New systems of care: what are the implications for DSNs?

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ARTICLE POINTS

1 Specialist teams in the future will provide diabetes management in the community.

2 The new GMS contract gives financial incentives for demonstrable high quality care.

3 DSNs will be able to forge new ways of working with PCTs and directly with GPs to achieve GMS quality indicators.

4 Patient held records and involvement of people with diabetes in their own care will be paramount

5 DSNs should be involved in the planning of these new services.

KEY WORDS
- **Chronic disease**
- **New GMS contract**
- **Funding**
- **Out of hours service**
- **Community**

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Introduction

The way diabetes is managed is set to change, with the balance of care being shifted towards high quality care in GP practices, through the new General Medical Services (GMS) contract and specialist care in the community. This article outlines possible implications for DSNs in this evolving role.

On 11 March 2004, Health Secretary John Reid announced plans to radically alter the way that chronic disease, including diabetes, is managed in England (DoH, 2004a). A total of 28 case-management demonstration sites will be set up, one in each strategic health authority area. Specialist teams will provide advice, care and treatment for chronic disease which aim to cut hospital admissions (and thereby costs) and provide care to at-risk groups nearer home. A 'whole systems' approach will be encouraged and will involve healthcare and social care, voluntary groups and local initiatives.

Chronic disease accounts for around 80% of GP consultations and will be the leading cause of disability by 2020 (DoH, 2004b). It will also become the most expensive problem for healthcare systems. People who have more than one condition are likely to require complex care; diabetes, frequently involves co-morbidities due to its complications.

John Reid's plan links into the new General Medical Services (nGMS) contract and its associated Quality Outcomes Framework (QOF). From 1 April 2004, general practices will receive financial incentives if they can demonstrate higher quality care assessed through a range of quality indicators. Good diabetes care can attract considerable additional funds into general practice if we get it right. So what does it all mean for DSNs?

The new GMS contract

The nGMS contract (DoH, 2004c) provides a complete shake up for primary care. For the first time funding is linked to the whole practice performance instead of being based on individual GP's lists. Local schemes will be agreed for Personal Medical Services (PMS) practices which have control of their finances already, initially through pilot sites and now as a permanent feature. There are three streams of funding:

- Essential services. ('Must do' for all practices, includes chronic disease management at a level determined by the

Diseases in the quality framework	Number of points
Asthma	72
Cancer	12
Chronic obstructive airways disease	45
Coronary heart disease	121
Diabetes	99
Epilepsy	16
Hypertension	105
Hypothyroidism	8
Mental health	41
Strokes or transient ischaemic attacks	31

Figure 1 Clinical standards in the nGMS contract QoF (DoH, 2003).

Table 1. Quality and Outcomes Framework domains

Clinical	Organisational	Additional services	Patient experience
550 points	184 points	36 points	100 points
CHD	Records	Cervical screening	Length of consultations
Stroke/TIA	Patient Communication	Child health surveillance	Patient surveys (two specific agreed)
Hypertension	Education/training	Maternity services	
Diabetes	Practice management	Contraceptive services	
COPD	Medicines management		
Epilepsy			
Hypothyroidism			
Cancer			
Mental health			
Asthma			

TIA = *transient ischaemic attack*
COPD = *chronic obstructive pulmonary disease*

practice).

- Additional services. (Optional services which practices can opt out of...but at a cost).
- Enhanced services (Optional. Essential or additional services, but delivered to a higher standard. Targets may be locally or nationally set, e.g. enhanced care of the homeless. Diabetes may be an enhanced service if high quality care can be demonstrated through agreed goals).

Changes will also be made to out of hours provision. Diabetes care is an essential service for all practices to provide but they may opt out of some other areas (additional services) such as maternity services or minor surgery. Alternatively, practices may be more likely to go for a higher quality service that attracts additional funding through the Quality and Outcomes Framework (*Table 1*). The higher quality payments rely on practices agreeing targets for the 18 quality indicators and achieving them through audit. The minimum they can opt for is 25% of their patients on their diabetes registers meeting the targets but success in reaching the higher levels shown will attract higher funding.

DSNs may find themselves increasingly involved in holistic care and advising on managing the whole patient rather than blood glucose control. There will be scope to enhance skills in clinical management of hypertension, CHD and stroke prevention, but also in education and training of primary care staff and medicines management, working with PCTs. Points literally do mean prizes in the nGMS and diabetes and its associated conditions accounts for the majority of those available. (*Figure 1, Table 2*).

Practices will agree the level they expect to attain towards the 18 Quality Indicators (*Table 2*) with the minimum level to attract funding being set at 25%. Higher percentages attract higher funding. For instance, if Practice A expects to achieve 90% of the patients on their diabetes register to have a blood pressure of 145/85 mmHg or less in a 15 month period they will be awarded the full 17 points at DM 12 and the commensurate funding. Practice B may expect to achieve 50% of its diabetes patients to have HbA_{1c} levels of 7.4% or less and would be awarded funding for 16 points (DM6). The maximum of 50% here is set to be realistic and may rise in the future as practices demonstrate their ability to reach these levels. Accurate recording, and sharing, of data will be very important.

Out of hours service

The out of hours service is changing too (as can be seem in *Table 3*). Services from 1830–0800 on weekdays, the whole of weekends and bank holidays

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1 DSNs may find themselves increasingly involved in holistic care and advising on managing the whole patient rather than blood glucose control.

2 Points literally do mean prizes in the nGMS and diabetes and its associated conditions accounts for the majority of those available.

3 The new contract focuses on getting systems right through new ways of working.

4 There will be fewer boundaries to care and a move to a patient-centred approach.

Table 2. Diabetes Quality Indicators in the new GMS contract

Indicator	Points	Maximum threshold
Records		
DM 1.The practice can produce a register of all patients with diabetes mellitus	6	
Ongoing management		
DM 2.The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	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	90%
DM 4. The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice has been offered in the last 15 months	5	90%
DM 5. The percentage of people of diabetes who have a record of HbA_{1c} or equivalent in the previous 15 months	3	90%
DM 6. The percentage of patients with diabetes in whom the last $HbA_{1c} \leq 7.4$ (or equivalent test / reference range depending on local laboratory) in the last 15 months	16	50%
DM 7. The percentage of patients with diabetes in whom the last $HbA_{1c} \leq 10$ (or equivalent test / reference range depending on local laboratory) in the last 15 months	11	85%
DM 8. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	90%
DM 9.The percentage of patients with diabetes with a record of presence or absence of peripheral pulses in the previous 15 months	3	90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure reading was 145/85 mmHg or less	17	55%
DM 13. The percentage of patients with diabetes who have a record of microalbuminuria testing in the previous 15 months (excepting reporting for patients with proteinuria)	3	90%
DM 14. The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	90%
DM 15. The percentage of patients with diabetes with proteinuria or microalbuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	70%
DM 16.The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	90%
DM 17.The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is ≤5	6	60%
DM 18.The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September–31 March	3	85%

will become the responsibility of the PCT. The question is, who is going to provide the diabetes out of hours care? DSNs would be well advised to start working with PCTs on forthcoming arrangements; diabetes care needs to be provided when GPs are not available, and practice nurses are generally not available at those times too. New schemes will have to be implemented.

Potential for nurses

However, it is not about counting the points. Patient care is the essence of the nGMS. The new contract focuses on

getting systems right through new ways of working. In the future nurses will be able to run practices. They will win contracts to provide a service. They will forge multiprofessional partnerships and can even form limited companies. GPs might employ specialist nurses to provide a total service for their practice, and PCTs may do likewise across a larger area. There will be fewer boundaries to care and a move to a patient-centred approach.

Chronic disease management

The DoH (DoH, 2004b) lists components of chronic disease management that can be applied to diabetes care (*Table 4*). Each are discussed in turn below:

1. Information Technology

GPs will be keen to work with DSNs to ensure that data is shared between primary and secondary care. Data will be collected on the total practice register. Information that is not recorded equates with loss of income to practices.

2. Identifying patients

As outlined in the NSF for Diabetes (DoH, 2002) diabetes registers are to be used to effectively, call and recall everybody on them. Community staff are likely to need more support with training and managing at risk patients.

3. Risk

DSNs may want to expand their role in

Table 3. Quality and Outcomes Framework domains

- Up to April 2004 this was the responsibility of the GP
- Between April–December 2004 it will be seen as an additional service.
- By December 2004 it becomes the responsibility of the PCT.

Table 4. What makes for good chronic disease management?

1. Use of information systems to access key data on individuals and populations.
2. Identifying patients with chronic disease.
3. Stratifying patients by risk.
4. Involving patients in their own care.
5. Coordinating care (using case-managers).
6. Using multidisciplinary teams.
7. Integrating specialist and generalist expertise.
8. Integrating care across organisational boundaries.
9. Aiming to minimise unnecessary visits and admissions.
10. Providing care in the least intensive setting.

FIGURE 2. USEFUL INFORMATION SOURCES

Modernistation Agency. Workforce Matters. A guide to role redesign in diabetes care is available from:

NHS Modernisation Agency, Richmond House, 79 Whitehall, London SW1A 2NS

Tel: 0207 061 6735. Further information online:

http://www.modern.nhs.uk/cwp/roleredesign.htm

The National Primary and Care Trust (NatPaCT) development programme has published a series of briefings on the nGMS contract including one for nurses:

NatPaCT, NHS Modernisation Agency, 2nd Floor, Blenheim House, West One, Duncombe Street, Leeds LS1 4PL. Tel: 0113 254 3800 http://www.natpact.nhs.uk

Liberating the Talents. Helping Primary Care Trusts and nurses to deliver The NHS Plan http://www.dh.gov.uk/assetRoot/04/07/62/50/04076250.pdf

Information for would-be nurse entrepreneurs:

2003 RCN Publication code 002 002 (one copy free to members).

Royal College of Nursing, 20 Cavendish Square, London W1G 0RN

Tel: 0207 409 3333. www.rcn.org.uk OR www.rec.org.uk/direct

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1 Targets cannot be met without the participation of people with diabetes and their carers.

2 Patient held records facilitate the sharing of information and encourage active participation in self-care.

3 Healthcare assistants increasingly work in diabetes care, technicians assist with annual reviews and roving teams link primary and secondary care.

4 Practice nurses will need education and clinical training to achieve targets in HbA_{1c} and blood pressure.

5 DSNs will increasingly be required in the community to work with patients, healthcare professionals and allied bodies (community pharmacists, podiatrists) to provide accessible care to people with diabetes.

high risk patients.

4. Self-care

Targets cannot be met without the participation of people with diabetes and their carers. Patient held records facilitate the sharing of information and encourage active participation in self-care. DSNs should be in the vanguard of encouraging this process.

5. Case-manager and coordinator

These roles will be the key to success and could become roles for the DSN.

6. The team approach

Roles are evolving to meet the new systems. Healthcare assistants increasingly work in diabetes care, technicians assist with annual reviews and roving teams link primary and secondary care. Examples of role redesign have been highlighted by the Modernisation Agency (2002).

7. Integrating expertise

Practice nurses will need education and clinical training to achieve targets in HbA_{1c} and blood pressure. Community nurses will welcome support in achieving the same goals for the housebound, elderly or those in care. The DSN could perhaps become the linchpin.

8. Integrating care

DSNs should be involved in discussions with PCTs introducing 'whole systems' approaches to diabetes care involving health, social care, voluntary bodies and local initiatives in their plans.

9. Minimise visits and admissions

DSNs will increasingly be required in the community to work with patients, healthcare professionals and allied bodies (community pharmacists, podiatrists) to provide accessible care to people with diabetes. GP visits and admissions to hospital could be lessened through this approach.

10. Care setting

This links into minimising visits and admissions, with patient-centred care becoming the norm.

Prevention of diabetes

Prevention of diabetes should not be neglected. Type 2 diabetes accounts for 75–80% of all cases of diabetes and can largely be prevented through lifestyle changes (BDA, 1996). DSNs should be working with other agencies to promote good health in their local population. Improvements in health now will lead to benefits in the future.

Conclusion

New systems of chronic disease management and the nGMS contract are further shifting the focus of diabetes care into the community. DSNs may wish to re-examine their role in the light of these new ways of working and may take the opportunity to redesign the service, working with PCTs, acute trusts and other bodies to provide an integrated service responsive to local patient need. *Figure 2* provides useful information sources. ■

British Diabetes Association/Kings Fund (1996) *Counting the Cost of Type 2 diabetes*. BDA, London

Department of Health (2002) *National Service Framework for Diabetes: Delivery Strategy*. Department of Health, London

Department of Health (2002) *Modernistation Agency. Workforce Matters. A guide to role redesign in diabetes care*. Department of Health, London

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Department of Health (2004b) Improving chronic disease management. www.dh.gov.uk/assetRoot/04/07/52/13/04075213.pdf Accessed: 18/3/04

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