Primary care practitioners will need much support to meet new targets

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The National Institute for Clinical Excellence (NICE) guidelines suggest that the target HbA_{1c} should be between 6.5% and 7.5%, based on the risk of macro- and microvascular complications (NICE, 2002). The UK Prospective Diabetes Study (UKPDS) data proved that tight blood pressure control significantly reduced the risk of vascular morbidity and mortality in people with type 2 diabetes (UKPDS, 1998a,b). Results for the effects of glycaemic control on macrovascular disease were less marked. The new GMS contract, for the first time, offers quality of care payments based on outcomes in certain key areas, including HbA_{1c}, blood pressure and lipids.

These are all very well, but will they improve the quality of care? For instance, the new contract has 'exception reporting' – an amazing 'lifeline' to many practices. Exceptions include the terminally ill and infirm and 'failure to attend' (both of which are understandable), but those on maximum doses of medication who have still not attained optimal control pose a few difficulties. How will this exception improve patient care?

Can the targets be achieved in daily practice?

Many GPs feel that the tight targets will only make practices more reluctant to take part (Chowdhury, 2003). An individual percentage fall in HbA_{1c} might have been more realistic than an absolute level.

Winocour et al (2004) note that of all the people with type 2 diabetes included in the UKPDS, less than 20% achieved an HbA_{1c} of 7% after 9 years' therapy. If this is the outcome in an intensive study, how are these targets to be achieved in day-to-day care? They also estimate that 50% of type 2 patients will need to start insulin therapy if we are to achieve the recommended targets.

Home et al (2003) feel that preventing delay in the introduction of insulin will help to reduce microvascular and macrovascular complications. They also believe that there is no longer any excuse for not negotiating insulin therapy with patients who will obviously benefit and who have had no success with previous treatments.

Robust though this evidence is, the practicalities of organising insulin initiation have overloaded systems in both primary and secondary care.

There is no doubt that people with diabetes benefit from insulin initiation in primary care, where they and their families are better known, access is usually easier and a variety of appointment times can be offered. Sarah Paterson, in her article, stresses the benefits to the emotional aspect of insulin initiation, with patients feeling more relaxed in a familiar environment with familiar health professionals. Her practice is fortunate in being able to offer open telephone access and having the time to discuss options and support patients in their transition to insulin. They also have pharmaceutical company support, which is not open to all practices for a variety of reasons.

Support will be crucial

So, how will other practices cope? Will they opt out, as Chowdhury suggests, or will they somehow fit an insulin initiation scheme into their already tight schedule?

Tier 2 funding is a possibility, with some PCTs looking into how it can be used to the advantage of people with diabetes. Greater Manchester Strategic Health Authority has supported the development of Tier 2 services, and this could be explored in other areas. Tier 2 funding is allocated for packages of care that provide an alternative to secondary care and support a reduction in waiting times. It is also used to improve the management of chronic disease and reduce emergency admissions by specific programmes of care. This can involve the use of GPSIs and practitioners with a special interest (www.gmsha.nhs.uk/tier2/index.html).

However, despite all the evidence available, our colleagues in primary care are undoubtedly going to need adequate support if they are to feel comfortable with meeting these targets. They will need training, resources and a good relationship with their secondary care colleagues, otherwise, in the words of Hughes and Kenny (2004), 'they will find themselves on board a ship setting sail from a safe port into uncertain waters.'

Chowdhury TA (2003) Diabetes and the new GP contract: a view from secondary care. *Diabetes Today* **6**(2): 36

Home PD, Boulton AJM, Jiminez J, Landgraf R, Osterbrink B, Christiansen JS (2003) Issues relating to the early or earlier use of insulin in type 2 diabetes. *Practical Diabetes International* **20**(2): 63–71

Hughes E, Kenny C (2004) Primary care diabetes – a ship without a rudder. Editorial. *Diabetes and Primary Care* **6**(1): 4

NICE (2002) *Inherited Clinical Guideline. Management of Type 2 Diabetes: Management of Blood Glucose*. London: National Institute for Clinical Excellence, 2002

United Kingdom Prospective Diabetes Study Group (UKPDS) (1998) Intensive blood glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes. *Lancet* **352**: 837–53

Winocour P, Shaw K, Greenwood R (2004) Will NICE guidelines on the managemant of type 2 diabetes improve diabetes care? Leader. *Practical Diabetes International*. **21**(1): 3–5

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