Agenda Item 13

TO: West Gloucestershire Primary Care Trust Board

FROM: Hugh Annett, Director of Public Health

DATE: 19th May 2005

SUBJECT: DIABETES SERVICES UPDATE

1.0 PURPOSE

1.1 To update members of the Board on the current status of diabetes services across West Gloucestershire Primary Care Trust (PCT) and to inform them of continuing progress made against delivery of the standards and targets set out in the National Service Framework for Diabetes.

2.0 BACKGROUND

2.1 Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. It can affect children, young people and adults of all ages and is becoming more common. The number of people with diabetes continues to grow with an estimated 1.8 million people in the UK diagnosed and a further 1 million undiagnosed. Although there is considerable research into the condition, diabetes remains a long-term condition for which there is no proven cure, only treatment. It can affect every organ in the body, and may lead to complications such as blindness, heart disease, kidney failure and amputations, and can impact mental health and well-being.

2.2 The increased prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of physical activity. Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorder. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions. The end result is that diabetes has a heavy impact on the lives of people who have it, their families, carers and friends. The impact on the resources of the NHS is also significant, with an estimated £5 million a day being spent on treatment. Much of this is due to the cost of complications which are now preventable with good professional care and good self management.

3.0 THE DIABETES NATIONAL SERVICE FRAMEWORK (NSF)

3.1 National Service Frameworks set out national standards and define service models for a specific service or care group and put in place programmes to support implementation and establish performance measures against which progress within an agreed timescale can be measured.

3.2 The Diabetes (NSF) was issued in two parts. The first of these, *Diabetes NSF: Standards*, was published in December 2001 and set out the first ever set of national standards for the treatment of diabetes to raise the quality of NHS services and reduce unacceptable variations between them. The twelve standards covered the range of diabetes services from prevention to the treatment and management of long-term complications (Appendix 1). Local health communities were asked to use these standards as the basis for an early review of local services in preparation for the publication of the *Delivery Strategy.*

3.3 *The Diabetes Delivery Strategy* was published in January 2003 and established a framework for a systematic programme of reform to improve diabetes services. It provided a clear direction of travel, together with scope for local determination of priorities and pace of change.

3.4 Together the NSF Standards and Delivery Strategy produce a vision of how services should be in 2013 and the steps necessary to deliver those services. It was recognised at the outset that this was a 10-year programme of change and improvement and that achieving the standards would take time. It is worth noting that no national revenue funding has been earmarked specifically for diabetes as the increase in the baseline financial allocations to the PCTs are intended to cover achievement of the various NHS targets.

4.0 THE LOCAL CONTEXT

4.1 There are approximately 17,000 people with diabetes across Gloucestershire, almost 8,000 of which are resident in West Gloucestershire PCT. West Gloucestershire PCT, as well as having the largest population of the county PCTs (225,000), has a higher prevalence of diabetes when compared to the rest of Gloucestershire as a consequence of its higher ethnic minority population and higher levels of deprivation. West Gloucestershire PCT has an ethnic minority population of 4.3%, compared to a countywide average of 2.8%. Indices of Multiple Deprivation (IOMD) have been developed nationally and are based on seven domains of deprivation. Using this measure, wards in Central Gloucester and some in the Forest of Dean, score particularly highly.

4.2 It was against the backdrop of the publication of the NSF Standards, that a countywide review and audit of diabetic services across Gloucestershire was undertaken in 2002, coordinated by the Gloucestershire Primary and Community Care Audit Group (PCCAG). This involved a comprehensive survey of both General Practices and Users culminating in a countywide Diabetes Study Day in November 2003 where the results were presented to an audience of healthcare professionals, PCT Non-Executive Directors and patients. The results were broken down by PCT and findings within the survey provided the impetus and rationale behind the formation of the West Gloucestershire PCT Diabetes Group in October 2003, the Terms of Reference for which were ratified by the PEC in December 2003.

5.0 DELIVERING THE EARLY TARGETS

5.1 *Improvement, Expansion and Reform*: *The Next 3 Years, The Planning and Performance Framework for 2003-2006,* and subsequently *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08* set the priorities for the NHS over the next three years. They establish two critical diabetes-specific targets for eye screening and registers in the early stages of delivery, namely;

- by 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end of 2007.
- in primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006, ensure practice-based registers and systematic treatment regimens, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a body mass index greater than 30.

5.2 Retinopathy Screening

Regular retinal screening for people with diabetes is important to ensure that early treatment can be offered to those that might be at risk of developing problems, which if untreated, can lead to blindness.

The county is fortunate in having one of the leading-edge diabetic eye screening services in the country. The Gloucestershire Diabetic Eye Screening Service was formed in 1999, using state-of-the-art digital screening technology. In 2004, the eye screening service successfully bid for capital funding from the Department of Health to purchase additional digital cameras and associated software. The PCT has identified recurring funding within the 2005/06 Local Delivery Plan (LDP) to facilitate the recruitment of additional screeners and graders and support the move to annual screening.

5.3 Diabetes registers

Diabetes registers have a vital role in identifying people with poor diabetes control, who are at particular risk of developing complications. Focusing on those people who are newly diagnosed with diabetes will help them to manage this major transition in their life and reduce their long-term risk of complications. It will also ensure that patients receive regular monitoring, intervention when and where required, review and follow-up.

Diabetes registers are now well established and embedded across all practices within primary care. With the active support of Data Quality Facilitators, practices have recently begun providing both PCCAG and the PCT with audit data from quarterly MIQUEST searches. The data is analysed at quarterly review meetings by the PCT Diabetes Group in order to identify and assess progress against the Quality and Outcome Framework (QOF) indicators and the NSF. Improved and sustained performance against the indicators for diabetes in the QOF, continues the drive towards the improved delivery of diabetes services in primary care. Anonymised practice results are also available for viewing on the PCCAG website.

6.0 DELIVERING THE TARGETS OVER THE NEXT TEN YEARS

6.1 Within 10 years, the Government expects all the diabetes NSF standards to be fully implemented and that local plans will need to reflect local priorities, building on these as capacity expands. PCTs will be monitored on their progress through performance management arrangements with their Strategic Health Authority. From 2003/04, the implementation of the Diabetes NSF is also subject to review from the Healthcare Commission. A number of national programmes and initiatives have been established and are designed to support local implementation of the Diabetes NSF. The National Diabetes Support Team has recently appointed Regional Managers to provide a more effective link between the Department of Health (DoH), the national diabetes team, Strategic Health Authorities and local diabetes networks. Juliet Webb, Regional Manager for the South-West leads nationally for retinal screening and will address the spring meeting of the Diabetes Managed Network.

7.0 PROGRESS TO DATE

7.1 County Diabetes Managed Network (DMN)

West Gloucestershire PCT takes the lead role for diabetes services on behalf of the county; the DMN is chaired by Dr. Hugh Annett. In July 2004, a decision was taken to arrange a one-day workshop in order to spend time identifying key areas for development and to inject fresh impetus into the planning and development process of diabetes services across the Gloucestershire healthcare community. Outside

facilitation was provided by Peter James, Associate Director of Leadership and Organisational Development for the National Diabetes Support Team. The event was opened up to those outside the DMN who had direct involvement in the planning and/or provision of diabetes services (the South-West Regional Manager for Diabetes UK also attended the workshop and has subsequently agreed to become a member of the DMN). The areas covered were:

- The construct of the DMN and our partnerships with other organisations and networks
- The broad vision for our Diabetes service
- The roles and methodology of the DMN
- Work streams and work programme

Positive feedback was received by all who attended the event. The DMN was charged with the responsibility to develop the strategy behind the implementation of diabetes services in accordance with the NSF and local requirements.

The DMN is currently undertaking a mapping exercise measuring progress against delivery of the NSF standards of care and identifying those areas requiring further development or service re-design.

NB. Copies of the Department of Health publication 'Improving Diabetes Services – The NSF Two Years On' can be obtained at www.dh.gov.uk/publications

7.2 West Gloucestershire PCT Diabetes Group

The West Gloucestershire PCT Diabetes Group is now well established. The group is chaired by Dr Hugh Annett and has a membership that reflects input from frontline diabetes services that is representative of practice, community and secondary care. Nuala Woodman, Data Quality Facilitator from PCCAG has recently joined our group and will provide data and analysis at practice level of achievements against Quality Outcome Framework Indicators and progress towards delivery of the NSF standards of care. The PCT group is currently considering appropriate user representation, roll-out of patient education for those people with newly diagnosed type 2 diabetes and the potential for the further development of insulin initiation in primary care.

7.3 Dr Fosters/Diabetes UK Survey

In August 2004, Diabetes UK commissioned Dr Foster to undertake a survey on the progress being made within primary care organisations against national framework standards and targets. The report[1], published in November contained many positive findings, however it did highlight a lack of progress in services relating to paediatric services, patient education and retinopathy screening. The findings were subsequently fed back through the West Glos PCT and DMN groups and used to inform discussions around future developments. Developments specific to these findings are now largely in train.

7.4 Primary Care Collaborative

In 2004, West Gloucestershire PCT signed up to Phase III of the National Primary Care Collaborative – Chronic Disease Management. Phase III focuses on COPD & Diabetes. In October 2004, the PCT employed a Project Manager (Helen Brock) on a one-year fixed-term contract to work with five core practices (Quedgeley Medical Centre, Kingsholm, The Park, Rikenel, Mitcheldean and Forest Healthcare, Cinderford) in recording monthly measures and facilitating service improvements in the local delivery of diabetes services. All practices are showing a demonstrable

improvement against their respective targets and a more detailed update and progress report will be provided to the PEC later in the year.

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[1] *The Diabetes UK survey: Your Local Care, is available at:* *http://www.diabetes.org.uk/yourlocal_care2004*

7.5 Diabetes Specialist Nurses

The 2004/05 Local Delivery Plan prioritised and identified the necessary funding to expand Diabetes Nurse capacity within primary care. In December 2004, Gail Pasquall was appointed as Diabetes Specialist Nurse (DSN) for Gloucester (.75 WTE) and in January 2005, Di Kalus was appointed as DSN for the Forest of Dean. Both Gail and Di are providing practical support, advice and training to the practice healthcare teams and are assisting and facilitating the setting up and running of diabetes clinics. Moreover, as part of the PCT's Demand Management agenda, the DSNs have been undertaking patient reviews at GP surgeries on request and have been assessing patients that would otherwise have been referred to Gloucestershire Royal Hospital (GRH) or unnecessarily continued to be followed up in secondary care. Gail and Di are initiating Patient Education Groups for newly diagnosed patients with type 2 diabetes and will be integral to the roll-out of DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed), a structured group education programme for people with Type 2 diabetes (see Future Developments). Other areas currently being addressed are the development of a protocol for the administration of insulin by unqualified staff i.e. in residential homes, and the mapping of insulin conversion and subsequent training of practice staff across the PCT for those that are disposed to provide this service (see Future Developments).

7.6 Community Counts

Community Counts is one of twenty Neighbourhood Management Pathfinders across the country and is part of the Government's Neighbourhood Renewal Strategy. The local programme is based in the Barton, Tredworth and White City areas of Gloucester. Community Counts has supported the PCT in undertaking a Health Needs Assessment of this area and as a result of this work, money has been made available to fund a DSN to work with the Black and Minority Ethnic (BME) communities in the area. Suzy Allard commenced in post at the beginning of April and her remit will involve establishing the needs of the BME communities in respect of diabetes services and to ensure that they are developed and delivered in the most culturally appropriate and accessible way.

8.0 FUTURE DEVELOPMENTS

8.1 DESMOND

The Diabetes NSF and NICE guidance make it clear that all PCTs are required to offer structured education programmes to people with Type 2 diabetes from the point of diagnosis. The DESMOND initiative, jointly developed and endorsed by Diabetes UK and the DoH, is the first national education programme that meets the NICE requirements. The programme provides 6 hours of structured group education for between 6-10 people and is delivered by two healthcare professionals who will have attended a two-day formal training programme to graduate as DESMOND Educators. The initial training for the first wave of Educators will commence in September and it is expected that all training will be completed by March 2006. The costs of the course are likely to be £5K for Year 1 and £3-£4K for Years 2 and 3 depending on the numbers of PCTs that formally sign up to the programme. The West

Gloucestershire PCT Diabetes Group has fully endorsed the DESMOND approach and methodology to patient education and has formally expressed it's interest in enrolling to provide the DESMOND programme across the PCT. We are currently aiming to identify funding from outside the PCT.

8.2 Patient Held Records

In 2004, funding was made available from the National Diabetes Support Team for the development of network-related issues. West Gloucestershire PCT, on behalf of the DMN successfully bid against the national money and received an allocation of £18K. It has been agreed by the DMN that the funding, released in February 2005, will be allocated to the countywide cost of providing new Patient Held Records (PHR). The final draft and design work is now complete and the order for 17,000 folders and inserts will be issued shortly. The new PHR will enable people with diabetes to keep a log of their care, assist in facilitating their self-management by providing advice and educational inserts (e.g. dietary, foot care, glucose monitoring advice etc.) and provide current information for healthcare professionals about the patient's last point of clinical contact.

8.3 Insulin Initiation

The PCT is currently evaluating the provision of insulin conversion for insulin naïve patients across primary care. It is the considered view of the PCT Diabetes Group that insulin initiation can and should be primary-care based. A mapping exercise, undertaken by our DSN, team is currently underway and early feedback demonstrates that there is patchy provision of these services. There are a number of practices who currently provide insulin initiation and of those, some feel that they require enhanced training. There are also a significant number of practices that do not offer this service for a variety of reasons; these include:

- Not wanting to provide service due to staffing/resource implications
- Not wanting to provide service due to the belief that it should be a secondary-care led service
- Would like to provide service but do not have the required expertise

'Insulin for Life' is a programme designed to assist the development of diabetes management in primary care. The programme is industry sponsored however training and education is undertaken by the accredited Warwick University Diabetes Care Course. Each participating PCT nominates candidates to become trainers for their area. The PCT Diabetes Group has endorsed this approach and both DSNs have now completed the course and are now able to deliver the programme to nominated healthcare professionals across practices, this will typically include a GP and practice nurse.

The first PCT Insulin for Life workshop is planned for 17th May and practices attending this first session include Rosebank, Hadwen/Glevum and London Road. Dr Luke Corrigan, GP representative on the PCT Diabetes Group will also be attending and providing a talk on 'Treating to Target in Primary Care'.

The PCT has also been engaged in preliminary discussions with the West Gloucestershire Local Medical Committee to investigate the options for the expansion of insulin initiation in primary care. The outcome of the mapping exercise will help to inform developments on this front and work has already begun on the development of a patient and treatment protocol in order to establish roles and responsibilities with respect to defining a service specification for this procedure.

8.4 Sharps

The safe disposal of sharps waste is continuing to prove problematic for those who self-administer insulin on a regular basis. Patients, who are now freely able to obtain sharps boxes on their FP10 prescriptions, are increasingly frustrated at the lack of available locations for them to return their clinical waste. The National Diabetes Support Team (NDST) has confirmed that the problem is replicated across the country. Local solutions are still being vigorously pursued and we continue to make limited progress. The Gloucestershire Local Authorities, who have a statutory obligation to provide collection of clinical household waste, are now engaged in the process and have agreed to pick-up the costs associated with resultant developments. A proposal that would see GP practices acting as a drop-off point for sharps boxes was recently vetoed by the Gloucestershire Local Medical Committee, however we are now pursuing an opportunity utilising local pharmacies in a similar capacity. We are currently awaiting a decision from a national waste management body, confirming that community pharmacies can operate under an exemption to provide this service without licence. We are also continuing to press the NDST for a national solution.

9.0 FUTURE PRIORITIES

9.1 Both the countywide and the PCT groups are in the process of beginning to identify a number of development priorities across the provision of diabetes services. These include:

- Improvement of transitional care for children/young people to adult services
- Opportunistic testing for the undiagnosed
- Increased provision and the further development of Insulin Initiation across primary care

An Avon, Gloucestershire and Wiltshire Diabetes NSF Development Day, facilitated by the National Diabetes Support Team is scheduled for 30th June 2005. The event is planned to support diabetes networks, to review their local progress towards implementation of the NSF and to help identify the development of priorities for the next period.

10.0 CONCLUSION

The pressure of the epidemic and the increasing numbers of those diagnosed with diabetes indicate that the PCT has no room for complacency with respect to putting in place measures to achieve the standards of the diabetes NSF. The conclusions of the countywide workshop last year are pertinent and both the DMN and PCT diabetes groups have identified early priorities as:

- Starting to build capacity in primary care to manage the growing numbers of patients who will be increasingly managed in primary care settings
- Education of newly diagnosed people with diabetes
- Access/capacity issues around waiting times and current specialist care capacity – particularly on the west of the county
- Retinal screening

The adequacy and/or continued appropriateness of these proposals will continue to be reviewed by the PCT Diabetes Group and the County DMN and in due course, both these groups will be proposing further measures in order to achieve the early targets of the NSF while laying the foundations for fully achieving the NSF standards by 2013.

11.0 RECOMMENDATION

The Board is asked to note progress made in the improvement of diabetes services across primary care to date.