Health & Social Care Committee

HSC(4)-32-12 paper 4

Inquiry into the implementation of the National Service Framework for Diabetes in Wales and its future direction

Purpose

1. This paper provides evidence for the Health & Social Care Committee's inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction.

2. The evidence paper looks at:
    - The Welsh Government's leadership in implementing the National Service Framework for diabetes in Wales;
    - Future direction for diabetes care in Wales; and
    - Supporting diabetes care through Public Health activity.

Background

3. The Diabetes National Service Framework (NSF) standards were launched in Wales in April 2002. This sets 12 standards the NHS in Wales are required to implement by 2013 (see annex for list of NSF standards).

4. The National Service Framework for Diabetes in Wales: Delivery Strategy was launched in March 2003. The NSF Delivery Strategy is a ten year plan that sets out national objectives against which NHS performance can be judged.

5. In 2006, an All Wales Consensus Group was established consisting of health care professionals, managers and service users associated with diabetes care. Sub-groups were identified to develop guidelines for each of the 12 NSF standards. These guidelines were published in 2008.

6. In 2006, NICE produced Technology Appraisal Guidance on the provision of structured patient education to people with diabetes to promote effective self care.

7. A Diabetes Task and Finish Group was set up in 2010 to look at an integrated service model for high clinical value, cost effective diabetes care across Wales based on: prevention; treatment and self management; primary, community and secondary care; and work already underway across Wales to improve the management of chronic conditions. The Group recommended a joint working model between primary and secondary care to provide core services to patients within the community through Community Clinics and Community Pharmacies.

8. In 2010, each Health Board was required to establish a Diabetes Planning and Delivery Group to develop and oversee local delivery plans to map the journey to compliance with the NSF by 2013,, reporting to the Board on progress.

Monitoring of the Diabetes NSF

9. The collection and reporting of information related to monitoring progress towards implementation of the Diabetes NSF is the responsibility of the individual LHBs.

10. Between 2003 and 2010, the Welsh Government received quarterly progress updates on the implementation of the Diabetes NSF from the LHBs.

11. A major review of progress towards implementation of the Diabetes NSF was conducted by the Welsh Government in 2010/11. The review collated all the progress report information from each LHB and identified weaknesses in their monitoring processes.

12. To address the monitoring process issues, the Welsh Government developed a Diabetes NSF self assessment tool and issued it to all LHBs. As part of the 2010/11 review, the Welsh Government requested that all LHBs submit a completed self assessment to gain a clearer picture of progress towards implementation of the Diabetes NSF across Wales.

13. The self assessment tool also included sections for LHBs to monitor their progress towards implementing the NICE Technology Appraisal Guidance on structured patient education to people with diabetes to promote effective self care.

14. Following this review, the Welsh Government provided individual feedback to all the LHBs in July 2011, identifying progress and highlighting issues which needed to be addressed.

15. From 2011, LHBs have been able to utilise the self-assessment tool to monitor their progress towards full implementation of the Diabetes NSF by 2013.

16. As part of a formal monitoring process, the Welsh Government currently holds LHBs to account through the performance measures set for the effective management of chronic conditions set out in the Annual Quality Framework.

Implementation of the Diabetes NSF – current situation

17. As at July 2011, implementation of the Diabetes NSF was variable across the LHBs.

18. The review process also highlighted common areas of weakness across Wales in relation to the full implementation of the Diabetes NSF, and the NICE guidance on provision of structured patient education. The specific areas were:
    - The implementation of comprehensive structured education for diabetes patients as required by NICE Technology Appraisal Guidance;
    - Training for staff to support personalised care planning;
    - Effective sharing of information between all diabetes care providers;
    - Involvement of patient in developing and implementing personalised care plans;
    - Effective audit of diabetes care, especially complications arising from diabetes;
    - Effective inpatient processes to deal with diabetes patients; specifically access to multidisciplinary care; and
    - Effective delivery of structured patient education.

    Actions currently underway to address these areas are set out in the next section.

19. In addition to giving essential information on the delivery of the Diabetes NSF, and highlighting key actions that individual LHBs need to complete over the next two years, the review set the basis for further development of diabetes care in Wales.

Current support for delivery of Diabetes NSF and NICE guidelines

National Diabetes Audit

20. LHBs have since 2007 taken part in the National Diabetes Audit (NDA), the world's largest published audit, enabling them to compare their delivery of diabetes care against other providers in Wales and England. The NDA includes data from both primary and secondary care participants and provides overall, sequential and comparative information at General Practice, hospital, Primary Care Trust (PCT), LHB, regional and national levels. NDA also produces reports based exclusively on data from specialist paediatric units providing care for children and young people with diabetes.

21. Welsh participation in the audit process has been improving, with over 80% of GPs signing up for participation in this year's Diabetes Primary Care audit. With the significant level of participation in the NAO, it will provide diabetes care providers in Wales with comparative data on delivery of their services against Diabetes NSF standards and NICE guidelines.

Information sharing and IT

22. NHS Wales Informatics Service (NWIS) is finalising plans on the development of an integrated national diabetes patient management system, which will provide timely access to accurate, current clinical information critical for the efficient and effective management of people

with diabetes, as well as effective service planning and delivery within the NHS.

Supporting diabetes care through Public Health activity

Diabetes and Obesity, Diet and Physical Activity

23. Simple lifestyle measures have been shown to be effective in preventing or delaying the onset of type 2 diabetes. This includes:
    - achieving and maintaining healthy body weight;
    - being physically active;
    - eating a healthy diet.
24. We have seen a slow down in rising obesity rates since 2007. However there is no room for complacency. We need to keep the momentum going to prevent thousands of adults and children facing deteriorating health and a lower quality of life and government facing spiralling health and social care costs. The main avoidable risk factor for Type 2 diabetes is being overweight or obese. A number of policies and programmes are in place.

25. An **All Wales Obesity Pathway** has been developed which sets out a tiered approach for the prevention and treatment of obesity, from community based prevention and early intervention to specialist medical and surgical services. Directors of Therapies and Health Science and Directors of Public Health, working jointly with Local Authorities and other key stakeholders, have mapped local policies, services and activity for both children and adults against four tiers of intervention and identified gaps and are implementing local solutions.

26. The **Change4Life W**ales social marketing campaign was launched in March 2010 as part of the Welsh Government's broader response to help the people of Wales achieve and maintain a healthy body weight; to eat well, move more and live longer. The overall objective is to encourage and support families and adults to make small, incremental changes to their lifestyles in terms of their diet and physical activity levels in order to reduce the risk of suffering from the negative outcomes of being overweight. It is also targeting adults with messages about alcohol. Over 43,000 families and adults have signed up to the programme to date.

27. A comprehensive package of health improvement programmes is in place to support people to eat healthily and be physically active. These include:
    - The National Exercise Referral Scheme which enables GP's to refer at risk patients, including those with diabetes. Protocols for patients with diabetes and obesity have been developed and additional training has been provided for instructors.
    - Funding LHBs to increase dietetic capacity in the community through utilising dietician's expertise to train and develop community workers and / or peer educators, volunteers working with children and young people and older people in the community on food and nutrition skills.

- MEND, a community, family based programme for overweight and obese children aged between 5-13 and their families. The multi-disciplinary programme places equal emphasis on healthy eating, physical activity and behavioural change, empowering the child, building self confidence and personal development.

Future direction for diabetes care in Wales

Diabetes Delivery Plan:

28. As outlined in Together for Health – A Five Year Vision for the NHS in Wales, it is the intention to deliver a more outcome focused approach in all major service areas through service delivery plans. Using the work of the expert Task and Finish Group set up by the former Minister for Health and Social Services, the Welsh Government are developing a Diabetes Delivery Plan to direct and guide Local Health Board activity for the period up to 2016. The Diabetes Delivery Plan for NHS Wales will set out new Welsh Government commitments to the public for diabetes care in Wales and will support the delivery of service standards set out in the Diabetes NSF. The Diabetes Delivery Plan will be issued for consultation at the end of this year and will address this Government's commitments for diabetes care up to 2016.

29. The Diabetes NSF set a number of standards for diabetes care that are still relevant, and it remains the aim of the Welsh Government to have these fully implemented by 2013. Following the Welsh Government review of progress in 2010/11, it recognised that achieving the full implementation of the Diabetes NSF across Wales by 2013 would be very challenging. The Diabetes Delivery Plan will re-confirm the Welsh Government's commitment to achieving the standards set out in the Diabetes NSF and, through setting up an all Wales implementation group to deliver clear leadership and focusing on delivering measurable patient outcomes, it aims to re-invigorate the process of delivering these key standards.

30. In addition to re-affirming this Government's commitment to the implementation of the Diabetes NSF, NICE guidelines and NDA recommendations, the document will look to address further the areas of weakness highlighted in the diabetes review of 2010/11.

31. The delivery plan will set in place a new monitoring structure, supported by a small set of population outcome indicators and NHS assurance measures designed to measure the effectiveness of diabetes care and their impact on health in Wales.

32. To support the delivery and monitoring of the Diabetes Delivery Plan, the Wales Diabetes Implementation Group will have as its remit to:
    - Provide a co-ordinated all Wales approach to supporting NHS Wales;
    - Facilitate the sharing and promulgation of best practice across Wales;
    - Identify constraints and solutions to specific clinical and operational issues; and

- Provide the Welsh Government with intelligience on local issues and progress towards implementation.

33. As part of the delivery plan, an all Wales Diabetes Implementation Group will be established to provide strong and joined-up leadership and oversight and to co-ordinate actions in a strategic way.

34. A key as aspect of the delivery plan will be the focus on putting the patient at the heart of service delivery, and the delivery of structured education. Structured patient education should be made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need.

35. The Welsh Government is aware that the current take up of structured education in Wales is low, and action needs to be taken to ensure that this vital part of diabetes care is delivered effectively.

Annex

National Service Framework for Diabetes in Wales

Standards table

Prevention of Type 2 diabetes	Standard 1 The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.
Identification of people with diabetes	Standard 2 The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.
Empowering people with diabetes	Standard 3 All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.
Clinical care of adults with diabetes	Standard 4 All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.
Clinical care of children and young people with diabetes	Standard 5 All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.
	Standard 6 All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.
Management of diabetic emergencies	Standard 7 The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.
Care of people with diabetes during admission to hospital	**Standard 8** All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.
Diabetes and pregnancy	Standard 9 The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.
Detection and management of long-term complications	Standard 10 All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.
	Standard 11 The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.
	Standard 12 All people with diabetes requiring multi-agency support will receive integrated health and social care.