, they received the care they needed in a timely manner.

Appendices

Appendix 1 Diabetes STP draft pathways

Permission to share 22/12/2020 Dr Jessica Randall- Carrick. STP and CCG joint Clinical Lead Diabetes and Obesity.



Appenndix 2 – Draft non-Covid Long Term Conditions guidance – for diabetes

Clinical Decision Cell
COVID-19

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

GUIDANCE ON PRIORITISING: DIABETES

This guidance has been developed to support primary care in prioritising management of long-term conditions during the COVID-19 response.

CLINICAL AREA – DIABETES

People with Diabetes (PWD) are at increased risk of infections, although this risk can be reduced by good glycaemic control.

PWD have a severe disease when infected with respiratory viruses, and diabetes is an important risk factor with a **mortality rate of 7.3% in PWD infected with COVID**, (Chinese CDC, Feb 20).

Co-existing heart disease, kidney disease, advanced age and frailty further increase the severity and mortality of COVID infection. Such co-morbidities are also associated with increased morbidity and mortality from non-COVID disease.

Therefore, it is asked that we amend our normal habits & processes for LTC Mx to focus on clinically prioritised patients identified through Eclipse:

Diabetes -> My Patients ->
Priority Patients: PP
Patients Needing Intervention: PNI
Patients Needing Review: PNR

For those practices not familiar with Eclipse, training will be provided.

PATIENT RISK GROUPS	HIGH RISK	MEDIUM RISK	LOWER RISK
	1. PP: "Systolic >170" **2.** PP: "Patients with Stage 4 or 5 Renal failure (eGFR <30)" **3.** PNI: "Patients with Neuropathy, Retinopathy, High Foot risk or eGFR <45 **and** BP >150/90 **4.** PP: " HbA1c >100" **5.** PNR: "Patients with high HbA1c (>75 and over 3 months)	**1.** PP: "Out of Range for 3 of 3 Treatment Standards" **2.** High risk foot OR Foot not examined past year **3.** PNI: "Patients with high HbA1c (>59-75 and over 4 months), without frailty".	1. PNI: " BP Systolic >150 (>3mths), not on BP tablets or not collected in 90 days" 2. PP: "Out of Range for 1 of 3 Tests and not tested in last 3M" 3. PNI: "Patients not on Medication (HbA1c >=59) 4. Pre-Diabetes – those with HbA1c 42-47 5. Women with a Hx of GDM

	6. PNR: "Patients with HbA1c >75 and no review in last 3 months" 7. DKA in past year		

USUAL PRE-COVID LTC MANAGEMENT	**This currently varies from practice to practice, but process is usually designed around achieving the Eight Care Processes (8CPs) - clinical areas of concern which require annual monitoring and achieving the Three Treatment Targets ((3TTs) - BP, Cholesterol, Hba1c) to reduce micro and macrovascular complications** **1. Blood glucose level (HbA1c)** • **Type 1** aim: HbA1c level of 48 mmol/mol (6.5%) or lower, to minimise the risk of long-term vascular complications. (NICE NG17 2016) • **Type 2** aim: HbA1c level of 48 mmol/mol (6.5%). For adults on a drug associated with hypoglycaemia, aim for an HbA1c level of 53 mmol/mol (7.0%). (NICE NG28 2019) **2. Blood pressure** Home BPM Targets (NICE NG136 2019): • below 135/85 mmHg for adults aged under 80 • below 145/85 mmHg for adults aged 80 and over. NB If the adult with Type 1 diabetes has albuminuria or 2 or more features of metabolic syndrome, target is:130/80 mmHg (NICE NG17 2016) **3. Cholesterol** (NICE CG181 2016) Total cholesterol should be **5.0** mmol/L or lower **Type 1:** *consider* offering Atorvastatin 20mg ON to **all** PWD Type 1; and offer to all Type 1 diabetes who: • Are aged more than 40 years. • Have had diabetes for more than 10 years or have established nephropathy. • Have other CVD risk factors. (ie don't use QRISK or other risk assessment tool in Type 1 Diabetes) **Type 2:** offer Atorvastatin 20mg ON to all with QRISK2 ≥10% **<u>Annually:</u>** **4. Kidney function testing (Urinary albumin: creatinine ratio)** **5. Kidney function testing (Serum creatinine)** **6. Weight check -** Encourage a healthy ethnic-specific BMI; refer Health coach/dietician PRN **8. Smoking status** & encourage cessation **9. Foot examination** & refer as needed

GUIDANCE/RECOMMENDATIONS DURING COVID RESPONSE

PRIORITY KEY

SHORT TERM	First priority, immediate, may take about 1 month or aim to be done in the first month/6 weeks.
MEDIUM TERM	Next/second priority, aim to do in the next 3 months.
LONG TERM	Final group, aim to start in 6 months, new business as usual in COVID-19 world.

The following guidance/recommendations includes reference to the **Government's COVID Alert Level System**. This has five levels, each relating to the level of threat posed by the virus. The alert level will be based primarily on the R value and the number of coronavirus cases and is therefore subject to change. The current threat level of the pandemic will be categorised on a scale of one to five in different parts of the country.

SHORT TERM Government COVID Alert Level 4 & 5	**Actions:** 1. Conduct Eclipse searches for HIGH risk PWD 2. Remote engagement with these patients - making sure patients are aware of importance of distancing; hygiene; what to do if they get symptoms of COVID; and what to do if their LTC worsens. 3. Dietary change is essential in PWD with uncontrolled HbA1c 4. Offer Health coach / Social Prescriber / Link worker support 5. Amend medications as needed with appropriate monitoring (U&Es etc) 6. Offer online structured education PRN	**CPFT:** All those HbA1c >86 can be referred to DSN peri-COVID Further referral criteria below. **Sick Day Rules:** Type 1: https://trend-uk.org/wp-content/uploads/2020/03/A5_T1Illness_TREND_FINAL.pdf Type 2: https://trend-uk.org/wp-content/uploads/2020/03/A5_T2Illness_TREND_FINAL.pdf **Driving Rules:**

		https://www.diabetes.org.uk/guide-to-diabetes/life-with-diabetes/driving https://www.gov.uk/diabetes-driving

MEDIUM TERM	HIGH RISK	MEDIUM RISK	LOW RISK
Government COVID Alert Level 3	1. Use Eclipse and re-run the High-risk searches via Eclipse; amend meds / refer accordingly. **2.** Liaise with Health Coach / Social Prescribers – ask to see their audit /summary of work with high risk patients – any gaps?	Conduct Eclipse searches for the Medium Risk patients and engage in similar fashion	Once addressed both high and medium risk patient groups, can conduct the Eclipse searches as above and then move onto usual care.

LONG TERM	HIGH RISK	MEDIUM RISK	LOW RISK
Government COVID Alert Level 1 & 2	Re-visit the Eclipse searches for High risk	Re-visit the Eclipse searches for Medium Risk	1. Once onto 'usual care' - consider vaccination clinics & organising these according to the Eclipse risk groups above. 2. Refer or suggest self-referral (via SMS) to those with Pre-Diabetes (NDH) onto Digital NDPP programme

Online Structured Education – PWD – Type 2

Please follow the normal DESMOND referral process to CPFT Diabetes Team as before COVID. Instead of group DESMOND, CPFT admin will offer your patient MyDESMOND only.

CPFT – urgent referrals that will be accepted & seen Tier 1 (Pandemic) RED level):

- *Low blood glucose – called "Hypos" or hypoglycaemia*
- *Pregnant women asking for advice (Peterborough)*
- *Patients who say they have ketones*
- *Patients who are unwell who need advice on managing their diabetes*
- *Patients who are on insulin pumps (Peterborough).*

PWD - Type 1 *concerned about their blood glucose levels, young person or adult or* with a HbA1c 86 mmols or above will have their insulin doses reviewed by the DSN

All newly diagnosed Type 1s are followed up by the DSNs in Peterborough. The acute hospitals follow up newly diagnosed type 1s in the other areas.

PWD - Type 2 *with high blood glucose levels and symptomatic or high blood glucose levels unusual for them or* HbA1c 86 mmols (10%) or over if they are on maximum oral medication or are symptomatic as will probably need an injectable.

** OR, If GPs have any concerns about patients or need advice, please ask them to ring the hub to be put through to a DSN **

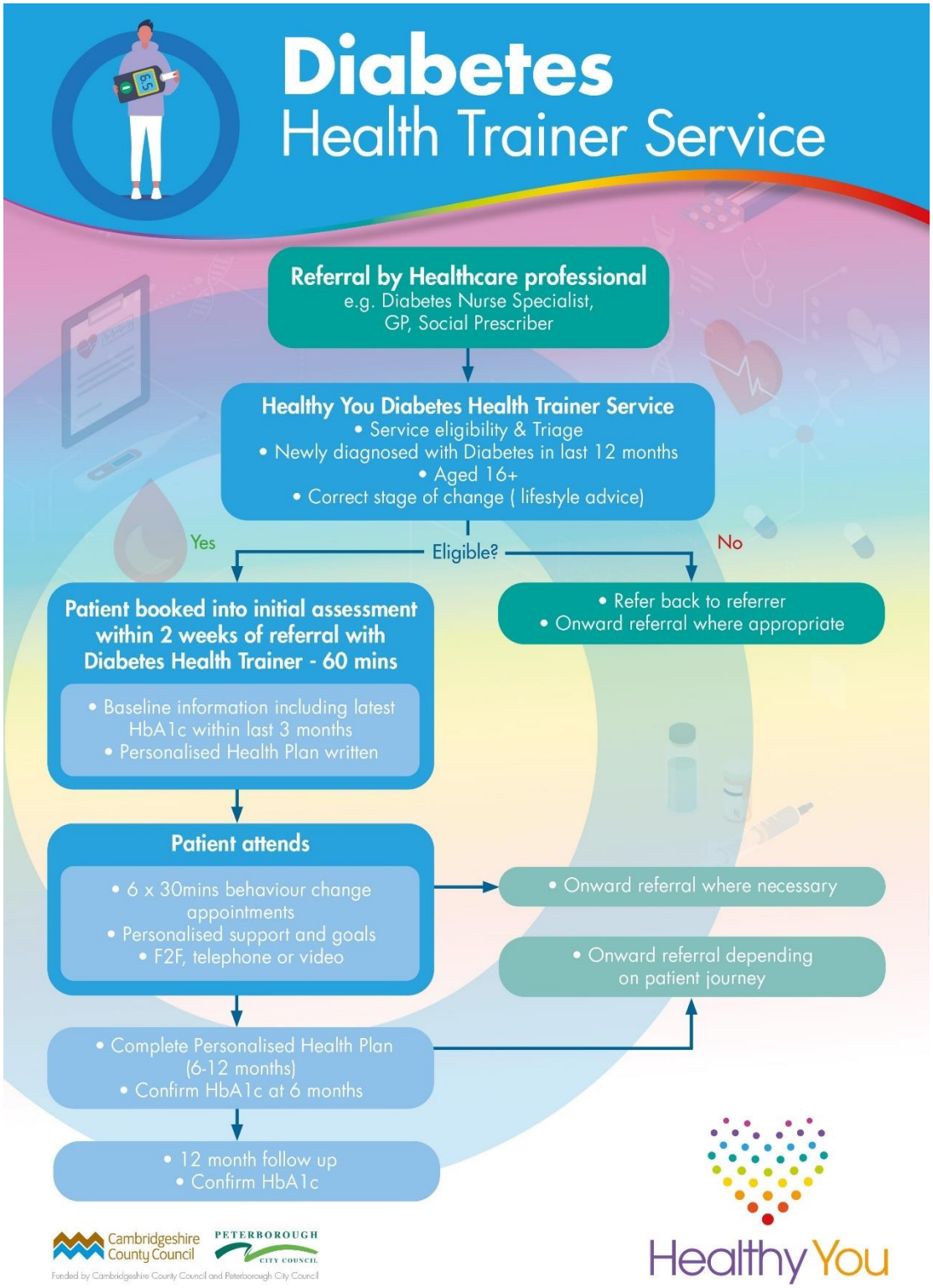
CPFT – Referrals that will be accepted & seen Tier 2 AMBER level):
As above except threshold reduced to HbA1c 75

CPFT – Referrals that will be accepted & seen Tier 3 GREEN level):
As above except threshold reduced to HbA1c 58 and more specialist involvement required.

Author:	Dr Jessica Randall-Carrick
Version:	1.0
Date of approval from Clinical Advice Cell:	
Date of review:	

Appendix 3 Referral to Diabetes Health Trainer Service

Local pathways and procedures for people accessing the Health Trainer Service provided by Everyone Health.



Appendix 4 Everyone Health Integrated Lifestyle Service Pathway

Shared by Kelly Guilders, Service Manager

Integrated Lifestyle Service Pathway

Cambridgeshire County Council
PETERBOROUGH CITY COUNCIL

Funded by Cambridgeshire County Council and Peterborough City Council

Cambridgeshire and Peterborough
Healthy You from 1st October 2020

Healthy You

Tier 1 Services

Physical Activity and Healthy Eating

Delivered by a consortium made up of the District and City Councils and Living Sport, across Cambridgeshire and Peterborough.

Tier 2 Services

Delivered by Everyone Health

Includes services such as: Stop smoking, Health Trainer Services, Falls Prevention, Weight management, outreach NHS health checks and behaviour change training, across Cambridgeshire and Peterborough.

Tier 3 Services

Weight Management

Delivered by Everyone Health in partnership with Cambridgeshire University Hospitals and Oviva, across Cambridgeshire and Peterborough.

Healthy You Single Point of Access

- **Website:** www.healthyyou.org.uk
- **Email address for professionals:** eh.healthyyou@nhs.net
- **Service user referral:** healthyyou@everyonehealth.co.uk
- **Telephone:** 0333 005 0093
- **Address:** Everyone Health, Fenland District Council, Melbourne Avenue, March, Cambridgeshire PE15 0EN
- **Text:** Healthyu to 60777
- **Fax**: 01223 281409