

# Diabetes and the new GMS contract: exploring the possibilities

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## ARTICLE POINTS

**1** The new GMS contract for general practice includes information on the quality and outcomes (Q&O) data on diabetes.

**2** The majority of UK practices have signed the new GMS contracts with their PCOs.

**3** Approximately one-third of GP income will be generated from Q&O payments.

**4** Of the 550 points awarded for achieving clinical quality indicators, 99 are for diabetes care.

**5** There are 18 clinical indicators in diabetes, which are rewarded according to the difficulty in achieving them.

**6** GPs may exclude individual patients from the disease indicators by exception coding.

**7** Payments will be dependent on national prevalence and an Adjusted Disease Factor calculation.

## KEY WORDS

- New GMS contract
- Diabetes care
- Q&O framework
- Read codes
- Exception reporting

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## Introduction

Over the past decade the evidence base for primary diabetes care has developed from individual clinical trials into a considerable body of data. These studies have in turn informed the four national diabetes frameworks\* within the NHS, which encouraged GPs to lobby for a mechanism of incentives for GPs to deliver this evidence to their patients in practice. What GPs got was a complex contract (British Medical Association, 2003) that requires careful reading – and the nuances of which are only now becoming apparent as the detail is worked through.

On 1 April 2004 the majority of UK practices signed contracts, for three years in the first instance, with their local primary care organisations (PCOs). These contracts represent the largest upheaval in the NHS since its inception. They will mean a considerable shift in activities for family doctors working in practices, which are now responsible for care, as opposed to the individual doctors themselves. The contract is designed to deliver uniform primary diabetes care throughout the NHS.

GPs' income will now be determined by a variety of measures, including:

- a global sum that forms at least half of the income for the practice
- payment for providing specifically determined patient services for the primary care organisation (PCO)
- seniority payments
- Quality and Outcomes (Q&O) payments for achieving a number of clinical and organisational goals.

## Q&O framework

Approximately one third of GPs' income will be generated from Q&O payments. Of the 550 points awarded for achieving clinical

quality indicators, 99 are for diabetes care (18% of the total). *Table 1* lists the quality indicators for diabetes. The clinical indicators are divided into three different types: structure, process and outcome.

To fulfil these quality criteria for diabetes, practices must have systems in place to address them. The contract is about not only doing the work, but also demonstrating that it has been done. Since data are best recorded electronically, paper-light or paper-free practices will have the advantage over those that are not. In response to this, there has already been a rapid expansion in resources for IT within primary care trusts (PCTs).

Disease and therapy registers, and the ability to enter, and search for, clinical data will be essential to achieving the clinical indicators. Read codes specified by the contract are very important (*Table 2*). Read codes are searchable by the practice, and externally verifiable by the PCT to confirm claims. All the codes for the new contract are on the BMA website at: [www.bma.org.uk/ap.nsf/Content/newreadcodes](http://www.bma.org.uk/ap.nsf/Content/newreadcodes). The diabetes codes and exception codes are at [www.equip.ac.uk/docs/readcodes/read\\_codes.pdf](http://www.equip.ac.uk/docs/readcodes/read_codes.pdf).

Many practices are appointing data managers, with protected time for data entry and audit, to improve the quality of practice data. Up to 40% of patients with diabetes may be attending hospital clinics, and it is important that the data from these clinics are assimilated into GP clinical systems.

\*National Service Framework for Diabetes: Standards (2001); Delivery Strategy (2003) <http://www.publications.doh.gov.uk/nsf/diabetes/index.htm> (accessed 21.09.04)

National Service Framework for Diabetes (Wales) (2003) <http://www.wales.nhs.uk/sites/documents/334/diabetes-standards-wales.pdf> (accessed 21.09.04)

Northern Ireland Diabetes Framework (2003) <http://www.diabetes.org.uk/n.ireland/nireland.htm> (accessed 21.09.04)

Scottish Diabetes Framework (2002) <http://www.diabetes.org.uk/scotland/downloads/sdf.pdf> (accessed 21.09.04)

**Disease register**

The first requirement is a disease register of patients with diabetes aged 17 years and over. Many practices will have been developing these over the years as part of chronic disease management, and may want to verify lists by searching under diabetes therapy. They will need to demonstrate to the PCO how the register is formed, verified and maintained. Practices should expect 2–3% of their population to have diabetes, although variations in prevalence can be adjusted for, as illustrated later in this article.

In practice most of the recording of diabetes data will work on a 15-month cycle, with practices trying to achieve one-year follow-ups. The most difficult patients to reach are adolescents, who are poor clinic attendees, the housebound elderly, and those in nursing homes.

**Body mass index (BMI)**

There is a requirement for a percentage of the population to have had their BMI recorded within the past 15 months. Obesity is strongly associated with type 2

**Table 1. Clinical quality indicators for diabetes mellitus in the new GMS contract**

This set of indicators refers to patients with both type 1 and type 2 diabetes.

Indicator	Points	Payment stages
<b>Records</b>		
DM 1 The practice can produce a register of all patients with diabetes mellitus	6	
<b>Ongoing management</b>		
DM 2 The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	25–90%
DM 3 The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once	3	25–90%
DM 4 The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	5	25–90%
DM 5 The percentage of diabetic patients who have a record of HbA <sub>1c</sub> or equivalent in the previous 15 months	3	25–90%
DM 6 The percentage of patients with diabetes in whom the last HbA <sub>1c</sub> is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	25–50%
DM 7 The percentage of patients with diabetes in whom the last HbA <sub>1c</sub> is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	25–85%
DM 8 The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	25–90%
DM 9 The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	25–90%
DM 10 The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	25–90%
DM 11 The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	25–90%
DM 12 The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	17	25–55%
DM 13 The percentage of patients with diabetes who have a record of microalbuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	25–90%
DM 14 The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	25–90%
DM 15 The percentage of patients with diabetes with proteinuria or microalbuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	25–70%
DM 16 The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	25–90%
DM 17 The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 mmol/l or less	6	25–60%
DM 18 The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	25–85%

**Table 2. GMS Read codes for recording diabetes care**

The practice should search for all patients on repeat prescriptions for insulin, oral hypoglycaemics, and blood and urine monitoring sticks

Insulin dependent DM	C108
Non-insulin dependent DM	C109
Impaired glucose tolerance	R 102-2

The new codes are:

Type 1 DM	C10E
Type 2 DM	C10F

**GMS Contract Codes**

The indicators refer to patients with both type 1 and type 2 diabetes.

**Diabetes (DM) Indicator 1**

The practice can produce a register of all patients with diabetes mellitus

Diabetes mellitus	C10%
Type 1 diabetes mellitus	C10E
Type 2 diabetes mellitus	C10F

**Diabetes (DM) Indicator 2**

The percentage of patients with diabetes whose notes record BMI in the previous 15 months

BMI recorded 22K If value is added via template, Read code not required

**Diabetes (DM) Indicator 3**

The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once

Never smoked tobacco	137I
Ex-smoker	137S
Current smoker	137R

**Diabetes (DM) Indicator 4**

The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months

Smoking cessation advice	8CAL
Health ed smoking	679I

**Diabetes (DM) Indicator 5**

The percentage of patients with diabetes who have a record of HbA<sub>1c</sub> or equivalent in the previous 15 months

HbA <sub>1c</sub> – diabetic control	42W%
HbA <sub>1c</sub> level	44TB

**Diabetes (DM) Indicator 6**

The percentage of patients with diabetes in whom the last HbA<sub>1c</sub> is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months

HbA <sub>1c</sub> level	numeric value
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**Diabetes (DM) Indicator 7**

The percentage of patients with diabetes in whom the last HbA<sub>1c</sub> is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months

HbA <sub>1c</sub> level	numeric value
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**Diabetes (DM) Indicator 8**

The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months

Diabetic retinal screening	68A7
Fundoscopy normal	31280
Fundoscopy abnormal	31281
Fundoscopy – diabetic check	66AD

**Diabetes (DM) Indicator 9**

The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months

Pulses right	24E%
O/E – right foot pulses present	24EB
O/E – Absent right foot pulses	24EA
Pulses left	24F%
O/E – left foot pulses present	24FB
O/E – Absent left foot pulses	24FA

**Diabetes (DM) Indicator 10**

The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months

10g monofil sens R foot normal	29BB
10g monofil sens R foot abnormal	29B9
10g monofil sens L foot normal	29BC
10g monofil sens L foot abnormal	29BA
Vibration sense R foot abnormal	29H4
Vibration sense R foot normal	29H5
Vibration sense L foot abnormal	29H6
Vibration sense L foot normal	29H7

**Diabetes (DM) Indicator 11**

The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months

O/E – blood pressure reading	246
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**Diabetes (DM) Indicator 12**

The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less

Blood pressure	numeric value
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**Diabetes (DM) Indicator 13**

The percentage of patients with diabetes who have a record of microalbuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)

Urine microalbumin	46W
Urine microalbumin positive	46W0

Urine microalbumin negative	46W1
Urine albumin:creatinine ratio	46TC
24-h urine protein excretion test	46N5

**Diabetes (DM) Indicator 14**

The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months

Serum creatinine	44J3%
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**Diabetes (DM) Indicator 15**

The percentage of patients with diabetes with proteinuria or microalbuminuria who are treated with ACE inhibitors (or A2 antagonists)

Albuminuria (diagnosis)	R1100
Microalbuminuria (diagnosis)	R1103
Prescribed drugs will be picked up on drug search	
ACE inhibitors contraindicated	8I28
ACE inhibitor not indicated	8I64
ACE inhibitor declined	8I3D
ACE inhibitors caus adv eff therap use	U60C4
A2 antagonist contraindicated	8I2H
A2 antagonist declined	8I3
A2 antagonist adverse effect therap use	U60CB
H/O: ACE inhibitor allergy	14LM
ACE inhibitor not tolerated	8I74
H/O: A2 antagonist allergy	14LN
A2 antagonist not indicated	8I6C
A2 antagonist not tolerated	8I75

**Diabetes (DM) Indicator 16**

The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months

Serum cholesterol	44P
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**Diabetes (DM) Indicator 17**

The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less

Total cholesterol measurement	44PH
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**Diabetes (DM) Indicator 18**

The percentage of patients with diabetes who have a record of influenza immunisation in the preceding 1 September to 31 March

Influenza vaccination	65E
Influenza vac contraindicated	8I2F
No consent – influenza immun	68NE
Influenza vaccination declined	9OX5
H/O: Influenza vaccine allergy	14LJ
Influenza vaccine not indicated	8I6D

diabetes, and weight loss can help with diabetes control. Unfortunately, weight loss is often hard to achieve in people with diabetes, and many diabetes therapies, with the exception of metformin, tend to cause weight gain.

**Smoking status**

Recording of smoking status is found in several of the quality indicators, and one coded recording of the status covers all. In diabetes, smoking leads to a four-fold increase in risk of death. The first of the two indicators relates to the percentage of diabetes patients with a record of smoking status. Lifelong non-smokers need only have a single computer entry, but smokers and ex-smokers must have their entry updated within the 15-month cycle. For smokers, the percentage offered smoking cessation advice or intervention should be recorded on the practice computer system.

**Blood glucose markers**

There are no points for merely measuring

blood sugar – it is important to record HbA<sub>1c</sub> for all patients with diabetes. Ideally, the test should be performed every 6 months in well-controlled patients and more often in patients with suboptimal control. Care should be taken to record accurately onto templates. There is a Read code for ‘HbA<sub>1c</sub> taken’, but the actual level may need to be recorded and searched for in a different way, depending on individual systems.

The contract divides patients with diabetes into those with HbA<sub>1c</sub> <7.4%, which equates with tight control in outcome studies, and those with HbA<sub>1c</sub> 10% or lower. Diabetes Mellitus (DM) 6 and 7 respectively reflect the difficulty in achieving these standards.

The upper band of control recognises findings from the UKPDS trial (UKPDS, 1998a). As glycaemic control worsens over time, more treatment is needed, but even with insulin therapy this may be difficult to achieve. It has to be accepted that some patients find it difficult to make the lifestyle choices necessary for good

**Table 3. Exception reporting**

Exception reporting falls into three groups:

**Patients exempted from the whole clinical disease area**

- a) Patients who have been recorded as refusing to attend a review who have been invited on at least three occasions during the preceding 12 months
- b) Patients for whom it is not appropriate to review the specific chronic disease parameters due to particular circumstances, e.g. terminal illness, extreme frailty
- c) Where a patient does not agree to investigation or treatment (and, after a reasonable discussion or written advice, they have given their informed dissent), and this dissent has been recorded in their medical records

**Patients exempted from one clinical indicator only (if a valid Read code is used)**

- d) Patients on maximum tolerated doses of medication whose level of outcome remains suboptimal
- e) Patients for whom prescribing a medication is not clinically appropriate, e.g. those who have an allergy, another contraindication or have experienced an adverse reaction
- f) Where a patient has not tolerated medication
- g) Where a patient does not agree to investigation or treatment (and, after a reasonable discussion or written advice, they have given their informed dissent), and this dissent has been recorded in their medical records
- h) Where the patient has a supervening condition which makes treatment of their condition inappropriate, e.g. cholesterol reduction where the patient has liver disease
- i) Where an investigative service or secondary care service is unavailable

**Patients exempted automatically from any of the indicators by reporting software**

- j) Patients newly diagnosed within the practice with diabetes or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months, e.g. blood pressure or cholesterol measurements within target levels

<b>Diabetes exception codes</b>	9h41 Exempted from diabetes quality indicators: Patient unsuitable
	9h42 Exempted from diabetes quality indicators: Informed dissent
	8BL2 Patient on maximal tolerated therapy for diabetes

control. This is partially recognised in the contract, which allows for exception reporting in defined circumstances (Table 3).

### **Retinal screening**

A national retinal screening programme is being introduced, with regional differences. Suggested ways of implementing the programme have been a mix of screening locally in individual practices, by optometrists and at hospitals. This was a key suggestion in many of the diabetes frameworks. It will be important for practices locally to use services that are appropriate for them, and to capture data wherever they are recorded, as the top clinical indicator level for this activity is 90%.

### **Foot pulses and neuropathy**

It is widely accepted that recording of foot pulses and neuropathy testing are important parts of an annual diabetes examination. Practices are beginning to assess neuropathy through consistent 10g pressure with a light touch monofilament. Foot pulses also require careful palpation. There are Read codes for all these data. Practices will need to cooperate locally with community podiatrists.

### **Blood pressure**

Like good glycaemic control, good blood pressure control is important but difficult to achieve, with patients with diabetes requiring several antihypertensive agents. In the UKPDS trial, controlling blood pressure was shown to be more effective in improving cardiovascular outcomes than maintaining tight blood glucose control (UKPDS, 1998b). In the new contract, the target blood pressure in people with diabetes is  $\leq 145/85$  mmHg, compared with  $\leq 159/90$  mmHg in those without diabetes.

This clinical indicator offers maximum points for recording blood pressure in 90% of patients with diabetes. Points for the percentage of patients with blood pressure  $\leq 145/85$  mmHg will be harder to achieve, yet at 17 points will be important and worthwhile.

### **Diabetic renal disease**

The three indicators associated with renal disease reflect screening for and management of diabetic renal disease. Both microalbuminuria and established proteinuria are markers for end-stage renal failure in type 1 diabetes, and predictive of imminent vascular disease in type 2 diabetes.

There is good evidence that treatment with angiotensin-converting enzyme (ACE) inhibitor and angiotensin II (A2) antagonist may be reno-protective. Once microalbuminuria is established by two abnormal albumin:creatinine ratios, treatment with either ACE inhibitor or A2 antagonist should be given.

The new contract also rewards the recording of serum

**PAGE POINTS**

**1** To achieve many of the diabetes targets, primary care health professionals need to enter into a concordant relationship with the patient with diabetes and agree mutual outcomes.

**2** Exception reporting allows GPs, for the first time, to detail patients with diabetes who cannot, will not, or should not have a particular intervention.

creatinine. This test is helpful in patients with diabetes who have established nephropathy, to detect non-diabetic renal disease, in those on ACE inhibitors, and to ensure the safe use of oral hypoglycaemics.

**Lipids**

The lipid indicators reflect the widely held view that treating patients with diabetes to the same standard as those who need secondary prevention of cardiovascular disease is cost-effective. Major studies of primary and secondary prevention of cardiovascular disease using statins show benefit in diabetes subgroup analysis.

In the contract, points are offered for recording total cholesterol and achieving levels below 5 mmol/litre, with maximum payment for 60% of patients with diabetes achieving this target. Commentators have observed that serum cholesterol alone is a crude observation in patients with diabetes, who have a subtle and complex lipid profile. There is debate as to whether

all patients with diabetes over a certain age should receive lipid-lowering therapy and aspirin irrespective of risk table analysis. This is not reflected in the current contract, but may evolve with time.

**Influenza**

All patients with diabetes should be offered influenza vaccination. This makes sense but is a small reward for the considerable effort required, with the maximum percentage set at 85% and only 3 points awarded for this.

When these and other aspects of the Q&O framework were published, practices had time to consider their aspirations within this framework. They then informed PCOs of their intended target aspirations and, as part of the new GMS contract, are receiving funding for these aspirations. These payments are coming to practices in monthly increments of one-third of the total aspiration points.

**Exception reporting**

Table 1 shows that there are maximum thresholds that allow practices to claim payments, e.g. only 50% of patients need to achieve the HbA<sub>1c</sub> threshold of 7.4%. Observers have noticed that a few patients may make a large difference to these thresholds, and this is important when considering exception reporting.

Those involved with primary diabetes care will recognise that, in order to achieve many of the targets in diabetes, practitioners working in primary care need to enter into a concordant relationship with the patient with diabetes and there needs to be general agreement on mutual outcomes. With exception reporting, GPs have – for the first time – a facility to detail patients with diabetes who cannot, will not, or should not have a particular intervention.

The new GMS contract allows GPs to exclude individual patients from the disease indicators in certain circumstances (Table 3). In most cases, it is necessary to add a particular Read code to except a patient. Excepting can be done at two levels:

- removing a patient from one specific disease area
- removing a patient from a denominator of the whole disease area.

**Table 4. Examples of exception coding in practice**

**Patient one**

Sean is a 53-year-old man with type 2 diabetes. He has had chronic schizophrenia for 23 years. He lives alone and is looked after by his sisters, who provide food and support. He does not respond to letters or telephone calls. His last HbA<sub>1c</sub> was 13.7%, which was 15 months ago. He has been prescribed a variety of medication but computer records indicate non-compliance.

*A clear case for exception coding – patient unsuitable*

**Patient two**

Robert is a 92-year-old man with type 2 diabetes treated with insulin. He lives in residential accommodation, where his medication is supervised. His HbA<sub>1c</sub> is 9.7%. The staff are keen that his insulin remains the same as they have had unpleasant experiences when he becomes hypoglycaemic. Robert's eyesight is poor so he is inactive, although his quality of life is good.

*Here the GP will have to decide to exception code for one area: unable to tolerate maximal therapy and keep the other criteria, OR give a general code for patient unsuitable*

**Patient three**

Hilda is a 59-year-old woman with type 2 diabetes and associated hypertension. She has been tried on a variety of medication for her blood pressure. She developed gout from the diuretics, peripheral oedema from the calcium-channel blockers, she wheezes, and she cannot tolerate beta-blockers. Many of her other diabetes indicators are well controlled.

*Here the GP will want to exception code for unable to tolerate therapy for hypertension alone.*

**Table 5. Calculating payments under the new GMS contract**

Square root of (prevalence of diabetes in practice/nationally agreed diabetes prevalence) multiplied by (practice list size/ average national list size) multiplied by (number of points obtained for diabetes) multiplied by (that year's value for points) = the sum the practice will receive

Thus, the sum received by practice =

$$\left( \sqrt{\frac{\text{prevalence of diabetes in practice}}{\text{nationally agreed diabetes prevalence}}} \right) \times \left( \frac{\text{practice list size}}{\text{average national list size}} \right) \times \left( \text{points obtained for diabetes} \right) \times \left( \text{points value for diabetes} \right)$$

**Table 6. Examples of potential payments under the new GMS contract**

Chronic disease management for diabetes payments before the new GMS contract ● **£475 per principal**

**UNDER THE NEW GMS CONTRACT:**

**Practice A**

2400 patients and 1.5 GP principals  
(Adjusted Disease Factor 0.74)  
 $0.74 \times 0.41 \times 99 \times 75 = \text{£2253}$  ● **£1500 per principal**

**Practice B**

6800 patients and 4 GP principals  
(Adjusted Disease Factor 1)  
 $1 \times 1.15 \times 99 \times 75 = \text{£8539}$  ● **£2145.50 per principal**

**Practice C**

13250 patients and 8 principals  
(Adjusted Disease Factor 1.29)  
 $1.29 \times 2.23 \times 99 \times 75 = \text{£21359}$  ● **£2669.87 per principal**

For valid exception coding to be achieved, these issues will have to be fully discussed with individual patients and carefully documented. Many practices that run specific diabetes clinics are recording their invitations to patients to attend these, noting refusals, and exempting patients after three non-attendances. However, if a patient is given a general exception code, they can still earn points for the practice if data around their condition are recorded. Table 4 gives examples of how this will work in practice.

Observers may feel that exception coding could be used too liberally by practices. An individual practice's activity in the area of diabetes care and the other clinical indicators will be assessed by the Quality Management and Analysis System (QMAS). This is a national data collection

and software analysis tool, which will be rolled out to practices, initially in England, and should allow them to compare their performances with those of others in their PCO and with national averages. The QMAS will work in tandem with, and inform, the PCT's annual Q&O framework review, which should be conducted by a clinical team that includes a GP.

**Calculating payments**

Having carefully examined the criteria for exception reporting and decided on denominator numbers for patients with diabetes, the practice now has to perform another complex calculation to decide potential income from diabetes work. A full explanation of the calculations can be found in the *GMS Statement of Financial Entitlements for 2004/5* (2004).

The contract negotiators recognised that practices with a high number of patients with diabetes need to have their workload recognised financially. This is important in diabetes where there are pockets of high prevalence within localities with high ethnic populations who are susceptible to diabetes. At the same time they wanted to encourage practices with small numbers to participate in the process.

From 14 February 2005 onwards – this date will recur annually as National Prevalence Day – the prevalence of each of the diseases in the Q&O framework will be decided, partially informed by data from the QMAS. It appears that a prevalence figure will be agreed for each of the four countries within the NHS.

It is against this background that the Adjusted Disease Factor (ADF) calculations for diabetes are made. The practice (contractor) begins by calculating a Raw Practice Disease Prevalence by dividing the

number of patients on the diabetes register by the Contractor Registered Population (CRP), which is agreed quarterly. (A formula is applied if the practice falls below the bottom 5% cut-off range.) *Table 5* shows the calculation.

*Table 6* illustrates how it will affect three practices. These separate practices show that the formula only partially recognises high prevalence. Practices with a particularly high prevalence will find that the formula only partially compensates them for their extra work, as the square root used in the formula tends to bring the ADF closer to one. Practices that looked at the headline figures in the contract without looking at their individual circumstances may be surprised when formulae are applied to their data next March.

### Conclusions

The principle of rewarding practices for applying evidence-based interventions

underpins the new GMS contract. Many of the diabetes interventions are justified by well-respected evidence. This is already having an impact on clinical practice, with practices informing PCOs of their intentions, and aspiration money is following these suggestions.

Practices will need to be aware of the implications of exception reporting people with diabetes in whom it is not appropriate to pursue targets.

Finally, practices will want to clarify how their individual circumstances in the context of disease prevalence and practice size will affect their remuneration from diabetes-related work. ■

British Medical Association (2003) *Investing in General Practice: The New General Medical Services Contract*. BMA, London

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