Freedom of Information Act Request – Diabetes Planning and Delivery Groups (DPDGs) Additional Information

Diabetes mellitus is a common endocrine disease affecting all age groups. Effective monitoring and control of risk factors can reduce morbidity and mortality. General practitioners and their primary care teams undertake much of the monitoring and management of diabetic patients, particularly for those with Type 2 disease. The Quality and Outcomes Framework rewards practices for ensuring that systematic care has been provided. However there is not a requirement that practices undertake all aspects of a regular review.

The purpose of Diabetes A and Diabetes B enhanced services is to enable the delivery of a more comprehensive, structured package of care to patients in primary care so that only patients of high risk or with complicated diabetes require hospital attendance.

There is an increasing prevalence of long-term conditions in general and diabetes in particular. This places significant demands upon all health services but particularly in primary care. Long term conditions:

- Account for 60 per cent of GP consultations
- Patients with long term conditions occupy over 60 per cent of hospital beds provision
- Patients with long term conditions are more likely to be admitted as emergency admissions
- Patients with long term conditions need ongoing care that is co-ordinated across primary, community and secondary care as part of a ‘whole systems’ approach.

The national prevalence is 4.3% of the total population.

Diabetes care can be provided effectively and efficiently within primary care ensuring that patients have easy access to high quality, local services.

Both enhanced services provide an incentive to practices to maintain the management of diabetic patients largely within primary care by further developing local services. Only some patients at high risk or with complicated diabetes will need hospital attendance.

Expansion of capacity and skills within primary care will improve the quality of diabetes care provided in the community, help deliver the National Service Framework standards and promote a safe, co-ordinated shift of patients from secondary care to primary care.

DIABETES A LES – SCOPE OF SERVICE

The development and maintenance of a register.
The practice must be able to produce an up-to-date register of all patients with diabetes. This will facilitate a functioning call/recall system. The practice must maintain adequate records of patient attendance and the service provided on
the clinical (IT) system via an LHB approved template and using approved read codes. Full records should be maintained in such a way that aggregate data and details of individual patients are readily accessible. Patient records will identify the care arrangements as follows: -

- Diabetic Practice Programme 66AP.
- Diabetes shared care programme 66AQ.
- Diabetes care by hospital only 66AU.

Information recorded should include adverse incidents.

Maximise provision of diabetes services locally

AUDIT TARGET – To exclusively manage 60% of patients on the practice’s Diabetes register in the Practice Programme with referral to specialist/secondary care reserved for complex patients only.

DIABETES PART BLES – SCOPE OF SERVICE

Appropriate management of diabetes.

All patients must be monitored and their diabetes managed according to accepted guidelines, which have been set down in NICE guidance. This will include:

- A systematic approach to the management of diabetes which typically would include a dedicated Diabetes Clinic.
- Active Call and Recall systems.
- Support for self management with evidence of targets shared with the patient for Hba1c, BP and Cholesterol.
- An annual review to include multiple risk factor management as described in the NSF Consensus guidelines. Of patients managed exclusively within primary care the following standards must be achieved:
  - 65% have Hba1c of less than 7.5%
  - 70% have a BP of less than or equal to 140/80
  - 70% have a total cholesterol of less than 5 mmol/l
  - 70% have LDL cholesterol less than 3mmol/l

Individual cases may be excluded from the calculation of the percentages, in the circumstances outlined in Direction 8 (c) (dd) (i) to (vi) of the Primary Medical Services (Directed Enhanced Services) (Wales) (No.2) Directions 2009 (as inserted by the Primary Medical Services (Directed Enhanced Services) (Wales) (No.2) (Amendment) Directions 2010.

- At least 1 follow-up appointment in that year offered to the patient, in addition to the annual review, however where necessary additional appointments to support individual patient management

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1 Office for National Statistics quoted in Chronic disease: the hidden health agenda, NHS Confederation, June 2003
2 Disease Prevalence in Wales: General Medical Services Quality and Outcomes Framework