St Helens and Knowsley Teaching Hospitals NHS Trust

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| Subject: | Diabetic Specialist Nurse and Dietician |

## REQUEST & RESPONSE

**Questions about Diabetic Specialist Nurse and Dietician**

**Diabetic Specialist Nurse**

What is your main role?

**Diabetes Specialist Nurse – work in collaboration with primary care in the community and secondary care in the Diabetes Centre at St Helens Hospital.**

Do you work alongside Endocrinologists?

**Yes and Diabetologists. Most of our Consultants specialise in both Diabetes (looking after patients with Diabetes) and Endocrinology (looking after patients with other hormone related conditions).**

Do patients have to be referred to you?

**Within the Diabetes Centre all patients who are referred to us by their GP go through a clinic called New Patient Clinic where they will see a Diabetes Consultant. From that clinic patients will be asked to see a Nurse Specialist if needed. Me personally, I have patients referred to me for home visits (These are housebound patients in either their home or Nursing Home that require specialist Diabetes input**)

How would you treat someone with Type 2 Diabetes? What would check/discuss at appointments?

**Typically patients with a new diagnosis of Type 2 Diabetes are diagnosed by their GP/practice Nurse and are initially managed by them.**

**Patients are referred to us when their GP/Practice Nurse needs specialist input with their Diabetes- for example when their diabetes is not well controlled, the patient has a complex history, they are having problems with their Diabetes or need injectable treatment. When we have provided that specialist input we then discharge patients back to their GP. At their appointment they will have their**

**height, weight, blood pressure, BMI, and a blood test called a HBA1C taken (this is a 3 month average of their glucose levels).We will also take details about their past medical history and current medication. From this information we then decide what further treatments need to be commenced for the patient and from there they will usually be booked into a further clinic to have that commenced.**

**Each year patients with Diabetes have something called an annual review. This is carried out at their GP practice and in ophthalmology. It is basically a 'Diabetes MOT'. They will have various blood tests taken to look at their kidney function, liver function, cholesterol and Diabetes. They will also have a urine test to look to see if they are leaking excessive amounts of protein; they will have a foot check, BMI and an eye test (the eye test is not carried out at the GP practice). The purpose of the annual review is to ensure patients with Diabetes are 'controlled' and to detect any diabetes related complications. If someone's Diabetes is not well controlled, it puts them at risk of complications of Diabetes, such as heart attacks, strokes, and problems with blood flow to their legs, eye damage and kidney damage.**

**Treatment for Diabetes will depend on various factors such as how high their HbA1C is, past medical history, age etc.**

What issues may someone with Type 2 Diabetes have that need monitoring?

**Refer to information above surrounding the Annual Review.**

How regularly do you see a patient?

**Depends on the patient it can vary depending on the reason why we have seen the patient. I could not give an exact answer to this- but on average every 3 months or so. As discussed above GP/Practice Nurses see patients typically every 6-12 months. Typically Patients with Type 2 Diabetes are not under us long term.**

**The only patients with Type 2 Diabetes who get provided with long term follow up in secondary care are patients with Kidney disease (Nephropathy)**

Do patients have to go to St. Helens Hospital for appointments or are you based at GP surgeries?

**If patients require our input, all appointments are at St Helens Hospital. But in my role as Community Specialist Nurse I support GPs and Practice Nurses**

Do you refer patients to any other services?

**Yes we refer to clinical psychology**

Barriers patients might face?

If a patient has mobility issues do you provide any transport that can collect and drop off patients?

**Patients can have ambulance transport.**

Do you do home visits, zoom calls, telephone appointments if a patient cannot get to you?

**Yes-home visits for new patients and telephone calls for follow up reviews.**

Are there resource barriers that you face? E.g. long waiting lists and staff shortages? Is there any way these can be overcome?

**Typically long waiting lists are not an issue at the minute and we don't have issues with staff shortages. The main barrier that we face at the minute is provision of face to face consultations (which patients seem to prefer) due to restrictions due to social distancing.**

Are there any costs involved for the patient? How is this overcome if they are on low income?

**Prescriptions are free for people with Diabetes. Main costs are travelling to and from the appointment. We don't support with travelling costs. It doesn't appear to be an issue.**

What psychological barriers have you experienced from patients? What fears may they have that may stop them attending appointments? How do you help them overcome this?

**Patient's fears can sometimes be around medication. So talking with the patient and their family and going through everything regarding their new medication and alleviating their fears usually helps. Explaining we are always here to support and the medication is there to make them feel better and improve their health helps to reduce such anxieties. Usually patients fear going on insulin but most patients after you have spent time and gone through everything and reassured them, they're fine. We also have access to clinical psychology if necessary.**

If patients are in a wheelchair or use walking stick, are there any barriers that may affect them accessing the service? If so, how do you help the overcome these?

**No- anyone that attends with a stick or wheelchair will not face any barriers or difficulties accessing our services. Our department is located on the main floor in the hospital and St Helens hospital is not a large hospital, there is also a drop off point at the main door for any patients that have difficulties and as mentioned if they cannot get here I attend their house for the appointment.**

Services available

Do you run any services for diabetes sufferers in St. Helens?

**please clarify what kind of services your question relates to.**

Are there support groups for people in St. Helens?

**We run focus groups for patients. Diabetes UK (charity organisation) also runs meetings in St Helens which we attend to provide education and talks on various aspects of Diabetes. There are also support groups in the Northwest for people with Diabetes.**

Do you recommend any other services for people with type 2 diabetes e.g. exercise classes or nutrition classes? If there is a cost to these is there any funding for people on a low income?

**Please see below info provided by a Dietician p5 onwards**

Are there any social media support groups e.g. Facebook, twitter, Instagram etc?

**Yes there is a Facebook group, we have a website and there are various different online groups across the Northwest. These are typically accessed by our younger patients with Type 1 Diabetes.**

Do you have an app that patients can download? If so what is on the app? Can patients communicate to you through the app? ( when I have an operation I was given a "Physiapp" which had exercises I had to do, information about how to do them, pain score and I could message the physio)

**No we don't have an app. There are apps that we recommend to patients for certain things but more specific for Type 1 rather than Type** 2.

Strengths and weakness

Part of their assignment is to assess one of the services Verna may use so they have to give positives and negatives.

What strengths does Diabetic Specialist Nurse services have for patients?

**The DSN (Diabetes Specialist Nurse) is there to support patients and families to allow patients to self-manage their condition. We commence patients on treatment to improve their health and quality of life but we are also here to educate patients on their medical condition and give them the tools to self-manage their condition. We are here to provide specialist advice that cannot be provided by their GP/Practice Nurses. We are also here to support GP/practice Nurses and other healthcare professionals with Diabetes Care. Our aim is to ensure that patients are on the right treatment for their Diabetes and we give patients the tools to help ensure their Diabetes is controlled. We provide education to other Healthcare Professionals in order for them to manage Diabetes.**

What weakness are there / areas of improvements needed e.g. more diabetic nurses needed to reduce waiting lists?

**Areas for improvement are engaging with patients, educating patients and educating other healthcare professionals.**

Is there a Care Quality Commission report on your services?

**The Trust has a CQC visit where they look at all services rather than visits to specific departments.**

**Questions for Dietitian**

What is your main role?
**Diabetes Specialist Dietitian**

Which services do your work alongside?

**I work in Diabetes & Endocrinology , Antenatal and Dietetics**

Do patients have to be referred to you?
**As the DSN mentioned when patients see the consultant in new patient they will then be referred to the dietitian if required. All patients on insulin pumps and young adults are referred to the dietitian. Patients with type 1 diabetes who need to learn how to carbohydrate count are referred to the dietitians. All pregnant ladies with Gestational diabetes, type 1 or type 2 diabetes are referred to dietitian when pregnant.**

How would you treat someone with Type 2 Diabetes? What would check/discuss at appointments?

**We would discuss carbohydrate awareness including the role of carbohydrates in the diet (energy as well as fibre for bowel health); the various sources (starchy carbs, natural sugars & added sugars). Also discuss physical activity, alcohol, weight, hypo education, the Public Health England 'Eatwell guide', lipid lowering advice and salt. All of these aspects of diet/lifestyle can influence the management of their diabetes. Depending on their treatment method (diet/medication/insulin) we will tailor specific advice to them. & encourage them to come up with some personalised goals that are important to them.**

What issues may someone with Type 2 Diabetes have that need monitoring?

**We would monitor their dietary choices, weight, cholesterol, physical activity levels & blood sugar levels**

How regularly do you see a patient?

**It can vary. Most newly diagnosed patients will see a dietitian once but will be offered further follow up if clinically indicated. Those in the young adult service are reviewed every 4-6 months unless they refuse input or are doing well. The dietitian**

**usually reviews those on pumps once /twice a year between DSN & Consultant appointments. The dietitian has one further telephone follow up with patients after they complete their carbohydrate counting training. Pregnant ladies with type 1 or 2 diabetes tend to see a dietitian each trimester, those with GDM (Diabetes in pregnancy) usually have one appointment to discuss diet & blood sugar monitoring. However, they may receive further input if warranted**

Do patients have to go to St. Helens Hospital for appointments or are you based at GP surgery's?

**St Helens Hospital**

Do you refer patients to any other services?

**Yes we refer to Clinical psychology/eating disorders/nutrition support dietitians in community and renal specialist dietitians in other Trusts**

Barriers patients might face

If a patient has mobility issues do you provide any transport that can collect and drop off patients?

**Yes, able to order ambulances**

Do you do home visits, zoom calls, telephone appointments if a patient cannot get to you?

**Mostly telephone calls as an alternative, do not provide home visits**

Are there resource barriers that you face? E.g. long waiting lists and staff shortages? Is there any way these can be overcome?

**Waiting lists for dietitian slots were an issue during the Covid 19 pandemic, less of an issue now. In future we will be able to overcome by more remote working – virtual/telephone.**

Are there any costs involved for the patient? How is this overcome if they are on low income?

**Discuss approaches to manage diet on a budget – freezer options, tinned fruit & veg etc.**

What psychological barriers have you experienced from patients? What fears may they have that may stop them attending appointments? How do you help them overcome this?

**Usually low mood, offer psychology support prior to dietetic input, so that we are discussing diet & lifestyle changes when it is a priority for them**

If patients are in a wheelchair or use walking stick, are there any barriers that may affect them accessing the service? If so, how do you help the overcome these?

**Support provided by staff /hospital porters if needed –not a barrier for patients at present**

Services available

Do you run any services for type diabetes sufferers in St. Helens?
Are there support groups for people in St. Helens?

**Local diabetes UK service users group**

Do you recommend any other services for people with type 2 diabetes e.g. exercise classes or nutrition classes? If there is a cost to these is there any funding for people on a low income?

'**Wellbeing St Helens' –free service locally**

Are there any social media support groups e.g. facebook, twitter, Instagram etc? Many things on social media for patients to follow. For example

**'Friends of the North facebook page'**

Do you have an app that patients can download? If so what is on the app? Can patients communicate to you through the app? ( when I have an operation I was given a "Physiapp" which had exercises I had to do, information about how to do them, pain score and I could message the physio).

**No apps**

Strengths and weakness

Part of their assignment is to assess one of the services Verna may use so they have to give positives and negatives.
What strengths does the dietician services have for patients?

**Dietetic input has an important role within the Diabetes Multi-disciplinary team. Dietitians can support patients with dose adjusting by explaining to patients which dietary sources affect their blood sugar. For example if they were having more carbohydrate than usual at a certain meal, they would need to give more insulin and vice versa they would need to give less if eating fewer carbohydrates. Diabetes dietitians do not advocate any restrictive diet, they support patients to follow a balanced approach to diet and to have a good relationship with food. No food is**

**'good' or 'bad' – emphasise the importance of balance & moderation to support a healthy lifestyle which helps patients to manage their diabetes.**
**Dietitians provide advice on managing blood sugars when physically active which supports patients to engage in activities that they enjoy. We teach them which foods are helpful before & after activity. We ask them to consider adjusting their insulin before /after activity if needed, based on identified blood glucose patterns. Pregnant women are advised on a healthy balanced diet which can limit weight gain, supporting pregnancy outcomes. For example ensuring baby doesn't get to big, making ladies more conscious of salt preventing pre-eclampsia (high blood pressure in pregnancy). WE also advise on which foods to avoid /limit during pregnancy. For pregnant women on a pump the dietitian will support them with the features available to them on their pump to support them with mealtimes.**

What weakness are there / areas of improvements needed e.g. more diabetic nurses needed to reduce waiting lists?

**Objectives include continue engagement with patients and health care professionals**

Is there a Care Quality Commission report on your services?

**The Trust has a CQC visit where they look at all services rather than visits to specific departments.**