Health and Social Care Committee

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction

DB 16 BMA Cymru

Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ

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National Assembly for Wales
Health and Social Care Committee

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INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health and Social Care Committees inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction.

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of just over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE TO THE INQUIRY

Although BMA Cymru Wales is not submitting a substantive response to this inquiry, we have consulted our members across Wales on the implementation of the National Service Framework and we do wish to bring a number of their comments to your attention.

Please do not hesitate to contact BMA Cymru Wales should you require any further information.

General comments

There are around 160,000 people with diabetes in Wales. This equates to 5.0% of the population. QOF data has shown a significant and consistent increase in prevalence each year. It's estimated that 66,000 more people have the condition but have not yet been diagnosed. Much of this is due to the rising number of people who are overweight and obese. The annual Welsh Health Survey says the problem affects 57% of adults, with 22% being obese. In children, 35% are considered overweight or obese (19% obese).

Diabetes costs NHS Wales £500m each year, and accounts for 15-20% of all hospital inpatients often with complex needs and requiring longer stays in hospital.

The prevalence of diabetes is remorselessly increasing and Wales figures are higher than UK average yet the resources to deal with this are travelling in the opposite direction as they come out of a budget that is shrinking in real terms.

We have been widely supportive of the 2003 National Service Framework (NSF). It is viewed by many as the key document for the planning and delivery of diabetes care in Wales.

Implementation of the NSF currently appears to be variable – even within LHBs –, for example, nearly all Type 2 diabetics in the North West are managed by GPs, with the hospital service looking after the bulk in the North East. As such, we would welcome a national analysis of the implementation of the NSF.

The status of the 2009 National Service Framework for Diabetes: Delivery Strategy, which provided an overview of compliance with the NSF, in unclear and we believe not used by Health Boards or Welsh Government.

We would support the revision and extension of the NSF/Delivery Strategy after an assessment of the implementation of the NSF both nationally and locally at the Health Board level - since performance against the standards appear to be largely unknown.

We believe that Health boards should be more accountable on their delivery of diabetes care and in meeting the requirements of the NSF, this should include regular reporting to the Welsh Government and detailed assessment and publication of their returns. It appears that data collection mechanisms do exist but that no analysis in undertaken by Government, therefore the Health Boards themselves do not know how they are performing comparatively. It is also testament to the failure of Welsh Government on this matter that the third sector has had to perform its own one-off data collection and analysis of Health Board performance.

Metabolic syndrome is a combination of medical disorders that, when presenting together, increase the risk of developing cardiovascular disease and diabetes. The term encompasses the whole spectrum and can be identified before diabetes has developed. In fact, if the Committee is looking at prevention as part of this inquiry then the focus should really be on Metabolic Syndrome and associated conditions, including:

- High blood pressure
- High blood sugar levels
- High levels of triglycerides, a type of fat, in your blood
- Low levels of HDL, the good cholesterol, in your blood
- Too much fat around your waist

Specific Comments

The aims of the NSF are well placed, and much has been established – such as GP registers and a recall system. But it is worth asking the question, were all the aims in the original document realistic and achievable? And are they still in 2012 since the nature and treatment of diabetes have changed since 2003.

The all Wales retinopathy screening also works well, though it is stretched and some members have stated that the annual review is slipping to every15 months. Access to podiatry also needs to be improved.

GPs screening of the population is considered by some not to be very effective in isolation. Many GPs are undertaking this screening as an enhanced service, but lifestyle factors have the biggest part to play in prevention and reduction of incidence.

GPs are responsible for about 75-80% of diabetes care and treatment. QOF has facilitated the establishment of registers and the software needed to manage this - all patients should now be able to

access an annual review at least, often more regular. Across Wales GP practices participate in the National Diabetic Audit via Audit+, this feeds in to the UK wide review of diabetes management.

In this way, it is important that primary care is involved in the local Diabetes Planning and Delivery Groups (DPDG) within Health Boards. It should be ensured that the DPDGs monitor rigorously the Health Boards progress in meeting the NSF. It is not clear whether this role is fulfilled at present; in fact it is questionable what the DPDGs do achieve. This should be looked at and their roles strengthened.

There needs to be a thorough review of how secondary care services are delivered and if this expertise would be better based in the community so support services can be accessed more easily.

Unlike activity based payments as seen in secondary care and despite the increased prevalence of diabetes, in primary care the nature of QOF (because QOF is a comparative payment not absolute) means that the increased numbers of patients with diabetes does not attract any additional funding for the GP team to deliver care. The movement of care into the community therefore results in GP practices having to pick up the cost from elsewhere as the extra work brings no resource once payment thresholds in the Diabetes DES have been exceeded.

Measures to tackle or reduce the number of people who are overweight or obese would greatly help to reduce the incidence of diabetes. The issue of the funding of surgery for those who are morbidly obese also needs to be looked at as many people, who have been clinically considered as suitable, with Type 2 diabetics can respond very well with this surgery.

An extensive public health campaign is needed to promote exercise, healthy eating and weight control. This could include an element of compulsion such as the introduction of robust legislation. The proposed Public Health (Wales) Bill could potentially have a huge role to play here. These two things will work to reduce the incidence of type 2 diabetes.

On the back of the Olympics perhaps Wales could take the lead in re-establishing physical education and sport as an important aspect of the curriculum in Wales from Infants through to University.

Only by an aggressive programme of health promotion, possibly backed by strong legislation, will we get there.

Other matters highlighted by members include:

RETINAL SCREENING
I agree that establishing the programme has helped to improve the baseline screening - but the service has been unable to meet the annual screen that was planned and is required under QOF - the programme needs to be modified in line with evidence supporting the most cost effective screening interval.

INCIDENCE /PREVALENCE
I agree that the health service in Wales needs to reduce the number of patients who have not been identified with DM but this will need to recognise that resources are required to support the increasing pressure on primary and community based services as a result of increase numbers of the population diagnosed with DM.

Increasing diagnoses will also have cost implications which need to be resourced.

LOCAL DIABETES SERVICE ADVISORY GROUPS
Involvement by GPs is patchy and limited.

Local Medical Committees and General Practice Committee Wales (GPCW) have a professional interest in ensuring services for patients are delivered in an effective and safe manner and can support Health Boards and others to ensure resources are utilised to deliver care – feedback from colleagues suggest that this does not appear to be recognised and few LMCs/GPs appear to be actively invited to groups.

Health Boards should facilitate and support involvement of both GPs and practice nurse representatives on these groups and provides support for practices to release staff inc practice nurses.

AUDIT AND PERFORMANCE MANAGEMENT

This area appears to fall short. Data collection should also utilise information gathered for routine clinical care and management.

In General Practice we need to ensure that any new codes required for monitoring or audit also add to the delivery of care and not just be useful as a management/performance requirement.

ENSURING PROFESSIONAL STANDARDS

GPCW agrees that ongoing Training/CPD and ensuring that staff are up to date and informed is of fundamental importance to service provision and development. CPD organisers must ensure that CPD activity is organised and available locally, is relevant and that support to release staff is provided.

REDUCING THE BURDEN OF DM

Reducing the incidence of DM (and other chronic disease) will require a partnership approach between Government, Health Boards, Local Authorities, education providers at various levels, private industry and with individual communities to encourage healthy food choices and active lifestyles. The BMA has undertaken extensive work in this area – for example on childhood obesity, nutritional labelling and active travel and we eagerly await the publication of the Public Health (Wales) Bill.

ETHNICITY

We recognise that there is a need to pay significant attention to the ethnic minority population of Wales. GP Practices in areas consisting of a high proportion of ethnic minority residents will need additional support from Health Boards in meeting their needs as this is not adequately covered by QOF.

OLDER PEOPLES CARE

Diabetic care and services should not discriminate against patients on any basis, including that of age. It is important to recognise that there are certain factors which clinicians do need to consider when providing care / treatment for older people – for example, very tight diabetic control may result in adverse outcomes due to the increased risk of hypoglycaemia and falls. That said diagnosis, support, access to treatment or care etc should be no different.

OFFENDER HEALTH

It would appear evident that DM and other chronic conditions are more common amongst the prison population due to the lifestyle factors that increase the risk of DM and other chronic conditions – it would greatly inform the debate if Welsh Government were able to provide figures for the incidence /prevalence of diabetes and total numbers in the prison population.

Although “close liaison with diabetic specialist teams “ should be established - it does need to be recognised that GPs providing GMS care within a secure setting can and do provide the appropriate level of care with suitably trained general nursing staff and do not need specialist nursing staff/teams to visit/run services within a secure service.

Primary healthcare teams within the “secure setting” need to ensure inmates receive the same level of care within a prison setting as any individual would expect from the NHS.

WORKFORCE ISSUES

As GPs and practice nurses deliver the vast majority of diabetic care, the primary care team are key and should be supported by diabetic nurses and diabetologists – this needs to be recognised and prioritised by those tasked with developing workforce plans.

As more care is provided closer to patients’ homes and in the community, we need to ensure that resources follow this move. Including looking at the number of GPs and Practice / Community Nurses.

FUNDING

It is encouraging that it is recognised that the majority of care is delivered by GPs and their team. Some of this care goes beyond what resourced by OOF. There must be adequate resources provided for the primary care team in delivering diabetes care.

PERFORMANCE MANAGEMENT

Need to be wary of duplications here and what the impact is of performance management procedures in the time clinicians have to deliver direct care to patients.

STRUCTURED EDUCATION PROGRAMMES FOR PATIENTS

I am supportive of this, buts the extent of provision across Wales is unclear and appears to be inconsistent at best.

RECORD KEEPING/SHARED CARE/PATIENT HELD RECORDS

Again we need be careful of duplications here, but this is an area which could be looked at and possible better ways of working identified.

EVIDENCE OF APPROPRIATE TRAINING /CPD

Agree this is required. For clinicians this will be evidenced through the clinical appraisal process and, when it commences, Revalidation.

GP/PRIMARY CARE LEADERSHIP

The Kings Fund recognises that the lead professionals ought to be based in primary care – I think that each HB/locality could identify and support GP champions to lead the services