CONSULTATION ON TOGETHER FOR HEALTH – A DIABETES DELIVERY PLAN

Welsh Government Consultation Paper

British Medical Association Cymru/Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government’s consultation on Together for Health – A Diabetes Delivery Plan.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of 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, which speaks 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

General comments

BMA Cymru Wales fully supports the general aims of the plan to enable the NHS in Wales to deliver on its responsibilities to meet the needs of people at risk of, or affected by diabetes mellitus. We support the main intentions of this plan in relation to improving access to services and structured education of both patients and primary health care teams.

We are concerned, however, that the plan as presented does not adequately address the significant amount of work that is done in primary care in the care and management of diabetes particularly in recognition of the fact that this sector is responsible for virtually all management of type 2 diabetes. If it is the case that it is the intention of the plan to be specifically targeted at secondary care, then this should be made more explicit as it is noted that within the plan there are references to primary care. Greater clarity as to the applicability of this plan may therefore be required.

We are also concerned that the document fails to address the huge increase in resources that will be required to address the very substantial increase in the prevalence of diabetes that is predicted within the next five years, let alone subsequently. This will lead, for instance, to a very significant increase in the number of GP appointments that will be required to accommodate newly diagnosed patients.

It may also be appropriate to consider how resources for diabetes are currently allocated between primary and secondary care. The bulk of work undertaken in the care and management of diabetes is delivered within the primary care sector, but this is not matched by the way resources are allocated. Consideration should be given to providing greater funding direct to GPs for the management of diabetes care. Consideration could also be given to providing GPs with access to clinical nurse specialists with specialist

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

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care being delivered in the community by GPs with a Special Interest (GPWSI) together with consultants providing support and advice when needed.

**Responses to specific proposals within the plan**

**5. Our journey so far**

In relation to the reference to the proposed introduction of an integrated management system, BMA Cymru Wales would welcome more information as to what this would entail. If this will involve the filling in of records separate to those that are contained on existing GP systems, then this will have resource implications which need to be considered owing to the additional time that might be required. If, however, the proposal is to introduce a system that would be automatically populated then there would be a need for information governance to be reviewed to assess the appropriateness of what is proposed. Given that GPs are Caldicott Guardians, it may be the case that this would prove a barrier to the automatic uploading of clinical information. There will also be a need to ensure any system is fully compliant with provisions in the Data Protection Act. More detail on how this proposed integrated management system would operate is therefore required in order to understand how these significant concerns could be addressed.

BMA Cymru Wales notes the reference to a reduction in emergency admission for diabetes by 9% last year, but believes this statistic needs to be carefully interpreted as a distinction should be made between type 1 and type 2 diabetes. A distinction should also be made between those who were admitted as a result of poor control of their diabetes and those admitted as a result of issues relating to another condition.

Although we note the statement that the Diabetes NSF has established core standards for the delivery of improved diabetes care, we would point out that that at local level care has been primarily driven by the Quality Outcome Framework (QOF) and the Directed Enhanced Service (DES)/Local Enhanced Service (LES).

We are also concerned that some of the processes outlined in the Diabetes NSF are no longer resourced in the QOF by agreement with Welsh Government. BMA Cymru Wales would be opposed to the creation of multiple marker targets that are not included within the current QOF proposals.

**6. What do we want to achieve?**

**6.1 Preventing diabetes**

We note that previously there were LESs that enabled regular reviews of patients with impaired fasting glycaemia in order to reduce the number of such patients who progressed to diabetes. We understand that funding for this was withdrawn in the case of Abertawe Bro Morgannwg University Health Board, but believe that this LES was useful work in the prevention of diabetes.

We would also point out that both screening and regular monitoring of at-risk pre-diabetic states would need to be resourced.

**6.2 Detecting diabetes quickly**

BMA Cymru Wales notes the reference in the plan to the need for QOF registers to be complete. This would imply that this is not currently the case, but we are not sure this is backed up by evidence.

Similarly, we question why it has been necessary to specifically spell out that people experiencing an abnormal test should be referred for further assessment and management as clearly this should be already happening as a matter of course. Also, the QOF for 2013/14 already includes a requirement for the provision of structured education programmes. Many type 1 patients, for instance, will already have undergone the Dose Adjustment For Normal Eating (DAFNE) programme or an equivalent programme.
A decision to use HbA1c levels to confirm diagnosis was in fact made some time ago, although we note that there is still some debate amongst diabetologists as to the role of glucose tolerance tests vs. HbA1c tests, especially in relation to impaired glucose tolerance.

We note the references in this section of the plan to case finding strategies and would seek further clarity as to what this will entail, including any resultant resource implications.

6.3 Delivering fast, effective care

BMA Cymru Wales notes the reference to the need to improve the delivery of planned chronic disease management at a community level and feels this implies that the current standard provided is not at an acceptable level. We do not, however, feel that such an inference is justified or supported by evidence.

We note that the second paragraph of this section excludes references to the impacts of the QOF and the DES/LES for diabetes. We believe this to be an omission that requires correction.

The section on paediatrics/transitional care includes reference to a need to implement key processes recommended by the National Institute for Health and Clinical Excellence (NICE). We believe that the appropriateness/deliverability of this in the Welsh context may need to be verified and, if necessary, resource implications will need to be considered.

The section on kidney complications omits any reference to the work of the QOF in relation to both diabetes and chronic kidney disease. We would point out that this has already led to increased understanding within GP practices in relation to this clinical domain.

The section on foot complications includes a reference to the need for annual risk assessments, but we would point out that this is something that is already in place in the QOF.

The section on vascular complications omits any reference to the current role of GPs.

The section on seamless care includes a reference to the development of enhanced skills among health care professionals in the community and in primary care. However, this fails to take account of the fact that most GP practices already have diabetic lead GPs and nurses who have obtained relevant diplomas. That said, it is important that this does not lead to an expectation that this should be mandatory, with others in a practice not being regarded as having the ability to manage diabetes health care. We also note the reference to the need to establish community diabetes teams with specialist nurses, but we believe this is already in existence in the shape of GP practice teams working with lead nurses and chronic care managers (CCMs).

In the list of actions for LHBs, there is a reference to Patient Education Models. We would note, however, that this is already included in the QOF for 2013/14.

We also note the requirement in the list of actions for LHBs for patients with a diabetes related foot problem to be referred to a multidisciplinary diabetic foot care team within 24 hours of admission, but believe that consideration needs to also be given to those whose diabetes related foot problem is identified within the community – particularly in view of the fact that the vast majority of diabetes care is provided in a community setting rather than in a hospital. It also should be clarified that, when a patient is identified as having a high risk diabetic foot the relevant LHB takes responsibility for the continuing care of that patient, as this may not be happening consistently across Wales at present.

We welcome the inclusion in the list of actions for LHBs of a commitment for all children and young people with newly diagnosed diabetes to be seen within 24 hours by a paediatric specialist.
6.4 Supporting living with diabetes

BMA Cymru Wales notes the commitment for every diabetic patient to be provided with an individualised care plan designed around their specific needs and for that plan to be assessed, recorded and delivered in an effective manner by primary care, the community and hospital. Whilst this intention is clearly laudable, we note that such a commitment could have significant resource and workload implications, particularly for primary care, which would need to be addressed.

We also note the commitment for the patient and all care providers to have access to an individual’s health record and care plan. We would be very concerned about the implications of this for information governance. One reason that the initiative on Individual Health Records has been as successful as it has is because there has been buy-in from GP practices on the basis of the close information governance that has been put in place around their use. BMA Cymru Wales would therefore need to understand how such information governance could be maintained before we could even consider the further commitment proposed in this plan.

6.5 Improving information

BMA Cymru Wales would welcome greater clarity on how the integrated national diabetes management system would work in practice as, again, we would be concerned about the information governance and workload/resource implications of this initiative. More detail would be required to ascertain the feasibility of this proposal in line with similar concerns we have expressed earlier in this consultation response.

6.5 Targeting research

In relation to the proposal for the establishment of an All Wales Diabetes Implementation Group, BMA Cymru Wales would want to be assured of appropriate representation within it.