Health and Social Care Committee
Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction
DB 19 Cardiff and Vale UHB

Eich cyf/Your ref: Consultation WG 14793
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Committee Clerk,
Health and Social Care Committee,
National Assembly for Wales,
Cardiff Bay,
CF99 1NA.

Dear Sirs,

I am writing on behalf of the Cardiff and Vale University Health Board in response to the National Assembly for Wales' inquiry into the implementation of the National Service Framework for Diabetes in Wales and its future direction.

Given that there are estimated to be 160,000 people in Wales with diabetes and 66,000 who have the condition but do not know it, improving the care and treatment of those with diabetes is one of the UHB's clinical priorities, and we therefore welcome Welsh Government's focus on this client group.

In the absence of a template our response has been completed as a structured return in line with the stated NSF Quality Standards.

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.

- The Health Board has already implemented a number of local strategies including an obesity strategy, early year's school nutrition, and exercise on prescription. The Health Board has a Local Public Health Strategic framework with accompanying action plans many of which directly relate to prevention and health promotion activity. These activities are monitored and feature in the boards monthly performance report. In addition a number of initiatives have been activated by Public Health Wales.

Standard 2 – The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

- Screening for type 2 diabetes is not currently undertaken in Cardiff and Vale.

- Opportunistic identification of people who have had acute coronary syndrome (ACS) and acute stroke occurs within the hospital environment. The move to using HbA1c as a diagnostic marker for diabetes may facilitate this, as many people will no long require an oral glucose tolerance test.

- The UHB has produced a Diabetes Delivery Plan. Embedded within the plan is the requirement to undertake periodic surveys to test public awareness to ensure that public education programmes are correctly focused. This work will be undertaken in partnership with the Health, Social Care and Well Being strategy and surveys undertaken through local authority.

- The UHB participates and supports campaigns through community pharmacy

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.

- Type 1 education is not currently available in Cardiff and Vale.

- Type 2 education is available in small numbers through locally run XPERT education programmes. There is a NICE-compliant structured education programme offered to people with newly diagnosed with diabetes.

- Secondary care identifies individualised patient targets and communicates this to GPs at discharge. The community diabetes model will further enhance this work.

- Patient representatives sit on the diabetes planning and development group from Cardiff and the Vale, but we have limited engagement of younger patients with diabetes.

- At the present time there is no specific psychological support for our diabetes patients, although a generic community liaison service is available..

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.

- The Health Board's new Community Model will further raise the standards of care for diabetic patients. Its implementation began at the beginning of September. . It will improve education to GPs, support to practices and practice nurse. It will enable, mentoring and quality assurance of care across Cardiff and Vale.

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.

- Quality Standard points 1, 2, 3, 4 5, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30 have been assessed, and evidenced as complete.

- Quality Standard point 8 has been achieved in part. The UHB is actively seeking to engage young people and carers of young people with diabetes in patient reference groups to feed into the DPDG.

- Quality standard point 14 requires the UHB to have NICE compliant guidelines for optimising glycaemic controls towards normal levels for children and young people with Diabetes. This is partially complete. There is an All Wales diabetes document for the management of children and adolescents with diabetes which the UHB is using to shape services.

- Quality Standard point 21 requires the UHB to ensure provision of NICE compliant insulin pump therapy services for children and young people

with Diabetes. Partial success has been achieved with an Insulin pump service available to children.

Standard 6 – All young people with diabetes will experience a smooth transition of care from paediatric 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.

- This standard is met in full. There are quarterly transition clinics and monthly young adult clinics supported by a DSN and dietician at the University Hospital of Wales.

Standard 7 - The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained healthcare professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

- The UHB currently implement the new JBDS DKA guidelines .We have "hypo" boxes and "hypo" guidelines on all wards. In addition we have a separate insulin prescription chart.

- Quality standard points 2, 3, 4, 5, 6, 7, 9, 11, 12, 13, 14, 15, 16 30 have been assessed, and evidenced as complete.

Standard 8 – All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Whenever possible, they will continue to be involved in decisions concerning the management of their diabetes.

- The national diabetes inpatient audit suggests that there are a large number of prescribing errors with insulin or oral hypoglycaemic agents. UHW in particular has particularly low rates of diabetes team review of inpatients with diabetes. Strategies to develop an in-reach service may reduce this and are currently in development.

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.

- Both the University Hospital of Wales and University Hospital Llandough have dedicated medical ante-natal clinics with support from specialist diabetologists and obstetricians. Ante natal clinics on both sites are supported fully by DSN and dietician also.

- The Diabetes/Obstetric Service participate in national and regional collaborative audits of the processes and outcomes of Diabetes care. Audit data is collected through Confidential Enquiry into maternal and Child Health (CEMCH).

- In order to achieve compliance with Point 2 the UHB have undertaken work to provide guidelines on the provision of contraceptive advice and counseling for younger women with Diabetes on the problems of teenage pregnancy. This work is partially complete.

- Pre-natal counseling and screening available through the medical ante-natal service and type 1 diabetes clinics.

- Quality standard points 1, 3, 4, 5, 6, 7, 8, 9, 10, 11 have been assessed, and evidenced as complete.

Standard 10 – All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

- GPs achieve through QOFF annual review. In addition patients receive diabetic retinal screening through the All Wales service.

- The UHBs (primary and secondary care) model of care is NICE compliant and requires that all people with diabetes are offered annual review.

- At present the UHB does not require that staff share results of annual reviews (e.g. biomedical results, etc.) with people with Diabetes in advance of their consultations. Primary Care Physicians share these results with patients. However, Secondary care providers are working toward the introduction of this policy and routinely copy the clinic letter to the patient.

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.

- Quality standard points 1, 2, 3, 4, 6, 13, 16, 17, 18, 19, 21, 28.29,31 have been assessed, and evidenced as complete.

- Quality standard point 5 calls for a comprehensive UHB-wide programme to screen for Diabetic neuropathy and peripheral vascular disease. Implementation is partially complete with annual reviews in general practitioner surgeries and podiatry services in the community.

- Quality standard point 7 is partially compliant and guidelines exist for foot ulceration, ischaemia and charcot neuropathy, but not specifically for the Accident and Emergency unit.

- Quality standard points 8 and 9 cannot be met at the present time due to work pressures elsewhere.

- Quality standard points 10,11,12,14 are being actively reviewed.

- Quality standard points 15, 20, 22 are completed via our vascular multi-disciplinary team in both primary and secondary care.

- Quality standard points 23, 24, 25 will be developed as part of the adoption of NICE guidelines on diabetic foot care.

- Quality standard points 26 and 27 require the health Board to compare the percentage of both new minor and new major amputations year on year. This progress is partially complete, and audit data is available.

- Quality standard point 30 requires the ability of Hospitals to demonstrate that they act on the findings of their monitoring processes on in-patient management of active Diabetic foot disease. Current IT infrastructure does not allow this, but periodic audits are undertaken on management of diabetic foot disease.

- There is evidence of excellent multidisciplinary team (MDT) working in this field. MDT clinics are held which bring together vascular surgery, orthopaedic surgery, infectious disease/microbiology, diabetologists, podiatry and wound healing expertise. The development of the UHBs proposed community model will further support this work.

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

- The community diabetes model will support this

The UHB is committed to achieving the Assembly Government's strategy for improving the quality of care and treatment for those living with diabetes.

Yours faithfully,

Paul Hollard
Deputy Chief Executive/Director of Planning/Interim Chief Operating Officer

Standard 1 – reduce risk of developing type 2 diabetes
GP surgeries opportunistically discuss lifestyle issues with patients attending their surgeries. Health promotion advice is available through community pharmacies.

Prevention in at risk groups
Work continues with black and minority ethnic groups to highlight the risks of diabetes such as attending conferences.

Standard 3 – partnership in decision making in managing diabetes
The Education for Patients programme provides more generic information for individuals to enable them to learn skills to live with their chronic conditions

Standard 4 – High quality care through a lifetime
Pathways are being put in place to enable patients to have seamless transition through services and to escalate them to specialist consultants and nurses when this is required. The GP remains the pivotal element in their care throughout their life.

Standard 8 – children and adults with diabetes will receive effective inpatient care
There is a team of specialist nurses who can advise ward staff on the care of individuals living with diabetes

Standard 12 – multi-agency support under integrated health and social care.
In addition the community resource teams which consist of multidisciplinary health professionals, social care and voluntary sector members can work with the specialist team to keep individuals in their own homes for longer, prevent admission and expedite discharge.