Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Betsi Cadwaladr
University Health Board
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Ein cyf / Our ref: GLP/JM
Dyddiad / Date: **29th September 2012**

Mr Mark Drakeford AM/Chair
Health and Social Care Committee
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Drakeford,

Re: Implementation of the National Service Framework for diabetes in Wales and its future direction: Response from Betsi Cadwaladr University Health Board

On behalf of Betsi Cadwaladr University Health Board, we would like to thank you for this opportunity to respond to the "Implementation of the National Service Framework for diabetes in Wales and its future direction Consultation."

We have pleasure in enclosing Betsi Cadwaladr University Health Board's Response – "Progress Against Diabetes NSF Standards: BCUHB considerations for all Standards."

Yours sincerely,

Grace Lewis-Parry.

Grace Lewis-Parry
Director of Governance & Communications

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Implementation of the National Service Framework for diabetes in Wales and its future direction: Response from Betsi Cadwaladr University Health Board

Progress Against Diabetes NSF Standards:

BCUHB Considerations for all Standards
Background Betsi Cadwaladr University Health Board (BCUHB) was established in 2009 and is the result of merging 9 previously separate health organisations, 3 NHS Trusts and 6 Local Health Boards. This has been an enormous task for the new organization, and for specialties such as diabetes this has highlighted the very different approaches to the delivery of services, not merely due to geographical differences and challenges but also due to historical resource availability, development, scope of practice within Specialist Care Diabetes Teams and Primary Care Services The BCUHB Diabetes Planning and Delivery Group (DPDG) was established in 2010. Due to the size of the organization and the inherited variances in service models and levels of service delivery it was decided that for the immediate future at least the 3 previous LDSAG's would remain operational to ensure that local service priorities were not lost and local focus retained. The LDSAG's report to the BCU wide DPDG, chaired by Dr Steve Stanaway, Consultant Diabetologist and Clinical Lead. The DPDG is multidisciplinary including therapies, adult and children services, pharmacy, public health, patient representatives, primary and community care. Additionally the following considerations have had a significant impact upon service delivery: • No additional funding to support delivery of the Diabetes NSF unlike Renal and Cardiac which attracted funding and services have significantly progressed as a consequence. In spite of this diabetes services have been developed and innovation implemented to ensure that resources are deployed to maximize patient services, however it is unlikely that

BCUHB will be able to fulfill all of the requirements within the Diabetes NSF by 2013. This will mean that service prioritisation will need to take place.

- The delivery of Structured Diabetes Education for people with Type 2 diabetes is currently under review in BCUHB. There is inequity in its provision and where it exists, it does not meet the criteria set out in the NSAG's Structured Education report. For Type 1 Diabetes, we have WIDAC in the East, DAFNE in the Centre and nothing in the West. Waiting lists for these programmes are not currently linked into mainstream patient pathway monitoring such as referral to treatment (RTT) monitoring. There is increasing demand to deliver more T1 programmes as these are a pre requisite for individuals considering insulin pump therapy. There are currently no agreed plans to increase provision of SDE for Type 1 or 2 Diabetes within the specialist DSN and Dietetic resource available within BCUHB

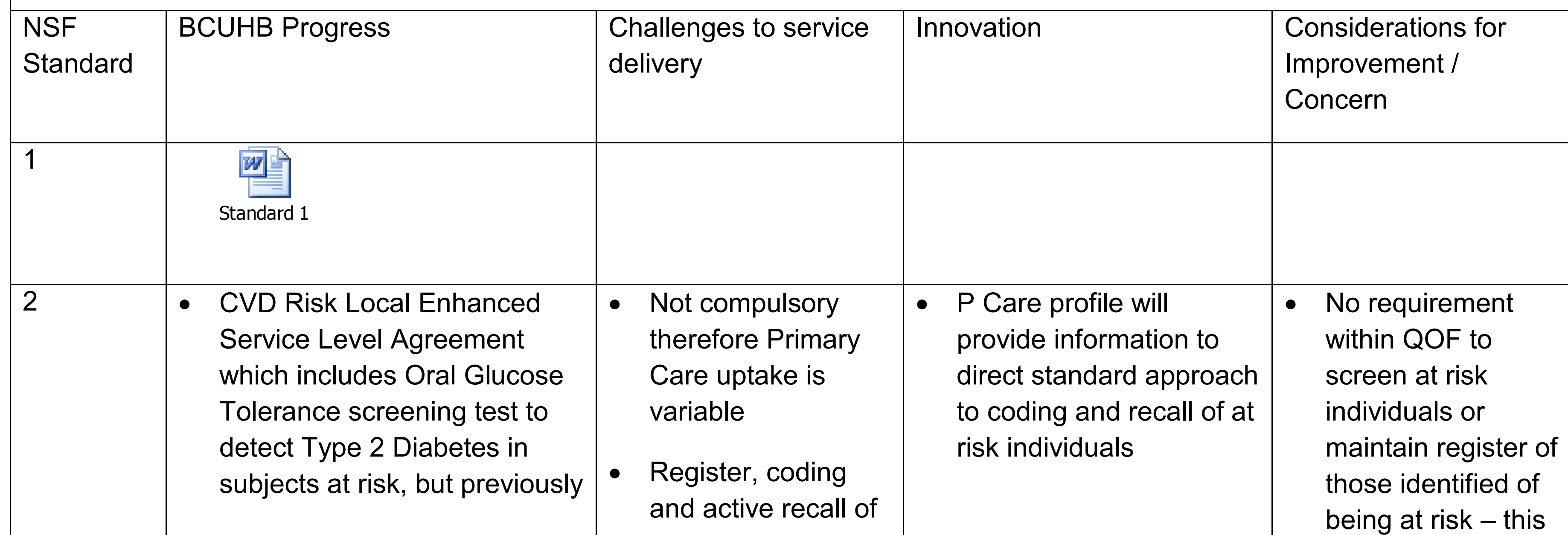
- The adult Diabetes Nursing Service structure is currently under review in BCUHB. There are 12.4 wte adult Diabetes Specialist Nurses employed to meet a population of more than 700,000. Increasing prevalence, a rise in referrals into diabetes specialist teams from Primary Care (>30% increase in 2011 in Centre and West sites compared to 2010 data), the provision of type 1 education, more sophisticated technologies, and the rising % prevalence of people with diabetes in hospital are restricting the ability of DSN's in North Wales to work towards National Strategies supporting care for people with Long Term Conditions closer to home. Service prioritisation will be part of the DSN re structure to determine where best to deploy the resource for maximum efficiency & effect.

- BCUHB Diabetes Lead Nurses are currently undertaking Primary Care Profiling in order to identify areas of exemplary practice in Primary care and where support and training can be targeted & indeed will assist the Health Board to further understand the current level of service delivery in the Primary Care sector against the NSF for Diabetes. Resource to facilitate additional support in practice has yet to be identified in some areas of BCUHB and participation / completion of the Primary Care profile is not compulsory (however the response rate to date has been high).

- Despite persistent lobbying from diabetes clinical teams in Wales, the Third Sector and the Diabetes NSAG; the Assembly has not appointed a Clinical Lead for Diabetes within its structure. If this appointment was made there would be an expert advisor who would be able to escalate and inform WG of key service pressure and issues which would then attract an increased focus.

- Striving to integrate diabetes services for the benefit of the patient and to provide a seamless approach to diabetes management is not possible without the appropriate IT infrastructure. If available the system would offer:
    - Robust Risk assessment along the trajectory of living with diabetes
    - Integrated seamless diabetes information
    - Access for people with diabetes to their health profiles
    - Improved clinical governance, audit and evaluation that is transparent

  All the above would ensure an improved compliance with the requirements of the NSF and reduce inefficiencies within the system (duplication and waste) and improve patient experience.



NSF Standard	BCUHB Progress	Challenges to service delivery	Innovation	Considerations for Improvement / Concern
1	Standard 1			
2	• CVD Risk Local Enhanced Service Level Agreement which includes Oral Glucose Tolerance screening test to detect Type 2 Diabetes in subjects at risk, but previously	• Not compulsory therefore Primary Care uptake is variable • Register, coding and active recall of	• P Care profile will provide information to direct standard approach to coding and recall of at risk individuals	• No requirement within QOF to screen at risk individuals or maintain register of those identified of being at risk – this

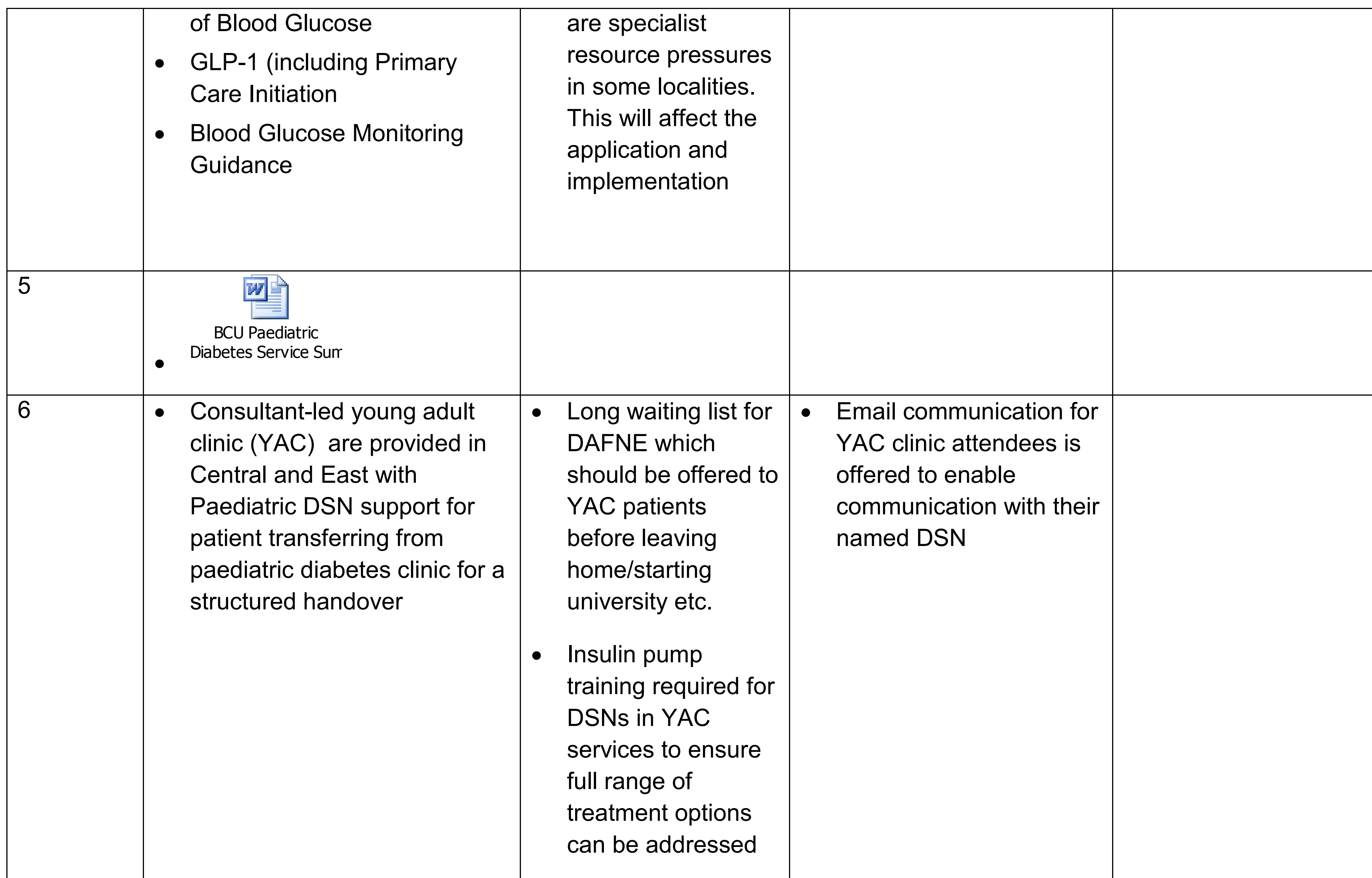
	undiagnosed	at risk individuals not standardised		would be helpful to facilitate the delivery of this standard.
3	• BCU has inherited a variety of approaches to delivering patient education, ranging from one to one education in some areas to structured group education programmes. • Type 2 SDE – X-PERT is the preferred programme • The Central area of BCUHB is accredited to offer DAFNE for adults with Type 1 Diabetes • The East area currently delivers WIDAC for individuals with Type 1 Diabetes based upon the Bournemouth model • Paediatric education varies across BCU however the	• The variability and equitable access to Structured Diabetes Education programmes in BCUHB is currently under review • Limited or no access to such programmes remains a significant and unresolved concern among Patient reference groups • X-PERT delivery rates varied from 0 – 4.4% of Type 2 population in 2011	• X-PERT Health – In 2011 Conwy was a category winner for the greatest impact upon cardiovascular risk factors • Following development in the Deeside Locality, individuals newly diagnosed with Type 2 diabetes can access a 2 hour group education session which signposts participants to X-PERT. The model will be rolled out across N Wales and has demonstrated reduction in 1:1 dietetic episodes & engaged individuals with diabetes to the concept of group	• The delivery of X-PERT is currently suspended pending executive decision as to the future plan to offer the programme within the Licence agreement • DPDG currently reviewing scope to offer one SDE programme for Type 1 Diabetes

	majority is delivered on a 1 2 1 basis in collaboration with carers/families. There is a structured programme for children over the age of 12 in East and all centres offer education for pump therapy on a one to one basis.	• No Type 1 or 2 programme exists in Gwynedd or Anglesey • Type 1 educator resource insufficient to meet demand in particular the dietetic element • Where they occur, DAFNE & WIDAC are pre requisites for individuals considering Insulin Pump therapy	education as an expected approach to diabetes care	
4	• BCUHB Diabetes Lead nurses are mapping current diabetes education provision across BCU primary, community and secondary care to identify gaps in education provision and where good examples can be shared	• There is no additional Specialist Nursing resource identified to meet increased training education requirements that will arise form the Primary Care profile and	• From April 2012 - A PG-Cert developed in partnership with Bangor University in Diabetes Management, validated for multi-disciplinary health professionals involved in the delivery of diabetes care. This has enabled the	

	• Long standing collaboration with local academic institutions and Diabetes Specialist Nurses enables the ongoing delivery of diabetes education at degree level for RGNs. • All 3 DGH's participate in annual national diabetes inpatient audit. • Primary Care Participation in the National Diabetes Audit is promoted, however the uptake was <55% across	Education mapping for Diabetes in BCUHB • WBL funding is not available in Flintshire & Wrexham, therefore alternative funding sources will be explored so as not to exclude this considerable area within our health Board • National Diabetes Audits - There is a need for this information to feed back into the work of the DPDG to	decommissioning of external programmes in favour of a Locally driven MSc level award • As an innovation WBL (work based learning approach) developed by Diabetes Lead Nurses in line with designed for competency methodology and in collaboration with UWB; RGN's and HCSW's who work in the independent care setting can undertake an accredited module for diabetes care. This accredited programme will be available from 2013 and will be delivered across BCUHB.	• The Community Diabetes Lead Nurses (where they exist) will work with primary care support unit and locality leads to try to influence an increased uptake in

	North Wales this year. • <u>Insulin Pump Service:</u> • Access to pump therapy is available to adults and children with type 1 diabetes. Structured education (where it occurs in BCUHB) is a pre requisite for adults. Increasing demand for this NICE approved technology is adding to the waiting list for Structured Type 1 Diabetes Education	ensure services are evaluated and improved and that the organisation learns from the audit results. PDSN: patient ratio is already > recommended levels therefore implementing CSII in Central Specialist site has become a significant resource pressure for PDSN and Specialist dietician time to meet The Central Specialist site now takes West referrals for CSII	• <u>Insulin Pump Service</u> - There is now an annual update which is mandatory for all adults wishing to remain on insulin pump therapy in BCUHB. This has been implemented in all 3Specialist Centres	NDA in the future. • IT infrastructure in Wales lacks sophistication necessary to robustly analyse the data <u>that is available</u> in order to determine clearly the target areas for improvement, especially risk assessment, integrations between Specialist Centres and Primary care and moreover where there is potential for people with Diabetes to access their health profiles

	• <u>Treatment pathways</u> have been validated & are available on the BCU intranet site. Developed in order to reduce the referrals to Secondary Care diabetes teams for newer treatment initiation and to offer a standard effective approach to managing Self Monitoring	following a safety analysis of the West site Specialist resource to continue to provide this service. A risk evaluation is underway to assess safety for the West to maintain management of existing pump therapy patients • The challenge is to roll out training for both pathways equitably across BCU where there		

	of Blood Glucose • GLP-1 (including Primary Care Initiation • Blood Glucose Monitoring Guidance	are specialist resource pressures in some localities. This will affect the application and implementation		
5	 BCU Paediatric Diabetes Service Sum •			
6	• Consultant-led young adult clinic (YAC) are provided in Central and East with Paediatric DSN support for patient transferring from paediatric diabetes clinic for a structured handover	• Long waiting list for DAFNE which should be offered to YAC patients before leaving home/starting university etc. • Insulin pump training required for DSNs in YAC services to ensure full range of treatment options can be addressed	• Email communication for YAC clinic attendees is offered to enable communication with their named DSN	

		• Lack of resources in West = No dedicated YAC service in the West & paediatric services required to hold on to young adults with diabetes who would otherwise progress through a transition service		
7	• DKA protocol in place in each area • Hypo boxes in all ward areas • Hypo training Mandatory for all staff in East • Audit undertaken recently by pharmacy re correct management of Hypos • Driving and Hypo leaflet developed and disseminated	• Lack of Nursing resource in West has made it difficult to undertake training required re the hypo boxes and the implementation of the DKA protocol • Hypo boxes not available in Central Acute site	• Central DSN's have implemented a rapid response for GP admissions to Acute Medical Unit – Audit awaited	• Establish hypo education as mandatory training in all areas for BCUHB staff • Standardise hypo boxes across the area • Hypo education was mandatory for all nursing staff in the Central Health Board area and

	across North Wales
	
	• Data pertaining to 999 call outs to treat a Blood Glucose below 4 mmol/L over a 6 month time period are currently being examined In collaboration with Welsh Ambulance
	
	• Podiatry and Orthotic services provide acute Diabetic foot ulcer and high risk care at 4 sites across BCUHB
	  • Wrexham Maelor
	  • Ysbyty Gwynedd
	  • Deeside Community hospital
	  • Ysbyty Glan Clwyd.
		• Working across agencies will require collaboration in the service design
		
		• Anticipated that additional staff resource and training would be required to meet the patient need in immediate post hypoglycaemic period
		
		• At present limited but services within Central have seen a 200% rise in referral rates due to media liaison and staff awareness
			Work in relation to this will either be undertaken as part of a research project or clinical service improvement design	was incorporated into mandatory training for all nurses up until Jan 2012 when it was suspended to allow for other service users to incorporate training in this way.

	• All sos and foot ulcer cases are seen within a 48hr period. Ongoing care and liaison via the MDT occurs throughout community sites and internally with the newly developed intermediate foot services. There is equity of provision across BCUHB			
8	• PDSNs provide diabetes education to relevant ward teams • Consultant led education for junior clinical staff is provided • Diabetes Inpatient Specialist nurses deliver training either in groups or on a one-to-one basis for Health Professional colleagues • Central DSN team provide Bi Annual training day for ward based RGN's Safe use of insulin	• Releasing ward staff to attend education sessions is often difficult • Lack of Nursing resource in West has made it difficult to undertake diabetes education for staff • Awaiting guidance on use of insulin		• Utilise data collected form inpatient audit to inform educational requirements • Implement E learning module on safer use of insulin

	• Currently reviewing and exploring ways for patients to administer insulin within hospital environment	passports – A Task & Finish group deployed by the DPDG is addressing this issue		across BCU area • Posters to be designed and displayed in ward areas • Review feasibility of insulin as a Community Pharmacy audit for 2013
9	• Antenatal diabetes clinics have existed in the Centre and East Specialist sites. This service has also commenced in Jan 2012 in West.	• Lack of medical, nursing and dietician resource • Increasing numbers of antenatal patients	• Central site-Group education is provided for Women with Gestational DM attending the High Risk Antenatal Service on their first visit • Community midwife training in the Centre has enabled diagnosis of Gest DM within 24-48 hrs of testing, education for SMBG and basic dietary advice is provided prior to the first clinic appointment	

10	• QOF data reviewed to highlight areas where practices are under achieving and clinical support offered to those practices • Foot screening provided by podiatry assistant in central and Flintshire areas and utilises a risk stratifying model with referral into Podiatry ongoing care and intermediate services or acute services • Diabetes education focusing on the annual diabetes review and diabetes management has been provided for District Nursing teams in East • A Glyndwr Uni District Nurse Rolling programme incorporates Diabetes Education • A work based learning programme for the Independent Sector is in	• Lack of community diabetes service in West to follow up poor QOF performance • Lack of community service in West and size of area covered by one facilitator in East • Foot screening provided by practice nurses in West and Wrexham areas with no liaison with podiatry re risk stratification and ongoing care needs	• A work based learning programme is currently under development by the Lead DSN's in collaboration with UWB (Utilising designed for competency	• No mechanism in place to support under performing practices as no community service in West • DSN service currently under review • Following recent discussions and WG paper it has been suggested that foot screening should be undertaken as part of the diabetes annual review within the GP practice and reported via QOF. Discussions underway regarding the future of these services at Health board level

	development by the DSN's and will focus on: ➢ Appropriate Blood Glucose Monitoring ➢ Hypoglycaemia recognition and treatment ➢ Function of Annual Review ➢ Carbohydrate awareness		methodology). This will provide the opportunity for RGN's and HCSW's working in the independent care setting to undertake an accredited module in diabetes care	• WBL programme to be delivered from 2013 across whole BCUHB area by Lead DNS's
11	• A primary care questionnaire has been compiled for completion by GP practices to establish diabetes service level within primary care	• Participation is not compulsory therefore Primary Care completion has been variable		• Lack of resources to address highlighted gaps in service provision
12	• Links established with Locality Leadership Teams (LLT) • Links established with social services and case managers. • Education and support is provided to social service, Integrated service teams, case managers and district	• LLT's are in early stages of development in some areas • Lack of community service in west to support LLT's	• Pilot project using diabetes manager software is being undertaken in Conwy East within 2 GP practices • District Nurses in central area have access to diabetes education as part of a rolling programme that has	

	nursing teams within each area • BCUHB Communication hub in development and links established via LLT meetings		accreditation with Glyndwr University	