

GMS Contract in Wales 2008-09 Enhanced Service for Diabetes Care Specification

1. Introduction

All practices are expected to provide essential services and those additional services they are contracted to provide to all their patients under the GMS contract. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

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 specification of this service therefore outlines a more specialised service to be provided, beyond the scope of essential services and the QOF. The purpose of this enhanced service 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. It also rewards tighter control of risk factors than required by QOF.

All such developments should be undertaken in collaboration with colleagues in secondary care to ensure integrated service improvement.

The targets in this Enhanced Service are audit standards to encourage a stepwise improvement in overall care standards. Doctors with a particular interest in diabetic care will know the "gold standard" targets from the Joint British Societies 2 guidelines (2006) are as follows and represent ideal treatment goals for individual patients.

<http://www.bcs.com/download/651/JBS2final.pdf>

Cardiovascular Disease prevention in clinical practice should focus equally on: -

- Patients with any form of established atherosclerotic CVD
- Patients with diabetes (type 1 or 2)
- Asymptomatic individuals without established CVD who have >20% estimated risk of developing atherosclerotic CVD over 10 years.

These three groups all require professional lifestyle and risk factor management to achieve defined targets which include:-

- Smoking cessation
- Body-weight distribution - waist circumference (<102cm in men and < 88cm in women, < 92cm in Asian men and < 78 cm in Asian women)
- BMI <25kg/m²
- Blood pressure <130/80mmHg
- Total cholesterol <4mmol/l or a 25% reduction whichever is lower
- LDL cholesterol <2mmol/l or a 30% reduction whichever is lower
- Fasting plasma glucose <6mmol/l
- HbA1c <6.5% (diabetics only)
- Use of cardiovascular protective drug therapies where appropriate. These have specific clinical indications and include anti-thrombotic drugs and drugs that lower blood pressure, lipids and glucose.

New guidelines from NICE and the All Wales Diabetes Consensus guidelines are expected shortly but are likely to closely align with the above. Practitioners are reminded that there is no implication in the setting of Enhanced Service audit standards that they supersede JBS or NICE guidance. Practitioners should continue to work towards ideal treatment targets for individual patients.

2. Background

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 consultationsⁱ
- 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.

The enhanced service provides 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.

3. Scope of the service

The enhanced service will fund:

(i) **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.

(ii) **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.

(iii) **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%
 - 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

- ... 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

4. Training.

To provide this enhanced service clinicians must demonstrate recognised training in diabetes care e.g.

- ... Diabetes Nursing Care module, School of Nursing Studies, Bangor, North Wales
- ... Diabetes in Primary Care(at level 5) University of Glamorgan,
- ... Diabetes Care (level 5/6), University of Glamorgan,
- ... SK120, Diabetes Care, Open University (level 4)
- ... Chronic Disease Management of Diabetes, Multidisciplinary Masters Module, Swansea University/University of Wales,
- ... Post Graduate Diploma in Diabetes, Caerleon, Cardiff University/University of Wales
- ... All Wales Foundation Course in Diabetes for General Practitioners, University of Wales College of Medicine

or equivalent experience or training as agreed by the LHB Medical Director.

5. Continuous Professional Development

Clinicians must demonstrate continuing practice in the provision of all aspects of diabetes care.

Doctors and practice nurses providing this service should undertake regular audit, participate in formal systematic annual appraisal on what they do and take part in regular relevant supportive educational activities. Clinicians should identify this activity within annual appraisal and address identified learning needs through an agreed Personal Development Plan.

Practice Nurses should either hold a relevant diploma or be working towards such a qualification.

6. Audit

Practices will be required to submit an annual audit of diabetes care as agreed in advance with the LHB.

7. Pricing

Practices that participate in this Enhanced Service will receive payment on the following basis:

- ... Management of 60% of patients in the Practice Programme exclusively in primary care - £10 per patient each financial year; and, if achieved
- ... Maintenance of patients according to the targets set for Hba1C, cholesterol and blood pressure - £20 per patient each financial year

8. Funding

All agreements to enter into these arrangements must be in writing. LHBs may commission this enhanced service at any time from the date the DES Directions have come into force. Until such time as the Directions are in place LHBs may, if they wish, commission this service as a local enhanced service.

LHBs, liaising with contractors, will need to determine the duration that the enhanced service is commissioned for and the timing for undertaking a review of the service.

9. Claims Process

Practices should submit claims to the BSC on a quarterly basis for the management target. Claims should be submitted quarterly to the BSC. Claims for meeting the targets set for Hba1C, cholesterol and blood pressure should be submitted as at 31st March.

10. Disputes

Any disputes will be dealt with in the prescribed way. LHBs and contractors should make every effort to resolve the dispute locally before formally submitting it through the NHS dispute resolution procedure.

ⁱ Office for National Statistics quoted in *Chronic disease: the hidden health agenda*, NHS Confederation, June 2003

ⁱⁱ Disease Prevalence in Wales: General Medical Services Quality and Outcomes Framework