Health and Social Care Committee
Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction
DB 21 Cwm Taf Health Board

INQUIRY INTO IMPLEMENTATION OF DIABETES NSF

CWM TAF HEALTH BOARD RESPONSE

STANDARD	PROGRESS	STATUS
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.	Within Cwm Taf the following progress has been made in relation to lifestyle management strategies which assist in reducing the risk of developing Type 2 Diabetes amongst and other chronic conditions. **SMOKING:** • A variety of community based Stop Smoking groups available via Stop Smoking Wales. • Packs of Credit card sized contact detail cards available for distribution to patients if required. • 29 pharmacies in Cwm Taf offering Stop Smoking services – info leaflets available. • Brief intervention training for staff available as part of Stop Smoking Wales Training calendar (also Alcohol Brief Intervention available). • On line e-training programme available to NHS staff via Stop Smoking Wales. • Making every contact count is a priority for all staff. Our aim is to ensure that all staff are able to provide the appropriate advice on local services to all patients, and refer where appropriate to the Stop Smoking Wales Community based sessions, community Pharmacies and via the in house Health Board service. **EXERCISE:** • Well controlled diabetics can access NERS for 16 week programme.	

	• Merthyr NERS currently linking with a GP Practice to pilot a system of providing info and considering referral for every diabetic patient undergoing their annual check. **WEIGHT MANAGEMENT:** • Community based weight management classes currently being set up in a number of Communities First areas. • Funding being sought to develop a comprehensive weight management programme pilot from Oct to March 2013 looking at nutrition, cookery skills and exercise delivered by a new team of staff across a variety of community settings linking to the NERS programme. This will initially be for orthopaedic patients but if successful would hope to look for a way to open out to a wide range of conditions. • Local Obesity Strategy currently out to consultation. • The public health team has been working in partnership with a number of Community First areas to provide their staff with the training and resources to set up a number of informal, community based weight management groups. There are also a number of activities such as walking groups attached to their areas. • Also a recent evidence review conducted by Public Health Wales highlighted that although the long term effectiveness of commercial weight loss programmes is currently unclear two commercial weight loss programmes (Weight Watchers and Slimming World) comply with current NICE guidelines. Both are diet based programmes led by the individual and promote physical activity. They offer participants with the opportunity to weigh weekly and both charge membership fees. • Potential forthcoming projects include the opportunity to use the exercise referral scheme to undertake weight management programmes using a programme developed by a working group of dieticians lead by WG together with the existing exercise component.	
Standard 2 The NHS will develop, implement	**RAISING AWARENESS:** • Annual Diabetes in primary care course; Formal medical lectures; core	

and monitor strategies to identify people who do not know they have diabetes	training hospital junior medical staff; dedicated Diabetes inpatient teams which also deliver "Think glucose" education package for ward staff. • The Health Board support Diabetes UK in their annual campaigns which seek to raise awareness of Diabetes and the risk factors. The 2012 and 2011 campaigns were particularly successful. **SCREENING:** Cwm Taf LHB has developed a comprehensive diabetes strategy that includes identifying patients in high risk groups and then screening for diabetes. Work is ongoing to include screening for diabetes as a component of the 'over-50 health check'. Patients with cardiovascular disease and hypertension are tested annually for diabetes in most practices.	
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.	**CHILDREN & YOUNG PEOPLE:** The Health Board has made good progress in relation to this standard for example: • As part of All Wales programme all families encouraged to be involved in care and treatment. • All paediatric patients encouraged to become involved in the management of their condition. • Information provided to patients and families with regard to healthy lifestyles. • Shared care plans in place for all Paediatric patients. **ADULTS:** **Programmes to strengthen and support self care management:** Structured Diabetes Education (SDE): • DAFNE Type 1 SDE program available in both PCH and RGH. Available to 6% Type 1 Diabetic population per annum. • XPERT Type 2 SDE. Limited availability in Cwm Taf. Available to 1% Diabetic population per annum.	

	Partnership and active involvement: • Patient Reference groups established. • RCT CBG monitoring diaries which includes ability to record other results (e.g. BP, lipids etc) and current treatment issued throughout Cwm Taf. • No single shared care plan at present.	
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 has made steady progress against this standard. The increasing prevalence of Diabetes however will present issues in relation to capacity and resources available to support the Diabetic population in Cwm Taf. • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support "expert" general practitioners and practice nurses so that the "Cluster Network" model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • The Health Board piloted a Diabetes Community Team for a 2 year period. Evaluation of the pilot demonstrated good outcomes (reduction DNA rate, significant reduction in secondary care referral rate, provision of high quality local care, upskilled primary care staff, high rates of patient and Primary care HCP satisfaction, practice based SDE) however the model was not sustainable to roll out across Cwm Taf. The Health Board are now developing an alternative model based on specialised federated model to support more integrated working between primary and secondary care and increase the skills and knowledge base within primary care. • A Diabetes Nurse Facilitator is based within the community and covers the Cwm Taf area. There are 3 key elements to this role: ○ Training and Education (students, health/social care staff and	●

	patients) ○ Facilitation and Supervision (for example, sitting alongside a Practice Nurse to provide shared care until such a time that the Practice Nurse has developed the required clinical competencies) ○ Direct Clinical support and professional advice to the District Nursing service, GP Practices, Care Home staff and Community Hospital staff regarding the clinical management of a patient presenting with Diabetes The Health Board would like to develop this role further. • Clinical Pathway Agreed by Diabetes Group and Local Medical Committee. • Patient hand held records available. • Dietetic Capacity Grant Scheme has been extended to include nutrition training for people working with older people. Potential to train staff from nursing/residential settings. • DAFNE programme in place in both DGH sites. • X-PERT available in both DGH sites. • Think Glucose pilot site for Wales. This is focusing on education and training to ward staff. Insulin prescription charts now on all acute wards which support staff in the administration, dosage and monitoring of insulin. • QOF provides template for annual assessment of Diabetic patients for many but not all aspects of Diabetes care. • Educational support via Diabetes in primary care course run annually. • GP practices have recall system for non-attendees. • Audit + - participation in annual National Diabetes audit poor. The Health Board is engaging with practices to improve uptake. • Diabetic (medical) e mail advice project planned. • T1DM SDE and CSII service introduced in PCH. • Diabetes inpatient team pilot demonstrated significant reduction in average length of stay for inpatients with Diabetes. 2 WTE reduction in DSN posts reduced provision of inpatient service.	
Standard 5 All children and young people with diabetes will receive consistently	Steady progress has been made against this standard however gaps remain. • Not all patients receive psychological support due to limited psychology	

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.	resources • Additional Paediatric Diabetes Nurse Specialist and Dietetic capacity required to support caseload of patients. • Nurse-led and Consultant clinics in place. • Education offered to all patients on an on-going basis not just on diagnosis. • Additional capacity would allow for audit of quality of care provided. • Structured education guidance "Successful Diabetes – Developing and Delivering Self Management Education". Integrated approach to education. Course being rolled out across Wales. Cwm Taf team involved in this programme. Review of capacity required in order to roll out such education programmes. • Parents of children with Diabetes group running. Provides support, advice and guidance. • Peer support group for paediatric patients with Diabetes runs bi-monthly. • CSII therapy now available for children. • No Dietetic support for children.	
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.	Steady progress has been made against this standard however gaps remain. • Guidelines required with regard to optimal transition age. Currently led by available capacity within local services. Currently transition discussed with patient and family at 16. • Transition normally takes place age 17 and 18. • Paediatric and adult service work together to support transition. • Joint multidisciplinary Paediatric-Adult transition clinics established in Cwm Taf. Transition tailored to individual.	
Standard 7 The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of	The Health Board has made good progress in this area. Of note: **Recognition:** • Taught as part of Undergraduate training in nursing and medical schools	

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<tr><td>diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.</td><td>Diabetes in primary care course.
Think Glucose project in both Hospitals.
Management:
Acute hyperglycaemia guidelines in process of being updated.
Hypoglycaemia guidelines introduced.
Diabetic foot pathway to be updated.</td><td></td></tr>
<tr><td>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.</td><td>Steady progress has been made against this standard however gaps remain. Of note:
Cwm Taf LHB is working with Diabetes UK and other LHBs to discern how the Royal College of General Practitioners "Care Planning" model (http://www.rcgp.org.uk/clinical-and-research/clinical-resources/care-planning.aspx) can be adapted to the Welsh NHS. The model builds upon the lessons learnt from the Diabetes Year of Care project in England.
Diabetic team informed of admission / diagnosis immediately.
Diabetic would follow-up patient on the ward.
Diabetic team commence planning for home management.
Training undertaken with ward staff in relation to Diabetes awareness. However protected time for training not in place therefore identified as an issue for improvement.
Recognition:
Taught as part of Undergraduate training in nursing and medical schools
Think Glucose project in both Hospitals.

Management:
Diabetes inpatient team pilot demonstrated significant reduction in average length of stay for inpatients with Diabetes.

Foot screening of PWD on admission to hospital not established.</td><td></td></tr>
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	Updated glucose monitoring and insulin prescribing charts including the management of hypoglycaemia implemented. Hypoglycaemia management boxes (hypoglycaemia treatment & management algorithm) introduced all clinical areas Hospital.	
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.	Good progress has been made against this standard. Of note: • Midwifery/DSN pre-conception and pregnancy clinics established RGH. • Joint Diabetic/obstetric antenatal clinic established. • Protocols for management of Diabetes during pregnancy & labour established.	
Standard 10 All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.	Steady progress made against this standard, for example: • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support “expert” general practitioners and practice nurses so that the “Cluster Network” model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • All annual reviews to be performed in primary care • All practices participate in QOF and have access to Audit+. Health Board is engaging with Primary care to increase Audit+ uptake to undertake NDA. • DRSSW needs to inform each General Practice of patients who DNA retinal screening. •	

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.	Steady progress has been made in this area. Of note: • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support "expert" general practitioners and practice nurses so that the "Cluster Network" model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • Referral guidelines established • Discharge guidelines established • Diabetic (medical) e mail advice project planned • All Wales Consensus guidelines established (available online)	
Standard 12 All people with diabetes requiring multi-agency support will receive integrated health and social care.	The Health Board has very good working relationships with its Local Authority partners. However we acknowledge that further progress could be made and a considerable amount of work is underway at present particularly in relation to a more integrated approach to discharge planning, access to Reablement services and multi-disciplinary / multi- agency community teams for frail elderly patients. A number of this patient group will have Diabetes. Specifically within the area of Diabetes, the Diabetes Nurse Facilitator provides direct clinical support and professional advice to Care Homes to support the management of patients with Diabetes. The Health Board also has a Local Enhanced Service for Care Homes which supports regular monitoring of Care Home patients.	