Progress and challenges in delivery of the diabetes NSF

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This article outlines the report Turning the Corner: Improving Diabetes Care on the progress made since the launch of the National Service Framework for Diabetes. It highlights some of the challenges still to be met and provides up-to-date information on prevalence and treatment levels.

The National Service Framework for Diabetes (Department of Health, 2001) set out standards for the care of people with diabetes. A newly published report, Turning the Corner: Improving Diabetes Care (DH, 2006), assesses the progress made in improving diabetes care and identifies the challenges for the future in managing this common long-term condition. Essentially it gives a snapshot of where diabetes services in England are in 2006 and highlights projects that are contributing to improving care.

Background

Diabetes is emerging as one of the great health threats of this century (DH, 2006). It is a serious, complex condition that, if not tightly managed, can result in a range of complications such as cardiovascular disease, kidney disease and blindness.

The essential elements of good care for people with diabetes are well established, with the main aim being to achieve normal blood glucose and blood pressure levels. Services are aimed at helping patients to become partners in their own care in meeting this aim (Pender, 2005).

Progress and challenges

There is now improved baseline data to enable progress in diagnosis and care for people with diabetes to be measured effectively. This is due to:

- The National Diabetes Audit (Healthcare Commission, 2005);
- DiabetesE (NHS Modernisation Agency, 2004);
- The Quality and Outcomes Framework (QOF) (National Diabetic Support Team, 2006);
- A more accurate prevalence model (Yorkshire and Humber Public Health Observatory, 2004).

According to the QOF only 72% of the estimated number of diabetes cases have been diagnosed. It is predicted that by 2010 the prevalence of diabetes will increase from 4.7% to 5.05% (DH, 2006).

Areas working well

The report highlights that diabetes networks are essential components of integrated diabetes care and can produce real improvements in services. The QOF is identified as a significant driver in delivering and measuring improvement, with the largest single number of points awarded for diabetes care.

The data from the 2005 QOF provides a good indication of the proportion of patients who have had routine assessments and that recording of HbA1c, blood pressure and cholesterol is improving (Box 1, p24).

Areas for improvement

While the QOF highlights good practice it also reveals that less than 50% of patients were recorded as receiving eye checks and that there is wide regional variation in the rates of myocardial infarction, cardiac failure and stroke among people with diabetes.

In addition it highlights that an audit of specialist
REFERENCES

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paediatric units shows that HbA1c targets are achieved in only 15% of children with diabetes. One of the biggest challenges identified is the trend of a growing number of people who develop type 2 diabetes. Research shows that two-thirds of these cases could be prevented by improved physical activity and diet (DH, 2006).

The other major challenge is identifying people with undiagnosed diabetes. This is important as about 50% already have one or more complications of diabetes on diagnosis and earlier diagnosis and treatment may have prevented this. The UK National Screening Committee has advised that screening certain subgroups of the population for type 2 diabetes is feasible and should be taken forward.

The report also highlights that people with diabetes are still experiencing problems accessing psychological support and that many feel this is a significant gap in diabetes services, particularly for children, young people and parents.

Practice projects
The report identifies numerous innovative examples of how to meet the needs of patients with diabetes and deliver the NSF (DH, 2006). These include:

- The Essex Strategic Health Authority project looking at the mental health implications of diabetes;
- The South Wiltshire’s New Diabetes Pack, a handbook of core diabetes information and record of care to be given to every adult with diabetes;
- The Bolsover Wellness Project in North Eastern Derbyshire, which aims to enhance physical activity in at-risk groups;
- The Do Activity Stay Healthy (DASH) scheme run by Somerset Coast Primary Care Trust to tackle increasing obesity in children with an early morning school-based club;
- The Apnee Sehat (Our Health) project led by South Warwickshire PCT in partnership with South Warwickshire General Hospitals Trust and the local community encouraging healthy diet and lifestyle choices in the Asian population;
- A Pro-Active Call Centre Treatment Support study at Salford PCT investigating whether proactive contact centre-based communication between healthcare professionals and patients with type 2 diabetes can enable better self-management;
- The OwnHealth project in Birmingham where patients with diabetes and other long-term conditions will receive regular telephone support at home by trained community nurses;
- An NHS Live peer adviser project in Somerset in which people with diabetes support each other;
- Improved HbA1c in North Northumberland by joint work between practice teams and the specialist service to review records for all patients with HbA1c over 7.4 and develop a tailored plan for each;
- A one-stop triage and laser clinic in Hull offering assessment and treatment of diabetic retinopathy so that patients with sight-threatening retinopathy can be treated in one hospital visit, reducing anxiety and treatment waiting times.

The future
The Austrian president of the EU has decided that reducing the growth of type 2 diabetes should be a central theme of his presidency and it is expected that this will give a boost to prevention programmes. Services should also benefit from new guidance to be issued by the Children’s and Young People’s Diabetes Services Working Party addressing the provision of psychological support and the Diabetes Workforce Executive Group’s work identifying potential models of care for psychological support.

Technology will play an increasing role in diabetes care, with remote monitoring, reminder services and e-clinics supporting self-care. Concerns regarding over-use of blood glucose testing strips has prompted research on the best way to use this technology.

Networks are expected to remain important in the delivery of diabetic care. To provide more clarity about their role a guide to diabetes networks is being developed and will be made available on the National Diabetes Support Team website at www.diabetes.nhs.uk. A special services liaison group has also been established to ensure that diabetes specialists can fully contribute to improving services.

These advances will ensure that care for people with diabetes continues to improve. It is essential that progress continues to be made – both for those who are living with diabetes and for the future of the NHS.