Standard 12

People with diabetes with serious or progressive complications should have timely access to expert/specialist help.

Key practice points

- Determining the level of risk for macrovascular and microvascular complications is a key component of treatment planning and target setting for each individual.
- People with diabetes with severe complications are high-risk, especially if these are progressive and should be managed appropriately through specialist services.
- Adequate service provision across the range of subspecialty services is essential to ensure people receive the care that is required, within appropriate timeframes and by those with the right level of expertise.

Read this standard in conjunction with the equality and diversity section in the Introduction to the Toolkit.

What the quality statement means for each audience

Service providers ensure that diabetes services recall, review and follow-up people with serious or progressive complications and ensure they have timely access to expert/specialist help.

Health care professionals ensure they are competent to assess people with diabetes for the risk and presence of associated complications and manage and refer them appropriately.

Planners and funders ensure they commission services that assess for the risk and presence of complications associated with diabetes and ensure people with diabetes have timely access to expert/specialist help.

People with diabetes with serious or progressive complications receive expert/specialist care.

Introduction

People with diabetes are at increased risk of developing microvascular and macrovascular complications (see Standards 9, 10, and 11). Appropriate screening for the detection of complications is important to ensure the right management occurs. The majority of this care can be provided in primary care but there will be circumstances where the person will require expert/specialist help and advice. This may be episodic or ongoing.

Due to the polypathological nature of diabetes and the subsequent polypharmacy, the impact of diabetes complications and their management can be wide-ranging across all body systems.

The following list is provided to illustrate this; however, it is not exhaustive:

- hyperglycaemia (leading to diabetic ketoacidosis or hyperosmolar, hyperglycaemic nonketotic syndrome)
- hypoglycaemia – mild and severe and hypoglycaemia unawareness
- obesity and related health issues
- fatty liver
- skin and musculoskeletal disorders such as: adhesive capsulitis, carpel tunnel syndrome
- macrovascular disease such as: hypertension, dyslipidaemia, cerebrovascular, peripheral vascular, peripheral ulcers
- microvascular disease such as: nephropathy, retinopathy, maculopathy, cataracts and glaucoma, periodontal disease, neuropathy
- autonomic neuropathies such as: postural hypotension, gastroparesis, gustatory sweating, neurogenic bladder, sexual dysfunction, hypoglycaemia unawareness
- peripheral neuropathy leading to pain management, neuropathic ulcers, Charcot foot.

Co-existing conditions, such as:

- obstructive sleep apnoea
- gout
- polycystic ovary syndrome
- gastro-oesophageal reflux
- depression/anxiety/distress
- coeliac disease
- primary hypothyroidism
- pernicious anaemia
- anaemia of chronic disease
- Addison's disease.

Conditions or their treatments commonly contributing to hyperglycaemia, such as:

- chronic obstructive pulmonary disease and asthma
- cancer, cystic fibrosis
- Cushing's syndrome
- pancreatitis
- hemochromatosis.

Guidelines

The **New Zealand Primary Care Handbook 2012** details the process for identification of patients at high risk of diabetes-related complications (www.health.govt.nz/system/files/documents/publications/nz-primary-care-handbook-2012.pdf).

Determining level of risk for macrovascular and microvascular complications is a key component of treatment planning and target setting for each individual with type 2 diabetes:

- the risk of complications varies greatly across the diabetic population
- the aim is prevention of complications, especially targeting those at high risk
- patients with existing complications (eg, foot, eye, kidney or cardiovascular disease) are in a high-risk category and should be managed intensively.

Detailed advice is provided in figures 2 and 3 (pages 50 and 51) in the New Zealand Primary Care Handbook 2012.

Refer to national guidelines and local clinical pathways for guidance on criteria and timing for referral for specialist services and ongoing care, specific to the relevant complication.

Implementation advice

People with diabetes who have advancing, advanced and/or severe complications most commonly require access to specialist expertise. Adequate service provision across the range of subspecialty services is essential to ensure people receive the care that is required, within appropriate timeframes and by those with the right level of expertise.

Workforce recommendations for specialist services are articulated in the Introduction to the Toolkit. Local decisions about how service provision for these high-risk population groups occurs should be determined via clinical governance groups with the relevant clinicians, consumers and managers present.

As described in Standard 3, care-planning consultations should be available to all people with diabetes and should reflect the information and technical and emotional support needed to enable the person with diabetes to make the best decisions about their care (Diabetes UK et al 2008; National Institute for Health and Care Excellence [NICE] 2011). The person with diabetes is more likely to undertake action if it is related to decisions they have made, rather than decisions made for them (Diabetes UK et al 2008).

People with diabetes need to be orientated to the care planning approach and what to expect. Health professionals should undertake further training in developing patient-centred interventions if required (Scottish Intercollegiate Guidelines Network 2010). If the patient agrees, families/whānau and carers should have the opportunity to be involved in decisions about treatment and care and given the information and support they need (NICE 2009).

At each care planning consultation, time should be allowed to share information about issues and concerns; share results of biomedical tests; discuss the experience of living with diabetes; and address the management of obesity, food and physical activity. The person with diabetes should receive help to access support and services and agree to a plan for managing diabetes that incorporates individual priorities and goals. These should be jointly agreed, including setting a goal for HbA1c. Specific actions are in response to identified priorities that include an agreed timescale (Diabetes UK et al 2008; Joint Department of Health and Diabetes UK Care Planning Working Group 2006; NICE 2011).

Implementation examples / innovations

Refer to Standards 9, 10, and 11.

Assessment tools

Structure

Evidence of local arrangements to ensure that people with diabetes with serious or progressive complications have timely access to expert/specialist help.

Process

(a) The proportion of people with diabetes with serious or progressive complications recalled for regular assessment within the past 12 months.

Numerator	The number of people in the denominator recalled for assessment within the past 12 months
Denominator	The number of people with diabetes with serious or progressive complications

(b) The proportion of people with serious or progressive complications referred to specialist services for management advice (this may be face-to-face or virtual).

Numerator	The number of people in the denominator referred to specialist services for assessment and management advice within the past 12 months
Denominator	The number of people with diabetes with serious or progressive complications

See also:

- high risk foot (see Standards 11 and 12)
- renal disease (see Standard 10)
- eye disease (see Standard 9).

Resources

A number of helpful articles and practice guides can be found on the **Best Practice Advocacy Centre** (BPAC) site:

- Improving glycaemic control in people with type 2 diabetes: Expanding the primary care toolbox (www.bpac.org.nz/BPJ/2013/June/docs/BPJ53pages6-15.pdf)
- Monitoring people with diabetes over the age of 75 (http://bpac.org.nz/Report/2012/docs/bpac_2012_diabetes_monitoring.pdf)
- Initiating insulin in people with type 2 diabetes (http://bpac.org.nz/BPJ/2012/february/docs/bpj_42_insulin_pages_20-27.pdf)
- Screening and management of the diabetic foot (www.bpac.org.nz/BPJ/2010/october/docs/BPJ_31_diabeticfoot_pages_34-46.pdf)
- Assessing diabetic peripheral neuropathy in primary care (www.bpac.org.nz/BPJ/2014/june/docs/BPJ61-diabetic-peripheral-neuropathy.pdf)
- Screening for diabetic retinopathy in primary care (http://bpac.org.nz/BPJ/2010/August/retinopathy.aspx)

References

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