

## **SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

### **6.3 DIABETES**

Diabetes is a life-long condition that can impact upon almost every aspect of life – lifestyle, relationships, work, income, health, well-being and life expectancy.

The potential impact of diabetes includes –

- Reduced life expectancy. In Type 1 diabetes, life expectancy may be reduced by as much as 20 years and by as much as 10 years in Type 2 diabetes.
- Five time higher mortality rates from coronary heart disease.
- Three times higher risk of stroke.
- Additional risks in pregnancy, with higher rates of congenital malformations and higher perinatal mortality rates.
- Diabetes is the leading cause of renal failure, accounting for one in four people starting renal replacement therapy.
- The second most common cause of lower limb amputation.
- The leading cause of blindness in people of working age.

Effective management of diabetes increases life expectancy and reduces the risk of complications developing. High quality diabetes care requires not only the co-ordination and co-operation of the range of professionals who make up the multidisciplinary team but also self-management. The empowerment and involvement of the individual with diabetes is crucial.

Diabetes is a major risk factor for cardiovascular disease and it is therefore important to include standards for diabetes care in a service framework for cardiovascular health and wellbeing.

The 3 standards focus on diagnosis, the importance of the annual review to a defined standard delivered by an appropriately trained multidisciplinary team and the need to ensure access to structured education programmes and emotional and psychological support.

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 13:

All people with diabetes should have an accurate diagnosis made.

#### Rationale:

Accurate diagnosis is essential to ensure appropriate treatment.

Type 2 diabetes may be present for several years before diagnosis and nearly half of those identified as having Type 2 diabetes already have complications. The rapid onset of Type 1 diabetes means only a small proportion of people remain undiagnosed.

Raising awareness of the symptoms and signs of diabetes among both health professionals and the public can help to ensure that people with diabetes are identified as early as possible.

#### Evidence:

WHO guidelines are the standard

[http://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes\\_new.pdf](http://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf)

#### Responsibility for delivery / implementation

HSC Trusts  
Primary Care

#### Quality Dimension

##### Safe

Diagnosis confirmed by appropriate laboratory tests.

##### Timely

Symptoms and/or signs recognised early and diagnosis made.

##### Effective

Accurate diagnosis leading to appropriate treatment

##### Efficient

Diagnostic tests carried out and not duplicated

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL  
BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people with a new diagnosis of diabetes confirmed by fasting blood sugar estimations or standardised Oral Glucose Tolerance Tests.	Sample of new diagnoses from QOF and Diamond checked with Biochemistry laboratory reports.	80%	March 2010
		90%	March 2011
		95%	March 2012

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 14:

All patients with diabetes should have access to structured education programmes and emotional and psychological support. Services incorporating these elements will encourage partnership in decision making, support individuals in managing their diabetes and help them to adopt and maintain a healthy lifestyle.

#### Rationale:

The management of diabetes is complex, challenging and mainly focused on achieving and maintaining behavioural changes. The majority of diabetes care is self-care and therefore self-management is widely recognised as the bedrock of good diabetes care. Information, education and emotional support and psychological care are key to delivering effective self-management.

#### Evidence:

There is a wide range of guidance, research and policy documents on which best practice guidelines are based. These include:

National Institute for Health and Clinical Excellence (NICE) guidelines  
<http://www.nice.org>

CREST & Diabetes UK Report <http://www.crestni.org.uk>

SIGN Guidance <http://www.sign.ac.uk>

NHS Scotland, Diabetes Framework  
<http://www.diabetesinscotland.org/diabetes/maintainPages/DownloadablePub.asp>

National Diabetes Support Team <http://www.diabetes.nhs.uk>

The World Health Organisation <http://www.who.int>

Diabetes UK <http://www.diabetes.org.uk>

#### Responsibility for delivery / implementation

HSC Trusts  
Primary Care

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Quality Dimension

#### **Safe**

Education and psychological support provided by appropriately trained staff

#### **Timely**

Education and psychological needs assessed at initial diagnosis and reviewed annually

#### **Effective**

Education through robust structured education programmes

#### **Efficient**

Education and psychological care needs form part of integrated planned services for diabetes

#### **Equitable**

Education and psychological support services available to all patients across Northern Ireland

#### **Patient Centred**

Emotional and psychological support and education engages meaningful involvement of the person with diabetes thereby facilitating optimal self management.

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of newly diagnosed patients in past year who have been provided with a structured patient education programme.	Sample of new diagnoses from QOF and Diamond checked with education programme attendances.	40%	March 2010
		50%	March 2011
		60%	March 2012
Percentage of diabetes teams who have access to specialist psychology support	Audit of structured diabetes education activity (RMAG).	50%	March 2010
		60%	March 2011
		70%	March 2012

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 15:

All patients with diabetes should have access to, at a minimum, an annual review to a defined standard by an appropriately trained multidisciplinary team.

#### Rationale:

Diabetes is a common, chronic condition which is increasing in the population. It can have a major impact on the physical, psychological and material wellbeing of individuals and their families, and can lead to complications such as heart disease, stroke, renal failure, peripheral arterial disease and blindness. Evidence shows that effective management of the condition increases life expectancy and reduces the risk of complications.

A range of evidence-based documents and guidelines set out the need for all people with diabetes to receive high-quality care throughout their lifetime. The importance of optimising the control of blood glucose, blood pressure and other risk factors for developing the complications of diabetes is also recognised. The multidisciplinary team approach is also acknowledged as important for delivery of optimal advice and care.

#### Evidence:

The documents and studies setting out this evidence include the National Institute for Clinical Excellence (NICE) clinical guidelines; Scottish Intercollegiate Guidelines Network (SIGN); National Service Framework for Diabetes (NSF) England; European Society of Cardiology (ESC) and European Association for the Study of Diabetes (EASD); UK Prospective Diabetes Study, Diabetes Control and Complications Trial (DCCT).

Additional information is provided on nutrition and footcare by documents such as The Implementation of Nutritional Advice for People with Diabetes produced by the Nutrition Subcommittee of the Diabetes Care Advisory Committee of Diabetes UK (2003)

[http://www.diabetes.org.uk/Documents/Professionals/nutrition\\_guidelines.pdf](http://www.diabetes.org.uk/Documents/Professionals/nutrition_guidelines.pdf)

International Working Group on the Diabetic Foot and Practical Guidelines on the Management and Prevention of the Diabetic Foot 2007

[http://www.iwgdf.org/index.php?option=com\\_content&task=view&id=28&Itemid=24](http://www.iwgdf.org/index.php?option=com_content&task=view&id=28&Itemid=24)

and the National Minimum Skills Framework for Commissioning of Foot Care Services for People with Diabetes, 2006

<http://www.footindiabetes.org/Guidelines/NatMinSkillFramewkFootNov06.pdf>

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

The National Screening Committee sets out the requirements for a comprehensive, quality assured diabetic retinopathy screening programme.  
<http://www.nsc.nhs.uk/>

**Responsibility for delivery / implementation**

HSC Trusts  
 Primary Care

**Quality Dimension**

**Safe**

Care delivered by appropriately trained multidisciplinary team

**Timely**

At a minimum annually, but more frequent if required

**Effective**

Care delivered in line with national evidence based targets

**Efficient**

Management /IT systems which support delivery of timely care, share information appropriately and help eliminate duplication

**Equitable**

Ensure service, including multidisciplinary team, is available across Northern Ireland

**Patient Centred**

Self management is central to diabetes care, so those with diabetes should be central to discussion and decision making at all times.

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people who receive annual review to the defined standard	QOF Data Diamond System	40%	March 2010
		60%	March 2011
		80%	March 2012