Improving care with the nGMS and NSF

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National Service Frameworks (NSFs) look at delivery of healthcare and standards of best practice. The diabetes NSF contains two big shifts: one in philosophy and one in organisation. The philosophical shift is that hackneyed word 'empowerment', and how many of us groan when we hear it yet again! However, it is describing what many people with diabetes have believed for years – that they know and manage their own diabetes. The organisational shift is that the majority of diabetes care will take place in the primary sector. The NSF for diabetes (Department of Health, 2001) sets out standards of care that should be expected within the NHS, with impressive emphasis on partnerships between healthcare professionals and people with diabetes.

The diabetes NSF was delivered to complement the new General Medical Services (nGMS) Contract (British Medical Association, 2003), which came into force in April 2004. The contract was considered necessary for two main reasons. Firstly, to look at care within the whole practice, not the individual GP; therefore looking at the whole picture, the practice area and its needs. Secondly, to provide financial incentives for quality care in areas such as diabetes. This is achieved by the practice 'earning' points. These points are accrued by recording clinical data. Information technology systems provide a means for primary care trusts to confirm the data before points can be awarded by a strict audit trail (unlike the former mini clinics and chronic disease management clinics).

The nGMS contract provides funding that is linked to chronic disease management, either at a basic level (essential services), which includes diabetes, or enhanced services, through which additional funding is provided through the Quality and Outcomes Framework (QoF) for a more specialised diabetes service.

The associated QoF (which includes tight clinical targets) is there to provide reassurance that this is not just a tick-box exercise. Diabetes UK were very insistent that this framework was built into the contract to ensure quality of care. Nowhere in the contract are points awarded for advice on lifestyle or psychological input, apart from smoking cessation advice.

Maximum diabetes quality indicators achieved will provide the practice with 18 % of their total contract funding. Some of the points are easily acquired (registers, height and weight, etc) and there are possibilities for exception within the contract.

So where do the NSF and the nGMS meet to improve diabetes care? It is easy to think that data will be collected for the sake of it, followed by minimal intervention if necessary. Is the time taken collecting the data going to reduce opportunity for lifestyle and psychological advice and support?

Standard 4 of the NSF deals with clinical care of adults with diabetes and the key interventions match the 18 requirements of the nGMS, such as blood pressure control, lipids, blood glucose control and smoking cessation to name but a few.

I am aware that I am sounding slightly negative, but on the positive side there are two very important facts to remember. Firstly, the continuing excellent care that people with diabetes receive in the primary sector (in most cases from the practice nurse). I, for one, have every confidence that their lifestyle intervention programme already in existence will continue, incorporated into the requirements for clinical care. Secondly, the contract's requirements are in themselves a trigger to detect and manage long-term complications in association with standards 10, 11 and 12 of the NSF. In discussion with local practice nurses, the general view is that it 'focuses' their thoughts and presents an ideal opportunity for negotiation and increased awareness of the condition.

However we look at it, both the NSF and the nGMS contract prioritise diabetes care as never before. Both Roger Gadsby and Gwen Hall in their articles express concern that there are areas of the nGMS contract that appear not to support the NSF. Nevertheless, they both agree that it is up to all of us, health professionals and people with diabetes alike, to use the positives within both developments to make the biggest impact ever on diabetes care. ■

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

Department of Health (2001) *National Service Framework for Diabetes: Standards.* DoH, London