Getting to the point of diabetes clinics

Gwen Hall

Introduction

This article reflects on the increasing claims on the time of primary care teams to meet diabetes targets and comply with national guidance. New ways of working to provide a systematic approach for all are considered plus hints and tips on achieving the targets whilst maintaining a high level of patient care. Many sources of information are highlighted to assist teams in redesigning their service, ensuring the effective involvement of people with diabetes.

Earlier this year John Reid, Health Secretary, announced plans to alter the way chronic disease, including diabetes, is managed in England (Department of Health [DoH], 2004a). Specialist teams in each strategic health authority area will provide advice, care and treatment aiming to cut hospital admissions, and thereby costs, and provide care to at-risk groups nearer home. The system will involve bodies other than health professionals, such as 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 health care systems. Diabetes, with its complications, deserves to be treated as a priority.

Those of us old enough to remember the GP contract of 1990 will recall the burgeoning of nurse-led clinics in response to changes in funding to GPs. So what's new? Here we are again – only this time it is the new General Medical Services (nGMS) contract that is shaping the future of diabetes care. This may be a good time to review how you work and devise new ways of providing diabetes care while maximising practice income and fitting the new agenda.

Step 1: Take aim

Be clear about your aim in providing a service for people with diabetes. It needs to meet the needs of your local populace. . . and of the practice staff, otherwise neither will be motivated.

Things to consider:

- Do the housebound or those in care homes get a systematic review of their diabetes?

– Many will have coronary heart disease (CHD). Does their review include secondary prevention measures, e.g. blood pressure, lipids and health promotion advice?

- What systems are in place for people whose first language is not English and for those in at-risk ethnic groups?

– Diabetes UK has publications in many languages.

– Can you access language-line interpretation service? (www.languageline.com, accessed 8.12.04).

- Are people who work normal hours easily able to access your service?

– Do you have flexible access times? Telephone support for people with diabetes?

- Are you making the best use of your team members?

– With increasing numbers of people with diabetes, we are devising new ways of working to meet demand. The Department of Health has published a guide (NHS Modernisation Agency, 2003a).

- Does your practice population include groups necessitating a different approach, e.g. travellers, prisoners, refugees and people with learning difficulties?

ARTICLE POINTS

1 Ensure your aims meet the needs of your local populace and practice staff.

2 Agree to a management protocol for people with diabetes and ensure all involved know their place in it.

3 New ways of working may need to be found or current roles adapted to cope with additional new GMS workload.

4 Additional funding is available if quality indicator targets are met. Use of practice registers and combining diabetes and CHD care can help ensure all are included.

5 Initiating a team approach including the person with diabetes may be the way to tackle the increased workload while continuing to provide quality care.

KEY WORDS

- GMS contract
- Protocol
- Teamwork
- Quality indicators
- Targets

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PAGE POINTS

1 In order to cope with the additional workload, new ways of working may need to be found or current roles adapted.

2 Healthcare assistants can free up health professionals' time: district nurses carry out systematic reviews and, practice nurses provide joint CHD and diabetes clinics.

3 The new GMS contract provides additional funding if practices meet specific targets (indicators).

4 If providing nurse-led practice-based clinics, combining CHD and diabetes may prevent duplication for patients and staff.

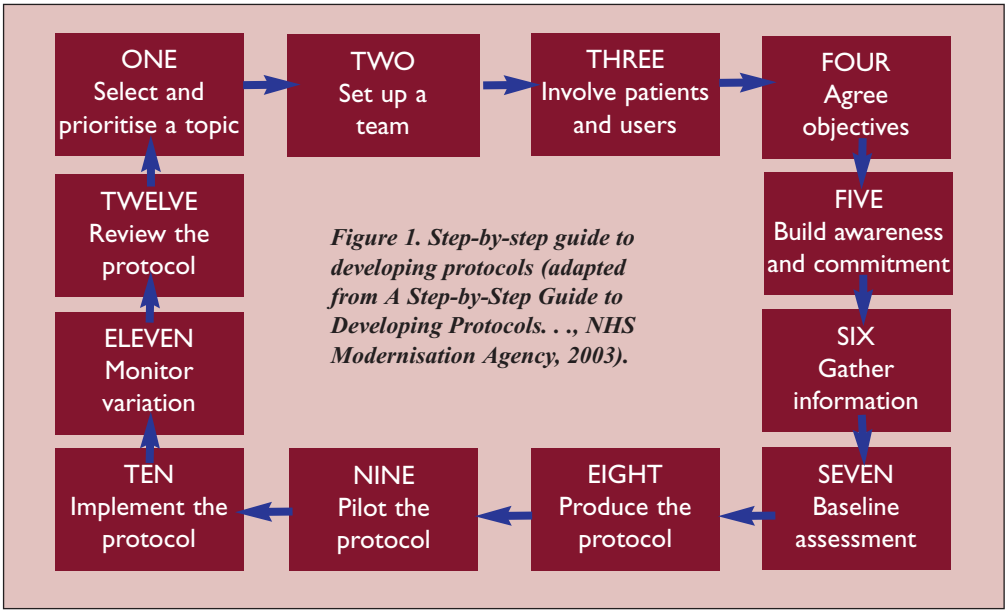

Figure 1. Step-by-step guide to developing protocols (adapted from A Step-by-Step Guide to Developing Protocols. . ., NHS Modernisation Agency, 2003).

- Are people with diabetes involved in planning care?

Step 2: Agree a protocol

Agree a protocol for the management of people with diabetes and ensure each person knows their place in it. It is best to have someone act as a linchpin coordinating the plan, but all should be involved in its development.

Writing a protocol is not daunting (see *Figure 1*) – and help is available from the Modernisation Agency (2003b) should you need it.

New ways of working and role redesign

In order to cope with the additional workload, new ways of working may need to be found or current roles adapted. Healthcare assistants can free up health professionals' time to concentrate on patient education, treatment and support, e.g. performing and recording blood tests, monitoring blood pressure and weight measurements, urine tests, basic foot assessment, audits and patient satisfaction surveys. District nurses can carry out systematic review for people with diabetes in their own homes. Practice nurses, with training in diabetes and CHD can provide joint clinics, preventing duplication of visits. Group education involving nurses, dietitians, podiatrists, etc, may reach a larger number of people.

Flexible appointment times will facilitate access for workers and telephone support could save on visits to the surgery. The National Service Framework (NSF) for diabetes advocates local contacts.

The expert patient programme (DoH, 2001), where people with various conditions are encouraged to participate in their own care, is becoming more widely available. Further details are on the website www.expertpatients.nhs.uk (accessed 8.12.04).

Table 1. Clinical standards in the new GMS contract (NatPaCT, 2003)

Disease areas	Number of points
Coronary heart disease	121
Stroke or transient ischaemic attacks	31
Hypertension	105
Diabetes	99
Chronic obstructive pulmonary disease	45
Epilepsy	16
Hypothyroidism	8
Cancer	12
Mental health	41
Asthma	72
Total number of points	550

Step 3: Meet your targets

Traditionally, nurse-led, practice-based, clinics have been set up to provide systematic care to people with diabetes (Pierce at al, 2000). But what about those who do not attend? The nGMS contract focuses on the total diabetes population

PAGE POINTS

1 CHD and diabetes, being linked conditions, account for the largest number of points – and therefore practice income – in the nGMS contract clinical standards.

2 Published guidance needs to be put in place for people with diabetes to target all of the risk factors identified in the UKPDS

3 Risk factors to be included in guidance: blood pressure, lipid levels, blood glucose, weight and obesity, activity levels and smoking.

4 British Hypertension Society guidance suggests an optimal target of <130/80 mmHg with audit standard of <140/80 mmHg to reduce coronary risk in diabetes.

and provides additional funding, if practices wish to aspire to it, through the Quality Outcomes Framework for specific targets (indicators) met. We may wish to re-examine our service to ensure we meet these targets for all – and, if providing clinics, combining CHD and diabetes may prevent duplication for patients and staff.

One key element of the planning and performance framework (DoH, 2002) for 2003–2006 was to ensure effective use of practice registers:

> ***'In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006 ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.'***

The importance of combining CHD and diabetes advice cannot be over emphasised. Type 2 diabetes accounts for around 85% of all cases of diabetes and more than 75% of those may have CHD (DoH, 2003). It is no accident that these linked conditions attract the largest number of points – and therefore practice income – to be gained in the nGMS contract clinical standards (see *Table 1*).

A full list of the quality indicators and suggested Read codes is available (BMA, 2004; DoH, 2004c). Some important indicators to note are listed in *Table 2*. The range of indicators and payment stages for diabetes are given in *Table 3*, and those relating to CHD in *Table 4*.

To achieve these targets published guidance needs to be put in place for all people with diabetes. The NSF places importance on the effectiveness of early treatment and management of diabetes but it is important to target all of the risk factors identified in the United Kingdom Prospective Diabetes Study (Turner, 1998; UKPDS, 1998).

Blood pressure

The British Hypertension Society has published new guidance (Williams et al, 2004; and see p158) and primary care will be pleased to note the removal of the risk charts for diabetes patients who now become 'coronary equivalents', so high is their risk. To significantly reduce the risk to people with diabetes, the British Hypertension Society suggests an optimal target of <130/80 mmHg, with an audit standard of <140/80 mmHg, which is not reflected in nGMS or National Institute for Clinical Excellence (NICE) guidance

Table 2. Quality indicator points in the new GMS contract

Indicator: A minimum of 25% must be achieved to attract any points. **The maximum target is that which practices can aspire to achieve for the highest funding**	**Points**	**Maximum threshold**
DIABETES		
DM 6: The percentage of patients with diabetes in whom the last HbA_{1c} is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	50%
DM 7: The percentage of patients with diabetes in whom the last HbA_{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	85%
DM 12: The percentage of patients with diabetes in whom the last blood pressure is 145/85 mmHg or less	17	55%
CHD		
CHD 6: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the last 15 months) is 150/90 mmHg or less	19	70%
CHD 8: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	16	60%

(NICE, 2002a). It is accepted that this is not achievable for all.

Lipid management

Management of fasting lipid levels are advocated and NICE guidance should be updated to take into account the change to the risk charts as above.

Blood glucose management

NICE guidance (NICE, 2002b) was published before the monotherapy license was granted for the glitazone group of drugs that target insulin resistance. They can now be used as first-line treatment where metformin is not suitable.

Weight and obesity

The House of Commons third report (2004) makes strong observations on obesity: 'We deplore the low priority given to obesity by the new GP contract. We hope that NICE guidance on the prevention, identification, evaluation, treatment and weight maintenance of overweight and obesity, currently expected in Summer 2006, will go some way towards increasing the priority of obesity within general practice, as well as helping primary care practitioners develop and improve the services they provide in this difficult area.' This needs to be taken into account when developing education plans not only for people with diabetes but prevention measures also.

Activity levels

As above.

Smoking

Cooperation with local health promotion initiatives may be possible, and recording smoking cessation advice is integral to quality indicator payments. It is possible to provide a high level of care through an integrated team approach and, as a sideline, gain the quality indicator points simultaneously.

Step 4: Integrate care

The DoH (2004b) lists components of chronic disease management that can be applied to diabetes care (*Table 5*).

1. Information technology – Data will be collected on the total practice register. Information that is not recorded equates with loss of income to practices.

2. Identifying patients – At-risk groups and those with impaired glucose tolerance should be targeted for early detection, e.g. hypertensives, obese, ethnic groups, leg ulcers or frequent infections.

3. Risk – High risk patients will need more intensive management to achieve success, e.g. those with multiple conditions or poor lifestyles.

Table 3. Details of the rationale for indicators (referring to both type 1 and type 2 diabetes), and proposed methods of data collection and monitoring for diabetes mellitus

Indicator	Points	Payment stages
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 body mass index 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_{1c} or equivalent in the previous 15 months	3	25–90%
DM 6: The percentage of patients with diabetes in whom the last HbA_{1c} 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_{1c} 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 reading is 145/85 mmHg 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 angiotensin II 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%

Rationale for inclusion of indicator set

Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of patients with diabetes, particularly those with type 2 diabetes, is undertaken by the general practitioner and members of the primary care team

4. Self-care – Targets cannot be met without the participation of people with diabetes and their carers. Patient-held records facilitate sharing of information and encourage active participation in self-care. People should hold their own information and modern computer systems can be set up to print clinic notes out directly without the need for additional paper records.

5. Coordinator roles will be the key to success.

6. The team approach – Roles must evolve to meet these new systems.

7. Integrating expertise – Team members should identify training needs in their professional development plans and discuss opportunities for joint working.

8. Integrating care – Primary care trusts will need to work with primary care in introducing the 'whole systems' approach to involving health, social care, voluntary bodies and local initiatives in diabetes systems of care.

9. Minimise visits and admissions – Specialists will increasingly be required in

Table 4. Details of the rationale for indicators, and proposed methods of data collection and monitoring in secondary prevention of coronary heart disease (CHD)

Indicator	Points	Payment stages
Records		
CHD 1: The practice can produce a register of patients with coronary heart disease	6	
Diagnosis and initial management		
CHD 2: The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment	7	25–90%
Ongoing management		
CHD 3: The percentage of patients with coronary heart disease whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once	7	25–90%
CHD 4: The percentage of patients with coronary heart disease who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	4	25–70%
CHD 5: The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	25–90%
CHD 6: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the last 15 months) is 150/90 mmHg or less	19	25–70%
CHD 7: The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	25–90%
CHD 8: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in last 15 months) is 5 mmol/L or less	16	25–60%
CHD 9: The percentage of patients with coronary heart disease with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	25–90%
CHD 10: The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	7	25–50%
CHD 11: The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor	7	25–70%
CHD 12: The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	25–85%

CHD – Rationale for inclusion of indicator set

CHD is the single commonest cause of premature death in the UK. The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. This indicator set focuses on the management of patients with established CHD consistent with clinical priorities in the four nations

PAGE POINTS

1 Increasing numbers of people with diabetes, especially type 2, are managed in primary care and most will at some point in their lives have other linked conditions or complications.

2 By initiating a team approach and new ways of working involving the person with diabetes it is possible to achieve targets and quality of life for patients simultaneously.

the community to work with patients, health professionals and allied bodies 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 number 9 (minimising visits and admissions), with patient-centred care becoming the norm.

Summary

Increasing numbers of people with diabetes, especially type 2, are managed in primary care. Most of these will, at some point in their lives, have other linked conditions or complications. Primary care needs to consider how it is going to tackle this increase in workload while still providing high quality care. By initiating a team approach and new ways of working involving the person with diabetes it is possible to achieve targets and quality of life for patients simultaneously. ■

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Table 5. Components that make for good chronic disease management (DoH, 2004b)

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
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