

# PCDS survey of diabetes care delivery and local enhanced services for diabetes in 2009–10

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**Citation:** Gadsby R, Khunti K (2013) PCDS survey of diabetes care delivery and locally enhanced services for diabetes in 2009–10. *Diabetes & Primary Care* 15: 14–8

## Article points

1. In 2009–10, the Primary Care Diabetes Society (PCDS) surveyed its members to examine diabetes service provision in England and Wales.
2. Information gained from 63 (43%) of the 147 primary care trusts (PCTs) in England in 2010 is presented here.
3. Results showed that more than half the PCTs were implementing local enhanced services and 90% were running structured education programmes, but there was little special provision for black and ethnic minority people with diabetes.

## Key words

- Diabetes care delivery
- Local enhanced services
- PCDS questionnaire survey
- Primary care

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**Diabetes service provision today is based mainly in primary care, often in conjunction with intermediate or community diabetes clinics. It has been suggested that there are differences between primary care trusts (PCTs) in the way that diabetes care is supported and encouraged locally, but there is little or no published information on these variations. In 2009–10, the Primary Care Diabetes Society (PCDS) carried out a questionnaire survey of its members to examine diabetes care delivery at PCT level in England and Wales. Completed questionnaires were returned from 63 (43%) of the 147 PCTs in England in September 2010, and the information gained from these results is presented and discussed in this article.**

**T**he prevalence of diabetes in the UK is increasing significantly: in 2010 the prevalence was 4.26%, suggesting that there were around 2.8 million people with diabetes in the UK at that time (Diabetes UK, 2010). The comparative prevalence for 2004 was 3.4% (NHS Information Centre, 2012). As well as the increasing numbers of people with diabetes, there have been significant changes in diabetes service provision over the past 20 years, from a situation where care was based mainly in secondary care to one where the majority is provided in primary care.

This change in service provision has been driven by a number of government policy initiatives, including *Our Health, Our Care, Our Say: A New Direction for Community Services* (Department of Health [DH], 2006), which aimed to get an extra 1 million outpatient appointments for chronic disease management to take place in primary care rather than at hospitals. The Quality and

Outcomes Framework (QOF), begun in 2004 through the new GP contract, gave financial incentives for the provision of high-quality chronic disease management in general practice, and achievement of the diabetes clinical indicators has increased year on year (Gadsby, 2009). The new 2004 General Medical Services contract also allowed primary care trusts (PCTs) to address local health needs through the provision of locally agreed payments for local enhanced services (LESs) over and above those delivered through QOF (Marks et al, 2011).

Intermediate or community diabetes clinics have developed over the past 10 years, enabling people with diabetes who have care needs that their general practice cannot provide to receive expert help without needing to be seen in secondary care (Gadsby, 2009). These clinics are usually staffed by diabetes specialist nurses (DSNs) and other healthcare professionals with specific diabetes expertise, such as dietitians.

Medical input is usually provided by one of the following: a consultant, a consultant community diabetologist or a GP with special interest (GPwSI) in diabetes.

The role of the GPwSI was defined in a document published by the DH and Royal College of General Practitioners (RCGP) in 2003 (DH and RCGP, 2003). GPwSIs are GPs who have had special training and experience in diabetes and who work for up to 1 day a week outside their own practice.

Anecdotal reports from Primary Care Diabetes Society (PCDS) members suggested there were variations in the skill mix in community/intermediate clinics. The PCDS hoped to gain information on this variation from a survey of their members.

Structured education programmes for people with diabetes are considered of vital importance in helping people to manage their diabetes properly (National Collaborating Centre for Chronic Conditions, 2008). The two programmes for people with type 2 diabetes mentioned specifically in the NICE guideline are DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) and X-PERT, and these seem to be the most widely used in England. The PCDS aimed to use the survey to document which programmes were being used.

People from black and ethnic minority (BEM) groups have a greater prevalence of diabetes and more complications. They may have language, religious and cultural differences that make access to diabetes services more difficult (Stone et al, 2005).

It has been suggested that there are differences in the way that diabetes care is supported and locally encouraged among different PCTs, with variations in LESs and payments, community diabetes services, the provision of structured education programmes and services for BEM groups. There is little or no published information on these variations in levels of provision and support.

The PCDS was launched in 2005 and now has more than 5000 members who provide diabetes care in the community. The majority of members are GPs or practice nurses working in primary care in the UK.

## Method

A simple one-page questionnaire (*Figure 1*) containing seven questions about diabetes care delivery at PCT level was developed. Questionnaires were made available at the PCDS annual conference in November 2009, the Welsh PCDS conference in May 2010, and the Intermediate Care Teams conference in July 2010, usually in delegate bags. Questionnaires were also distributed with the journal *Diabetes & Primary Care* and put on the PCDS website. Data from the completed questionnaires were collated manually and the results recorded on a Word document.

## Results

The number of completed questionnaires returned from the various sources is summarised in *Table 1*.

A total of 139 usable, completed questionnaires were collected. These contained information from:

- 63 of the 147 PCTs (43%) in England in September 2010 (NHS Choices, 2010)
- 2 of the 11 care trusts in England in September 2010 (NHS Choices, 2010)
- 4 of the 8 local health boards in Wales in September 2010 (NHS Choices, 2010).

Completed questionnaires were received from PCDS members in 63 PCTs in England, with a mean of two forms per PCT (range 1–12). There was good correlation between the answers where several forms were received from a single PCT. The information gained from the completed questionnaires about the 63 PCTs in England is discussed in detail below.

## Diabetes LESs in England

Thirty-six PCTs (57% of the sample) were reported to have a LES for diabetes and 18 PCTs (29%) had no LES for diabetes. Respondents from the remaining 9 PCTs (14%) did not know whether their PCT had or did not have a LES for diabetes.

Respondents from 15 PCTs provided further information about the reimbursements made under their LES scheme. All but one scheme included insulin initiation and follow-up. For insulin initiation, reimbursements varied from

## Page points

1. The Primary Care Diabetes Society (PCDS) was launched in 2005 and now has more than 5000 members, the majority of whom are GPs or practice nurses working in primary care in the UK.
2. Anecdotal reports from PCDS members suggesting that the skill mix in community/intermediate diabetes clinics varied prompted the PCDS to survey its members to examine this variation.
3. A simple questionnaire (*Figure 1*) containing seven questions about diabetes care delivery at primary care trust (PCT) level was developed and made available at the 2009 PCDS annual conference, the 2010 Welsh conference and Intermediate Care Teams conference, and were also distributed with the journal *Diabetes & Primary Care* and put on the PCDS website.
4. A total of 139 usable, completed questionnaires were collected from 63 (43%) of the 147 PCTs in England in 2009–10.

Figure 1. Questionnaire distributed to PCDS members to examine diabetes care delivery in PCTs in 2009–10.

PCDS ENQUIRY INTO DIABETES CARE DELIVERY IN PCTS		
Dear PCDS member,		
Thank-you for your help in finding out more about local diabetes service delivery in the PCT in which you are working. The answers to this questionnaire will be collated and a report published.		
Name .....		
PCT.....		
Questions	Yes/No	Additional Information
1 Do you have a PCT diabetes lead?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes, their name and contact details
2 Is there a local enhanced service (LES) for diabetes in your PCT?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes - How much does the LES pay per person with diabetes?  Does the LES cover insulin initiation in primary care?  Does achievement of the LES cover initiation in primary care?  Is there any other information you can give about the LES?
3 Are there intermediate (community) diabetes clinics in your PCT?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes, who is involved? (please circle) DSN <input type="checkbox"/> Dietitian <input type="checkbox"/> GPSI <input type="checkbox"/> Consultant <input type="checkbox"/> Others - please add
4 What proportion of your people with diabetes are managed -	Solely in - a) primary care .....(%) b) secondary care .....(%) c) intermediate care .....(%)	
5 Are there structured education programmes for type 2 diabetes in your PCT?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes, is it - DESMOND <input type="checkbox"/> (please circle) X-PERT <input type="checkbox"/> Other <input type="checkbox"/>
6 Does your PCT have any additional diabetes services for black ethnic minority people?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes, what services - please add
7 Does your PCT have screening services for type 2 diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>	If Yes, what services - please add

**Table 1. Numbers of completed questionnaires returned from the various sources.**

Source	Completed questionnaires	PCTs (England)	Boards (Wales)
National PCDS annual conference	99	43	2
Welsh PCDS conference	6		4
Intermediate Care Teams conference	21	18	
Journal/website	12	12	
Arrived in post	1	1	

PCDS=Primary Care Diabetes Society; PCTs=primary care trusts.

£80 to £200 per patient, plus £120–162 per year for follow-up (usually three follow-ups per year).

One respondent reported that for glucagon-like peptide-1 initiation in practice the LES paid £150 per year, and one reported that the PCT had an LES for oral glucose tolerance testing in practice.

#### Intermediate/community diabetes clinics

Respondents indicated that 41 of the 63 PCTs (65%) had an intermediate/community service and 18 PCTs (29%) did not have this service. Respondents from the remaining four PCTs (6%) did not know whether their PCT offered this service.

Table 2 shows the healthcare professionals involved in the intermediate/community diabetes clinics.

#### Structured education programmes in the 63 PCTs

Fifty-seven PCTs (90%) were reported as having structured education programmes and three PCTs (5%) as not having such programmes. Respondents in the remaining three PCTs (5%) did not know whether their PCT had a structured education programmes.

#### Which structured education programme was being used?

Thirty-two PCTs were reported to be using the DESMOND structured education programme, 16 were using X-PERT and 20 were using other programmes. Several PCTs were reported to be using more than one structured education programme.

#### Additional services for BEM people with diabetes

Only 11 PCTs (17%) were reported as providing specific services for this group. The services described included Ramadan teaching (one PCT), X-PERT in Asian language (four PCTs), DESMOND BEM pilot (one PCT), Apnee Sehat (one PCT) and various Asian-speaking diabetes workers (in four PCTs).

#### Numbers of people seen in primary/secondary/intermediate care

Only a minority of respondents reported the number of people with diabetes being managed by primary care and by specialists. Where

#### Page points

1. Only 11 primary care trusts (PCTs; 17%) provided specific services for people with diabetes from black or ethnic minority (BEM) groups. The services described included Ramadan teaching (one PCT), X-PERT in Asian language (four PCTs), DESMOND BEM pilot (one PCT), Apnee Sehat (one PCT) and various Asian-speaking diabetes workers (in four PCTs).
2. Forty-one PCTs (65%) provided an intermediate/community diabetes service, 18 PCTs (29%) did not and it was not known whether the remaining four PCTs (6%) offered this service.
3. Thirty-two PCTs were using the DESMOND structured education programme, 16 were using X-PERT and 20 were using other programmes; several PCTs were using more than one structured educational programme.
4. A weakness of the survey is that the number of returned questionnaires represents only 43% of the PCTs in England in September 2010, and cannot therefore give a complete picture of diabetes care provision in England at that time.

**Table 2. Healthcare professionals involved in the intermediate diabetes clinics.**

Healthcare professional	PCTs providing this service (n=41)
Diabetes specialist nurse (DSN)	35 (85%)
Dietitian	21 (51%)
GP with special interest (GPwSI) in diabetes	16 (39%)
Consultant	17 (41%)
Other (podiatrist added)	3 (7%)

PCDS=Primary Care Diabetes Society; PCTs=primary care trusts.

**“Clinical commissioning groups are now being developed and the contracts that they place are likely to have significant impact on the future of diabetes service delivery.”**

figures were given, the percentage of people with diabetes seen solely in primary care was mainly 80–90%, the percentage seen in secondary care was 10–20% and the percentage seen in intermediate care was 10–20%.

### Conclusions

LEs for diabetes were being implemented in more than half the 63 PCTs surveyed. The large majority included payments for insulin initiation in practices. However, the large variations between PCTs in the level of payments being made indicate that national guidance for enhanced payments might be helpful.

Ninety per cent of the 63 PCTs surveyed were running structured education programmes, with DESMOND being the programme most widely used. This contrasts with the 2010/11 National Diabetes Audit data that show that only 8.4% of people with diabetes who were newly diagnosed with diabetes in 2008/9 have a record of being offered structured education during 2009 to 2011 (The Information Centre, 2012). The explanation for this could be that PCDS members are more likely to come from PCTs that are pioneering diabetes care.

There is as yet not a lot of special provision for people with diabetes from BEM backgrounds.

This survey has shown that PCDS members are willing to fill in questionnaires about diabetes care in their PCT. However, a weakness of this survey is that the number of completed questionnaires returned represents only 63 (43%) of the 147 PCTs in England in September 2010, and is therefore insufficient to give a complete picture of diabetes care provision in England at that time.

It is interesting that a mean of two completed questionnaires were received from most of these PCTs, with a maximum of 12 from one PCT. This suggests that there is a variation between PCTs in the number of healthcare professionals with an interest and passion for diabetes, in that they attend PCDS events and are willing to fill out questionnaires. The fact that no completed questionnaires were received from

84 PCTs (57%) might indicate that these PCTs lacked healthcare professionals with that same interest and passion.

Clinical commissioning groups are now being developed and the contracts that they place are likely to have significant impact on the future of diabetes service delivery. However, details about the groups and how they will work is still sketchy so it is as yet difficult to predict how things will change. ■

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