Diabetes National Service Framework (Wales)

Responses to Consultation on the Standards Document
Responses to Diabetes National Service Framework Standards

The Standards document has been developed to help achieve better standards of care and support in the management of diabetes. The standards document is the first part of the National Service Framework for Diabetes and sets out the twelve new standards to be adopted in Wales. This work supports the new NHS plan for Wales, *Improving Health in Wales*, which recognizes the need for joint working to establish better ways of addressing the health care challenges.

Comments and feedback have been invited on how we can best achieve these standards across Wales. The consultation period was extended from the end of July 2002, until the end of August 2002. The information was gathered from, people with diabetes, their families and carers, health and other professionals and the voluntary sector.

The information gathered, together with the Audit Commission’s Baseline Review Report, Market Research Wales – Focus Group Report, reports from members of the Implementation Group and Assembly staff and other healthcare professionals and sub-groups of the Implementation Group will be taken into account in the Delivery Strategy Document. The many practical issues involved in delivering local services will be taken into account.

Three particular areas were identified to structure the feedback of the responses on:

1. How can each of the Standards be implemented most effectively across Wales?

2. What are the priority areas?

3. What multi-disciplinary mechanisms would best support local delivery? (e.g.) the future of Local Diabetes Service Advisory Groups (LDSAGs), setting up Local Implementation Groups.

1. HOW CAN EACH OF THE STANDARDS BE IMPLEMENTED MOST EFFECTIVELY ACROSS WALES

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.

Health Promotion – Multi-agency – local councils, education department, voluntary sector and Local Health Board (LHB) - activity across the multi-racial communities to increase population activity levels and healthy eating (7, 10, 11, 12, 13, 17, 20, 21, 23, 24, 25, 29, 32, 40, 41, 42, 43, 47, 54)

Increase awareness of diabetes prevention in the population (10, 17, 20, 32, 41, 43, 54)

National prevention program based on Finnish/American studies (24, 28, 46, 48, 49)

Links with CHD initiatives (7, 10, 13, 17, 46)

Healthy school meals – Healthy schools initiative (5, 11, 17, 29, 54)

Improved education in prevention for health care professionals on the subject of prevention and initiatives in place in the local area (7, 11, 17, 29)

Community pharmacy to be encouraged to develop its role in health promotion weight management and disease prevention programs (3, 20, 43)

Focus on health inequalities (18, 21)

Ensure that all initiatives accept referrals from all HCP and easy to access by people living with diabetes (13)

Development of dieticians role – health promotion (12)
**Standard 2**  
**Identification of people with diabetes**  
The NHS will develop, implement and monitor strategies to identify people who do not know that they have diabetes.

| Agreement of local methods to identify and screen high-risk individuals and agreement of criteria for screening, especially people in harder to reach groups (11, 13, 14, 20, 21, 24, 25, 29, 32, 40, 42, 43, 46) |
| Education to increase awareness of signs and symptoms of diabetes amongst health care professionals (7, 11, 13, 20, 24, 20, 29, 32, 42, 43, 54) |
| Opportunistic screening for those with risk factors according to protocols (10, 11, 13, 16, 17, 20, 29) |
| Diabetes UK poster campaign to raise awareness or something similar (11, 16, 17, 20, 24, 29, 54) |
| Monitoring of those with Impaired Glucose Tolerance (IGT) and history of gestational diabetes or those at high risk in primary care (11, 12, 13, 20, 24, 29) |
| National screening program (11, 17, 24, 29) |
| Links with CHD (10, 20, 24, 32) |
| Active identification of undiagnosed people with diabetes by community pharmacies – according to a protocol agreed by the LDSAG and local GP practices– in a private consultation area (3, 46) |
| READ codes to describe prevention and monitoring activity (11, 29) |
| Utilize WHO standards for diagnosis (10) |
| Implementation of NICE guidelines on weight reduction (13) |
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 should be fully engaged in the process.

On-going structured patient education (10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 24, 26, 28, 29, 32, 40, 43, 45, 46)

Hand held records (11, 12, 13, 14, 20, 24, 29, 32, 40, 42, 43, 46, 54)

Users must be involved in service planning (17, 18, 20, 32, 42, 43, 45, 46, 54)

Personal care plans (11, 13, 15, 20, 24, 29, 40, 43)

Information for the patient on what care they can expect from various agencies/ professionals and what their responsibilities are (10, 16, 20, 32, 43, 45)

Well-educated primary care staff able to support and not disempower people living with diabetes (12, 13, 16, 19, 42, 54)

Referral by professionals to local Diabetes UK or other voluntary groups (17, 20, 43, 45, 54)

Expert patient program – chronic disease self management programme (7, 11, 19, 24, 29)

Funding for patient education literature from Diabetes UK. (11, 15, 25, 29)

Patient self-management program - Merthyr/Cynon area (20, 32, 43)

Two-way duty of care, partnership (17, 24, 25)

Resource centers of information (11, 12, 29)

Education and support for people living with diabetes in a structured manner at the point of prescription dispensing, particularly relating to medicine management (3, 6)
Need to see IT developments for self assessment tools (11, 29)

Flexible approach to service delivery (13, 32)

Information – on skin and foot care (7)

Provision of appropriate services for individuals from minority ethnic communities (8)

Increased awareness in the population of people living with diabetes (10)

Diagnosis pack (54)
### Standard 4

**Clinical Care of adults with diabetes**

All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

<table>
<thead>
<tr>
<th>Activity</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed protocols and guidelines for initial assessment and management used by staff</td>
<td>10, 11, 12, 13, 20, 21, 29, 32, 43</td>
</tr>
<tr>
<td>Support work to develop diabetes registers</td>
<td>10, 15, 18, 23, 24, 27, 31, 33</td>
</tr>
<tr>
<td>Education of Health Care Professionals</td>
<td>11, 12, 13, 17, 20, 29, 43, 46</td>
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<tr>
<td>Exercise support for people with diabetes and support to maintain a healthy lifestyle</td>
<td>5, 7, 10, 12, 16, 43</td>
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<tr>
<td>Dieticians and podiatrists based in primary care so improving access for people with diabetes</td>
<td>12, 16, 18, 24</td>
</tr>
<tr>
<td>Regular call and recall and data management– IT systems</td>
<td>6, 7, 15, 32</td>
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<tr>
<td>Joint community (primary and secondary) clinics or outreach clinics</td>
<td>11, 13, 17, 29</td>
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<tr>
<td>Protocols for the identification and management of non-attendees</td>
<td>11, 20, 29, 43</td>
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<tr>
<td>Protocols for those who are housebound or in residential settings</td>
<td>11, 17, 29, 43</td>
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<tr>
<td>Links with CHD and cardiac risk assessment tools</td>
<td>10, 12, 13, 16</td>
</tr>
<tr>
<td>Rapid access clinics</td>
<td>11, 16, 29</td>
</tr>
<tr>
<td>Increased clinical staffing in primary and secondary care – Specialist registrars, consultants is a particular problem</td>
<td>24, 40, 46</td>
</tr>
<tr>
<td>Good records and communication between primary and secondary care</td>
<td>10, 16, 24</td>
</tr>
<tr>
<td>Primary care diabetes specialist nurses or liaison nurses</td>
<td>12, 14, 15</td>
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</tbody>
</table>
Quality controlled HbA1c analysis and blood glucose monitors (11, 29, 54)

Implementation of NICE guidelines (21, 25, 28)

Ban on cigarette advertising (11, 29)

Medicine management support and home blood glucose monitoring support by community pharmacists (4, 32)

Provision of appropriate services for individuals from minority ethnic communities (8)

24 hour help line – NHS direct (13)

Target HbA1c <7% (6)

Smoking cessation programs (13)
Standard 5
Clinical care of children and young people with diabetes
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.

Protocols for the initial and ongoing assessment and management of children with diabetes (10, 11, 12, 20, 29, 43, 45)
Psychological support (11, 13, 20, 29, 40)
Education of school staff and health care professionals by PDSN (11, 24, 29, 40, 54)
Protocols for the identification and management of non-attendees (11, 12, 29)
Support for children in residential care - all should have the PDSN’s number (11, 29)
Prompt diagnosis (32, 46)
Programs for exercise and obesity reduction in obese children (7, 40)
Structured education for family friends and child with diabetes (40, 46)
Staff to remember children are children (54)
IT equipment (40)
Screening for other auto-immune conditions at the point of diagnosis (45)
Develop alternative ways of working – e.g. groups (13)
Links to Children and Adolescent Mental Health Service (CAMS) and the children’s NSF (7)
Referral to local support group (20)
**Standard 6**
All young people with diabetes will experience a smooth transition of care from paediatric diabetic services to adult diabetic 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.

Young persons clinic (17, 32, 40, 43, 45, 46)
Age relevant information, agreed care protocols (11, 13, 29, 40, 46)
Psychology services (11, 20, 29, 40, 46)
Support for people in residential care settings (11, 29, 46)
Identification of non-attendees and maintaining contact via email and text (11, 29)
Links to school nursing services (13, 17)
Good communications GP/Secondary care and within secondary care (13, 40)
Close liaison pediatric and adult services (24, 40)
Referral to local support group (20)
Links with CAMs and children’s NSF (7)
Family planning advisor (13)
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 minimize the risk of recurrence.

Agreed guidelines and protocols across primary and secondary care (10,11, 20, 24, 29, 40, 46)

Education for families and carers – SICK DAY RULES (11,13, 20, 29, 32, 43, 54)

Compulsory basic first aid training for health care workers to include the initial management of diabetic emergencies (7, 40, 43, 46, 54)

On call and SHO training (17, 24, 40)

Review of ambulance staff activity in this area (40, 46)

24hr help line –NHS Direct (13, 46)

DSNs involved in paramedics and GP training (11, 29)

Rapid access clinics (13)
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.

Diets appropriate for people with diabetes at appropriate time (11, 13, 17, 20, 24, 29, 46)

Agreed guidelines and protocols for use on all the wards based on care pathways (11, 13, 20, 24, 29, 43)

Training of all hospital staff in diabetes and its management (7, 13, 24, 43, 54)

User empowerment and education on how to manage their condition when in hospital (13, 32, 40, 46)

DSN’s to cover the wards and lead/link ward nurse education on diabetes (11, 13, 24, 29)

Self-administration of medicines and snacks by people with diabetes whilst they are in hospital – unless they are unable (17, 46, 54)

Referral to diabetes team (46)

Pre admission consultations / guidelines (13)

Communication between primary and secondary care (13)
<table>
<thead>
<tr>
<th>Standard 9</th>
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<tbody>
<tr>
<td><strong>Diabetes and Pregnancy</strong></td>
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<tr>
<td>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 their pregnancy to optimize the outcomes of their pregnancy.</td>
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</tbody>
</table>

Antenatal, intrapartum and postpartum care using agreed guidelines and protocols and care pathways (10, 11, 12, 13, 17, 29, 36, 43, 46)

Protocol for the detection and management and follow-up of people with gestational diabetes (11, 17, 20, 29, 36, 40, 43, 46, 54)

Pre-conception care for all with type 1 and type 2 diabetes of childbearing age (11, 13, 29, 32)

Improved communication within secondary care between obstetric, diabetes services and primary care (12, 24, 40)

Development of the role of specialist midwives role (13, 36)

Management for all babies born to mothers who have diabetes (11, 29)

Open access by pregnant ladies with diabetes (24)

Training of obstetric and midwifery staff in diabetes (7)
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.

National Retinal screening program, including management guidelines for non-attendees, (11, 13,15, 17, 20, 21, 24, 26, 27, 28, 29, 31, 32, 33, 37, 40, 43)

Agree implement and audit local guidelines for annual review (annual to mean annual) (10, 11, 13, 20, 29, 32, 40, 43, 45, 46, 54)

All people living with diabetes must have regular appointments with a podiatrist and ongoing easy access, by sufficient podiatrists, in a convenient venue (4, 10, 13, 20, 24, 40, 43)

Regular call and recall systems that are audited (7, 11, 13, 29)

Ensure that patients still undergo routine optometry screening and optometrists may have a role to play in retinal screening (13, 51, 52, 53)

Guidelines for insulin usage following Myocardial Infarction (MI) and Audit of subsequent outcomes (11, 29)

Agreement of standard risk assessment tool for CHD and diabetes (10, 13)

Understanding that an eye-screening program will lead to an increase in cataract surgery, laser treatment and low vision aid services (40, 53)

Education for the patient to help them understand the different roles of all the members of the multidisciplinary team to help them get the best from the service (13, 20)

Improved communication between primary and secondary care, between care staff and the patient and surgery and community based staff (13)

Developments of care pathways (13)

Improved data collection and storage (13)

Protocols for hard to reach groups – nursing homes, prisons, minority ethnic communities, residential homes (13)

Performance management (24)

Attention to modifiable risk factors and support from community pharmacists (3)
Advice on skin care (7)

‘One stop shop’ (40)

Specific diabetic clinics in general practice/ protected practice time (24)
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 the risk of disability and premature death.

Agreed guidelines protocols care systems and care pathways for the management of complications by the educated multidisciplinary team (7, 10, 13, 17, 46)

Support and development of amputee and stroke rehabilitation services by physiotherapists and other PAMs (7, 11, 29)

Rapid access for those with foot problems (7, 54)

Sexual dysfunction management clinics to be established and evaluated (11, 29)

More importance to be placed on the care of skin (7)

Good records and communication between primary and secondary care (10)

Joint working with other LHBs to develop secondary based services (12)

Time with the specialists to come to terms with complications (54)

Direct referral to diabetic foot teams by qualified podiatrists (4)
**Standard 12**

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

Improve knowledge of social care and nursing staff in residential/nursing homes (7, 13, 25, 28, 41, 46, 54)

Good records and communication between agencies (10, 17)

Rehabilitation and support for those with amputations, strokes (11, 29)

Needs of Foster carers (41)
### 2. What are the priority areas?

National Retinopathy screening service (11, 13, 15, 17, 18, 20, 21, 23, 24, 26, 27, 28, 29, 31, 32, 33, 37, 40, 43)

**EDUCATION** Further education and training for all staff in diabetes knowledge (3, 7, 10, 11, 12, 13, 14, 16, 17, 18, 21, 22, 24, 25, 27, 29, 42)

To identify the resource implications of implementing the NSF for diabetes at the outset and provide that resource (2, 4, 7, 11, 13, 15, 16, 20, 21, 22, 25, 28, 29)

Ensure that information systems are in place to monitor the progress in adapting the standards set out in the NSF – linked to IM&T strategy (2, 10, 11, 13, 16, 18, 19, 21, 22, 25, 29, 40)

Issuing of the relevant READ codes with the NSF (5, 10, 11, 13, 14, 15, 16, 18, 19, 22, 29)

More nurses in the role of Diabetes Specialist Nurses in primary care/ Diabetes nurse facilitators / Interface nurses (11, 12, 13, 14, 15, 16, 17, 24, 25, 29, 38)

Large investment in numbers of all personnel - primary and secondary care (5, 10, 16, 24, 27, 28, 31, 33, 40)

More resources and staff in the community (5, 10, 11, 12, 13, 16, 18, 27, 29)

**WAG** to publish the strategy with a strong sense of direction, clear communication, and containing protocols/templates and guidance on structured arrangements for delivery (7, 14, 15, 16, 18, 19, 22)

Improved joint working, communication and co-operation between all involved in diabetes services (12, 15, 16, 23, 25, 40, 47)

Prevention strategies and screening guidelines (7, 10, 13, 18, 40, 42)

Close working with the Coronary Heart Disease Services Co-coordinating Group and other NSFs in Wales (2, 10, 13, 18, 19, 21)

Audit tools and funding to carry out audits (10, 13, 14, 15, 18)

Funding of hospital biochemistry departments for increase in workload (13, 17, 35, 46)

GP/ Hospital communication needs to improve – clinic letters based on READ codes (10, 15, 16)
All Wales Diabetic Service group that would advise each LHB and thus practices and develop guidance, instructions, protocols and care pathways. They should also set and review the targets and milestones (5, 7, 13)

Roll out of good practice examples identified by the baseline service review (7, 19)

Inter-agency working (11, 29)

Utilize and support the ongoing work of Diabetes UK (10, 25)

Improved joint working between all members of the multidisciplinary team whether they are secondary, primary or community based (15, 25)

To identify the most effective ways in which the pharmaceutical industry can bring its unique understanding and experience to different therapies to bear on the vital work of defining a Delivery Strategy for Wales. (1, 25)

Strong performance measures (21)

Recognition of greater workload of practices with a high proportion of patients from minority ethnic communities (5)

Workforce planning i.e. more podiatrists etc need to prepared for the role (18)

Link with Health Alliances (21)

Priority areas should be identified locally (30)

Ring fenced funding (14)

Specialist GPs (17)

Holistic approach to the person rather than the condition (12)

Involving community pharmacists and the contribution that they can make (3)

Development of foot teams specializing in the care of people with diabetes (4)

Cheap exercise for patients (5)

Links with Scotland, England and Northern Ireland (7)

Resourcing of Diabetes UK Black and Minority Ethnic project in Wales (9)
3. What multidisciplinary mechanisms would best support local delivery?

LDSAGs important and work should be supported (7, 11, 13, 18, 19, 20, 23, 24, 29)

Consider the roles, responsibilities and geographical boundaries of the current LDSAGs and reconfigure if necessary (7, 14, 18, 19, 23, 24, 29, 31, 32, 40, 43)

Local Implementation Group (10, 14, 16, 21, 25, 40)

Improved training for primary care staff to work on implementation teams (10, 16)

User involvement in service planning (17, 20)

LDSAG with an executive strategy group (32)

LDSAGs to refer to work carried out to implement Cancer NSF and CHD NSF (7)

LHBs and Trusts need to consider responsibilities both in purchase and provision of services that prevent, manage and screen for diabetes (7)

LDSAGs or LIG should have a budget (17)

3 clinical networks (7)
Annex A

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