Diabetes and primary care: a Welsh perspective

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Introduction

Health care in Wales has progressed significantly in recent years. The establishment of the National Assembly for Wales in 1999 signified a change in direction and thinking. Several initiatives have been put into action to address healthcare issues. This article highlights those concerning diabetes care — a common strand running through all these is a commitment to improving care and reducing inequality, particularly in areas of high deprivation. Diabetes care in Wales is now in a stronger position to meet the challenges of the imminent NSF for Diabetes.

The negative aspects of the internal market were divisiveness, competition and fragmentation of services, inefficiency and unfairness. These are being discarded in favour of a new set of values: fairness, effectiveness, efficiency, responsiveness, integration, accountability and flexibility (DoH, 1998). However, the legacy of the internal market is suspicion. Learning to trust one other, work openly together and integrate care will require effort, transparency and time.

Overriding aims

The National Assembly for Wales is providing leadership in this process of change by encouraging co-operation and partnership.

The role of the Assembly is to ensure that the NHS in Wales reflects a commitment to improve the health of the population and to provide care as locally as possible. The themes that will enable these goals to be realised are:

- A health gain focus.
- A person-centred approach.
- Resource effectiveness.

Resource effectiveness is supported by the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSF) through clinical governance. The NSF for Diabetes is not expected to be published in Wales until 2002, although in England it is imminent.

Primary diabetes care

Primary diabetes care in Wales, as in Ireland, varies across the country. This was highlighted in a recent Audit Commission (2000) report which stated that:

- Primary care teams provide care for 75% of their patients with diabetes and 33% of clinics are run by practice nurses alone.
- Less than one-third of practices have routine access to a dietitian or podiatrist.
- 33% of GP practices lack referral guidelines for foot care.

The report also highlighted that trusts do not always provide the best care as:

- Patients reported delays in clinics and insufficient time with staff.
- Patient education was inadequate at half of the hospitals visited.
- The number of doctors and nurses varied fourfold.

The key recommendations of the report for staff in primary care and community settings were as follows:

- Systematic programmes to monitor and audit processes and outcomes and recall patients for regular review should be developed.
- Patients' views on local services should be sought.
- Staff, particularly GPs and practice nurses, should be well trained and kept up to date with new developments.
- Access to podiatrists and dietitians should be ensured, if carrying out annual reviews with patients.

The key recommendations for the

ARTICLE POINTS

1. The National Assembly for Wales, established in 1999, is providing the impetus for changes in Wales.
2. Recent reports have highlighted the variation in standards of diabetes care.
3. Developments in the recent past, present and future demonstrate a commitment to improving diabetes care in Wales.
4. Integrated care should be the goal towards which we strive.
5. Care should always be person centred, have a health gain focus and use resources effectively.

KEY WORDS

- Wales
- Diabetes care
- Integrated care
- Education
- Support

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1 The recently established Commission for Health Improvement (CHI) for Wales monitors the quality of services provided to patients.

2 Health authorities in Wales are due to be abolished. Primary care commissioning is carried out by local health groups.

3 The Taff Ely health authority has a successful diabetes working group, which obtained funding for a diabetes facilitator.

4 The primary care diabetes facilitator has been instrumental in helping to establish funding for various initiatives including an in-house podiatry service.

National Assembly for Wales are that they should build on the findings of the Audit Commission (2000) report when they develop the NSF for Diabetes and clarify funding arrangements and, in particular, ensure that GP payment is linked to the activity and quality of diabetes care in general practice.

New infrastructure

A Commission for Health Improvement (CHI) has been set up in Wales to monitor the quality of services provided to patients. It provides:

- National leadership on clinical governance.
- Independent scrutiny of local arrangements.
- Review of the implementation of NSFs and NICE guidelines.
- Rapid investigation of and intervention in serious and persistent problems.
- Responsibility for external incident enquiries.

Local health groups (LHGs) have been established and there are now 22 LHGs in Wales (DoH, 1998). Initially, LHGs acted in support of health authorities in commissioning care for their local populations, but as they have developed they have taken on devolved responsibility for managing budgets and increased their commissioning functions. There are no LHG trusts to date; however, this may change, particularly since Jane Hutt's recent announcement that health authorities in Wales will be abolished within two years (Tindle, 2001).

Local experience

Taff Ely is in the borough of Rhondda Cynon Taff (RCT) and is an ideal example of the changes in diabetes care in Wales. It is a defined area with a general population of approximately 100 000. The incidence of diabetes is about 3%, following the national average. Health care is generally well organised in the locality; there is an established LHG and it is developing a diabetes strategy. It has access to a district general hospital. The area has pockets of high deprivation, as it is on the fringes of the south Wales valleys.

In 1999 a diabetes retinopathy screening service was established, which screens patients with diabetes across Bro Taf Health Authority and which is funded by the National Assembly for Wales. This service has established itself as the 'gold standard' and has generated interest from other areas in Wales and England (*Figure 1*).

Diabetes working group

Diabetes health care in Taff Ely is uniquely organised. The partnership of local GP practices in the Taff Ely emergency service (TEEMS) made possible the establishment of a diabetes working group, which has been successful in obtaining funding for a diabetes facilitator through the LHG and for primary care development. TEEMS, set up several years ago by the ten local GP practices, offers a multipractice approach to emergency out-of-hours cover.

Facilitator role

The role of the primary care diabetes facilitator is to improve diabetes care through education, support and collaboration with the multidisciplinary team involved in diabetes care, and by assessing the needs of the local service, anticipating the NSF for Diabetes and seeking funding to support its implementation.

The facilitator has secured a number of developments through primary care development funding in Taff Ely. These include:

- An in-house podiatry service in primary care.
- A collaborative programme of a diabetes patient education, backed up by a written curriculum as recommended by the Audit Commission (2000).
- Consistent provision of patient education literature through purchasing good quality materials from Diabetes UK to support the education programme.

Newport, and more recently the Cynon Valley, has followed Taff Ely's lead in appointing a diabetes facilitator. No doubt, other LHGs in Wales will appreciate the importance of this role in forging closer relationships and integrating diabetes care.

Education programme

Healthcare professionals in primary and secondary care have worked in collaboration to develop the education programme, which

has helped to:

- Break down barriers between primary and secondary care.
- Enable closer working relationships and integration of care.
- Encourage closer relationships with other members of the multidisciplinary team, e.g. GP, practice nurse, podiatrist, dietitian and physiotherapist.
- Ensure that the patient's voice is at the centre of the development process.

Education and support

Education is a key focus for both patients and healthcare professionals (NHS Executive, 1997; Audit Commission, 2000). Implementation of the forthcoming NSF for Diabetes requires a well-educated workforce to cope with its demands. The multidisciplinary team in diabetes care should, therefore, be anticipating this by working towards developing education of healthcare professionals to an accredited standard. This includes involving people with diabetes in the planning and delivery of education to health professionals and fellow patients.

Wales has 11 local diabetes service advisory groups (LDSAGs) and 40 self-help groups supported by Diabetes UK (Cymru), the thriving Welsh office of the organisation.

In Taff Ely and Rhondda, an LDSAG covering both areas is in the process of development. In addition, Rhondda has an established self-help group. We hope to set up and support a self-help group in Taff Ely through the patient education programme.

In southeast Wales there is a thriving DSN group, which meets every six months, and an All Wales Diabetes Nursing Forum, which holds its AGM yearly in mid-Wales. These groups enable DSNs from all areas of Wales to benchmark both their services and individual practice, update themselves and discuss the implementation of evidence-based practice. They also provide support, particularly for those members who work in isolation, e.g. in small rural areas, and provide an opportunity to share work with each other.

Conclusion

Services in RCT are evolving at a rapid pace and are structuring themselves to address the implementation of the forthcoming NSF for Diabetes in Wales. We still have a long way to go to achieve the ideal service but there is a feeling of commitment and enthusiasm and a willingness to work together to eradicate old barriers, which encouraged empire building, secrecy and duplication of work.

Perhaps we now need to work harder to eradicate the 'us and them' barriers caused by the labelling of where care is carried out. We should be striving to achieve high standards of diabetes care services across the board, rather than focusing on the division between 'primary' and 'secondary' care. Only then will we achieve the 'integrated' care for which we all strive. ■

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PAGE POINTS

1. To achieve optimal care, patients and healthcare professionals need to be well educated.
2. There are eleven local diabetes service advisory groups and forty self-help groups in Wales.
3. Support and education for DSNs are available through a DSN group and an All Wales Diabetes Nursing Forum.
4. Achieving high standards of care requires that all healthcare professionals work together.