# State of diabetes care in the UK: A Welsh perspective

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National Collaborating Centre for Chronic Conditions (2008) *Type 2 diabetes: national clinical guideline for management in primary and secondary care (update).* Royal College of Physicians, London

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Within the principality of Wales, even though we have no commissioning, or even plans of such, the face of diabetes care is changing. A move towards a Directly Enhanced Service (DES) for diabetes is likely to change the way people with diabetes receive care, and the way in which clinics are compensated for the care they provide.

There is a drive by the Welsh Assembly Government (WAG) to promote diabetes care primarily in the community. We may well say 'at long last' and argue that primary care has long been the major care provider – screening, monitoring, and managing, often providing insulin initiation and recognized patient education packages – with secondary care seeing those who require the specialists' input.

There is an anxiety among secondary care consultants surrounding the treatment of people with diabetes; I know of one hospital that is actively discharging patients unless they are 'complicated'. Some secondary care consultants are concerned regarding the quality of services within general practice.

The Welsh Endocrine and Diabetic Society (WEDS) has acknowledged that the type of care can vary across local health boards and between practices. The WEDS is therefore actively supporting the Diploma in Diabetes at Swansea University that allows GPs and practice nurses access to a standard level of understanding in diabetes care, and a similar programme at Cardiff University aimed at registrars and GPs with a special interest (GPSI) in diabetes.

So how does the WAG propose to manage diabetes care in Wales? A DES for diabetes is on the cards. The service would require 60% of registered people with diabetes to be managed exclusively within a dedicated primary care diabetes clinic. Patient management plans would be audited, and at least one follow-up appointment annually would be required to perform review assessments. The DES is also likely to stipulate higher targets than those in the quality and outcomes framework, probably incentivized payments based on the achievement of certain criteria:

- 65% of patients with $HbA_{1c}$ levels <7%.
- 70% of patients with a blood pressure of ≤140/80mmHg.
- 70% of patients with total cholesterol of <5mmol/L.
- 70% of patients with low-density lipoprotein cholesterol of <3mmol/L.

There has been talk that payments should be made for each patient commenced on insulin within the primary care setting. NICE has certainly supported more insulin usage, suggesting that insulin should be considered if $HbA_{1c}$ is greater than 7.5% (National Collaborating Centre for Chronic Conditions, 2008). Recompense for this service, therefore, seems justified.

The WEDS has raised concern that within the current proposal there is no requirement for a practice to prove that they are competent and experienced in insulin initiation. To date, there has been no comment on whether financial reward would be given to clinics where patients are educated and started on non-insulin injectable therapies to control their diabetes.

These are certainly interesting times in Wales for diabetes care. The DES for diabetes that was circulated to the local medical committees and local health boards has now been called back for further review and discussion. We in primary care, who have an active interest in diabetes, will certainly be watching for any new developments. ■