



GIG  
CYMRU  
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WALES

Bwrdd Iechyd  
Aneurin Bevan  
Health Board

Our Ref: JP/lb

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21 September 2012

Mark Drakeford AC/AM  
Chair  
Health and Social Care Committee  
National Assembly for Wales  
Cardiff Bay  
CARDIFF CF99 1NA

Dear Sir

### **Implementation of the National Service Framework for Diabetes in Wales and its Future Direction**

I am writing on behalf of Aneurin Bevan Health Board in response to your letter of 26 July 2012, to contribute to the Health and Social Care Committee inquiry into the implementation of the National Service Framework for Diabetes in Wales and its future direction.

As chair of the Diabetes Planning and Delivery Group, I confirm that representatives of the Health Board would be prepared to give oral evidence to the inquiry if requested to do so, with reasonable notice.

### **Progress on implementing the National Service Framework**

The Diabetes Planning and Delivery Group have formed in Gwent following the NHS reconfiguration with a remit of developing service provision and taking forward the NSF.

Significant progress has been made in some areas, and a summary is related to the original NSF standards below. This is not an exclusive list, but provides a flavour of the actions required and taken

### **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 inequalities in the risk of developing Type 2 diabetes**

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Bwrdd Iechyd Aneurin Bevan yw enw gweithredol Bwrdd Iechyd Lleol Aneurin Bevan  
Aneurin Bevan Health Board is the operational name of Aneurin Bevan Local Health Board

- i) *Ensure that action to improve diet, nutrition, increased physical activity, reducing overweight and obesity and monitor healthy weights are integrated into national and local strategies with particular emphasis on ethnic and vulnerable groups and children*

A needs assessment of the population has been undertaken led by Public Health, and the Aneurin Bevan Health Board's Public Health Strategy identifies a range of actions required to support a reduction in Type 2 diabetes. The Local Authority specific Local Service Boards, Health, Social Care and Wellbeing and Children and Young Peoples plans also reflect the relevant elements of the Public Health Strategy, with implementation and monitoring of progress carried out through those forums, and this will be carried forward in the developing Single Plans.

- ii) *Reduce the risk of Type 2 diabetes consistent with the CHD NSF, through increased awareness and support*

The Cardiac Disease NSF, also covers key actions required to improve population health, including for example the development of NICE compliant guidelines for the identification and management of obesity in people with diabetes. Implementation of weight management programmes, coronary heart disease programmes and diabetes education programmes is however still largely around the former LHB footprints, and the need to standardise across Gwent has been identified by the Diabetes Planning and Delivery Group and recognised as a key priority.

- iii) *Ensure continuous professional development for health care professionals and others particularly in Primary Care to support and update knowledge and skills in risk factor management of at risk groups*

CPD opportunities have been identified and prioritised, with a focus on socially excluded groups, care homes, custodial settings and minority ethnic groups. As one of the Neighbourhood Care Network (Setting the Direction) GP leads, I have a lead role for development of diabetes practice in primary care and chair the Diabetes Planning and Delivery Group, and have led a number of initiatives in developing services within Primary Care. Membership of the Primary Care Diabetes Society is encouraged for all GPs and there has been a range of educational events.

## **Standard 2 - Identification of People with Diabetes**

- i) *Raise awareness of the signs and symptoms of diabetes amongst health and other professionals most likely to come into contact with people with undiagnosed diabetes*

Comprehensive programmes are in place to support and train staff in the management of diabetes. Aneurin Bevan Health Board is engaged with community pharmacies in undertaking a screening programme that could be used in pharmacies to detect people at risk of developing diabetes.

- ii) *Strengthen the identification, monitoring and benchmarking systems in high risk individuals*

Systems are in place to follow up and regularly test people who have previously been found to have impaired glucose tolerance and the uptake of influenza and pneumococcal vaccination by people with diabetes. Policies are in place to encourage re-engagement from people who do not attend for annual reviews (DNA).

- iii) *To improve diet, weight management and physical activity, particularly among children, ethnic minority & other vulnerable groups*

This is covered under Standard 1 above.

Some parts of Gwent have British Heart Foundation funded weight management programmes promoting heart health by physical activity and healthy diet to manage weight.

**Standard 3 - Empowering people with diabetes 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 are fully engaged in this process.**

- i) *Develop Programmes to strengthen & support self care management, to help empower all people with diabetes to maintain a healthy lifestyle, involving families and carers*

There is Aneurin Bevan Health Board wide access to education and self management programmes for Adults and Children with both Type 1 and Type 2 diabetes. There is not yet consistency across Gwent in the delivery of the programmes, with different areas using different programmes, and Blaenau Gwent residents accessing programme delivered by neighbouring boroughs. An evaluation is being carried out, and plans being developed to standardise the delivery across the Health Board.

- ii) *Develop partnership with active involvement of parents, carers and people with diabetes in the development of local service and care plans.*

Diabetes Planning and Delivery Group established and functioning, with patient and Voluntary Sector representation.

**Standard 4 - Clinical care of adults with diabetes. 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.**

- i) *Develop, implement and audit protocols for initial assessment and continuing care and monitoring of people with diabetes.*

Regularly updated integrated personal Diabetes care records are made available for all people with Diabetes. Blood Glucose testing guidelines have been developed across Aneurin Bevan Health Board, the Diabetes work programme includes analysis of the prescribing of insulin analogues especially in relation to their place in the management of type 2 diabetes (NICE).

A comparison, year on year: the Diabetic lower limb pathway achievement rates on the percentage of people screened; the percentage of people identified as having at risk feet; percentage of people identified with new ulceration; the percentage of new minor amputations; the percentage of new major amputations; the number of admissions related to active Diabetes foot disease and those who are readmitted with recurrent ulcer; the number of people with Diabetes who develop an avoidable foot problem has been completed.

- ii) *Review local provision of diabetes services to identify gaps and areas for service development.*

This work is ongoing, and a detailed action plan being developed to identify the next steps. Models of care make explicit the roles of various providers via care pathways. Guidelines are in place to direct referral and discharge from specialist diabetes services in secondary care. A GP survey has just been conducted to identify their perceptions of primary and secondary care service provision.

**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.**

- i) *To ensure that diabetes services for children and young people are of a high standard and appropriately adapted to meet their needs*

The NSF has been superseded by specific guidance for the management of children with diabetes, which is implemented and subject to separate Welsh Government scrutiny.

- ii) *Support the needs of children & families with diabetes*

Education is adjusted to the development stage of the child /young person and repeated regularly

**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.**

- i) *To ensure the smooth transition from paediatric to adult services*



Dedicated Young Persons Diabetes clinics are in place, the Adult diabetes team runs a young person clinic following transfer from children's team. There are also designated handover clinics between the Paediatric and Adult Diabetes teams, in both Nevill Hall and Royal Gwent Hospitals.

**Standard 7 - Management of diabetic emergencies 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.**

*i) Strengthen the recognition & management of diabetic emergencies.*

Guidelines in place for diabetic ketoacidosis and Hypoglycaemia, and periodic audits are conducted. Further policy for management of Intravenous Insulin waiting to be launched

**Standard 8 - Care of people with diabetes during admission to hospital 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**

*i) Effective care & self management of diabetes in a hospital setting.*

Measures are being put in to have a dedicated Diabetes Inpatient Care team to advise on the care of people admitted with diabetes. Staff involved in diabetes services are trained in techniques to support self care, personalised care planning and to help patients make changes with their lifestyle. Supportive discharge strategies are in place

NICE Guidance followed for; The initial assessment and care of adults presenting with Diabetes in health care settings;

Written guidelines for Accident and Emergency teams on the assessment and initial management of people admitted to Accident and Emergency with active Diabetic foot disease

All three acute hospitals in Aneurin Bevan Health Board participate in the National Diabetes Inpatient Audit, conducted annually

**Standard 9 - Diabetes and pregnancy 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**

*i) Ensure effective management of pregnant women with diabetes.*

NICE compliant guidelines are in place for follow-up and regular testing of women with a history of gestational Diabetes. NICE compliant guidelines on; the provision of pre-conception advice for all women with Diabetes of child bearing age; the provision of contraceptive advice and counselling for younger women with Diabetes on the problems of teenage pregnancy; detecting women who develop abnormal glucose tolerance in pregnancy (gestational Diabetes); the detection and management of neonatal hypoglycaemia and other neonatal complications in babies born to women with Diabetes.

Weekly joint antenatal/diabetes clinics take place both at Nevill Hall and at Royal Gwent Hospitals. Insulin pump service available for patients who need it during pregnancy

**Standard 10 - Detection and management of long-term complications - all young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.**

- i) *Ensure all people with diabetes are receiving regular surveillance for long term complications of diabetes.*

This is covered under the Quality and Outcomes framework for primary care, and through follow up arrangements for patients with complex diabetes related problems treated in secondary care.

**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**

- i) *Detection, management & timely referral / diabetic complications*

Responsibility of patient, Primary and Secondary Care clinicians to refer onwards appropriately. Diabetic retinopathy service operates independently, appropriate referral process in place, and an annual report is required including; the number offered appointments and screened; the names of those who failed to attend for their retinal screening appointments by GP practice

It is proposed to review at least annually the incidence of the following complications of diabetes and compare rates via participation in the National Diabetes Audit MI; Stroke; Angina; Minor Amputations (below ankle); Major Amputations (ankles & above); Laser retinal photocoagulation; Blindness; End stage renal failure & death.

**Standard 12 - All people with diabetes requiring multi-agency support will receive integrated health and social care**

- i) *Ensure effective multi-agency support between health & social care.*

Compliance with this standard varies across Gwent, and will be picked up through the Diabetes Action Plan. There is much evidence of multi-agency support, and work has been done to improve joint working. Discharge planning from Hospitals includes assessment of the other medical and social needs of the patient and their dependents. Advice and training is provided to nursing/residential homes in the management of people with Diabetes but this is not yet consistent.

**Adequacy and Effectiveness of the National Service Framework in preventing and treating diabetes in Wales**

The existing National Service Framework is, in the view of the professional staff driving the agenda forward now outdated, as much has moved forward in the field in the last nine years and many of the standards in the NSF have been supplemented by additional requirements, such as NICE Guidance, a diverse range of revised and improved professionally driven initiatives to improve care as well as adherence to the Public Health Strategy and requirements of the Health, Social Care and Wellbeing and Children and Young Peoples partnership priorities.

In the interim period a comprehensive local action plan is being developed, and the Health Board would welcome a revised national Service Framework or successor document to help drive forward change.

Yours sincerely



**Dr D K Minton**  
**Chair ABHB DPDG**

