The 2013/14 General Medical Services contract: Implications for diabetes and obesity care

Colin Kenny

The General Medical Services (GMS) contract is an agreement between individual general practices and their local primary care organisation, to provide services to patients that are defined as essential, additional or enhanced. The 2013/14 GMS contract, effective from 1 April this year, has been introduced against a background of considerable controversy. In England the Health and Social Care Act is also being implemented, with its emphasis on local commissioning, which may include diabetes services. Here, a brief overview is provided of the changes likely to have most effect on diabetes and obesity care.

For the first time since the Quality and Outcomes Framework (QOF) was introduced on 1 April 2004, the UK government has effectively forced the General Medical Services (GMS) contract on practices, with the General Practice Committee (GPC) of the British Medical Association (BMA) in England refusing to agree this round of contract changes, describing it as an "imposed contract". The GPCs in Northern Ireland, Scotland and Wales have agreed to local versions of the contract, which take local workforce considerations into account. Again, for the first time since its inception, the GMS contract would appear to have significant variations between the four nations of the NHS, although it seems that the QOF clinical indicators (NHS Commissioning Board et al, 2013) are broadly the same throughout the UK.

In the Autumn of 2012, the UK Government set out its proposals to implement the NICE-suggested amendments to the GMS contract from April 2013, making clear its commitment to pursue changes to the GMS and to impose these should it not be possible to reach a satisfactory negotiated agreement. The GPC of the BMA sought to negotiate with the Government, stating that, while many of the proposed contract changes had been suggested by NICE, many of these changes, especially the raised thresholds, would significant impact on the workload of primary care and had the potential to negatively impact on patient care. The GPC surveyed GP members, who were almost universally opposed to the changes (BMA GPC, 2013). In a letter to the Government, Laurence Buckman (GPC Chair) stated that "we believe that the proposals simply ask too much of an already stretched service." It would seem inevitable that this has the potential to impact on the care of people with diabetes.

Below-inflation funding increase for practices

The Department of Health (DH) recently announced that it would increase GMS funding by 1.32% in 2013/14 in England (1.5% in Northern Ireland), despite advice from the independent Doctors and Dentists Review Body that general practice should be awarded a 2.29% rise (BMA, 2013a). In keeping with this large overhaul of QOF, the majority of organisational indicators, worth around £20 000 per practice, will be removed (DH, 2013). Practices in England will still be expected to carry out the work covered by these "retired" indicators as part of clinical governance, but will now be expected to fulfil four new enhanced services to earn back the equivalent sum that they brought to the practice.

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Article points

1. The General Medical Services (GMS) contract is an agreement between individual general practices and their local primary care organisation, to provide services to patients that are defined as essential, additional or enhanced.
2. The 2013/14 GMS contract, effective from 1 April this year, has been introduced against a background of considerable controversy.
3. The clinical indicators for diabetes in the updated Quality and Outcomes Framework include new and modified items. In addition, some indicators have been retired.

Key words

- Clinical indicators
- General Medical Services
- Quality and Outcomes Framework

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The other three nations have adopted variations of this.

These enhanced services will cover:

- A more proactive approach to people who may have dementia, including family support.
- Improving care management for seriously ill patients or people at risk of unplanned hospital admission, such as frail older individuals.
- Ensuring individuals can book appointments and order repeat prescriptions online.
- Arranging remote monitoring for people with long-term conditions.

In the next section, changes to obesity- and diabetes-specific clinical indicators are considered.

Changes to obesity-specific clinical indicators

The single clinical indicator for obesity, which is listed under the public health domain, remains broadly as it was in the previous iteration of QOF, with the exception that the time-period has been reduced from 15 months to 12 months:

1 OB001 – The contractor must establish and maintain a register of patients aged 16 or over with a BMI ≥30 kg/m^2 in the preceding 12 months.

Changes to diabetes-specific clinical indicators

Modified diabetes indicator

One diabetes indicator has been modified:

1 DM001 – A register of people with diabetes must be established and maintained for all patients aged 17 years or over with the condition. As before, where a diagnosis has been confirmed, this must be clarified between type 1 and type 2.

New diabetes indicators

Four new diabetes indicators have been introduced into QOF (excerpts from the rationales given are provided in *Table 1*):

1 DM013 – The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the preceding 12 months.
2 DM014 – The percentage of patients newly diagnosed with diabetes in the preceding period between 1 April and 31 March who have a record of being referred to a structured education programme within 9 months of entry on to the diabetes register.
3 DM015 – The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 12 months.
4 DM016 – The percentage of male patients with diabetes with a record of erectile dysfunction who have a record of advice and assessment of contributory factors and treatment options in the preceding 12 months.

Since the publication of these new indicators, there has been much debate between my colleagues and in broader circles on the interpretation of the term "suitably competent professional" for the dietary review item, DM013. On face value, it might appear that, should practices not deem their staffing structure to be "suitably competent", the burden placed on outside dietetics services could be potentially massive. Indeed, there might not

Table 1. Excerpts from the rationale provided for new clinical indicators for diabetes (NHS Commissioning Board et al, 2013).

DM013 (dietary review record) – Read code 66At	**DM015** (questioning on ED in males) – Read code 66Av
"For people with diabetes, an understanding of their condition, an informed choice of management opportunities, and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. This includes the provision of good dietary advice and nutritional information to help people manage their diabetes."	"In the Massachusetts Male Aging Study 113, the age-adjusted probability of complete ED was three times greater in men with type 2 diabetes than in those without. ED is a traumatic complication for some men with diabetes. Although a benign disorder that is not perceived as life-threatening, it can have a significant impact on the quality of life for men with diabetes, their partners and families."
DM014 (structured education referral [newly diagnosed]) – Read code 8Hj0	**DM016** (advice for and assessment of ED, where recorded) – Read code 67IA
"Diabetes is a progressive long-term medical condition that is predominantly managed by the person with the diabetes and/or their carer as part of their daily life. Accordingly, understanding of diabetes, informed choice of management options and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. These needs are not always fulfilled by conventional clinical consultations."	"NICE recommends that men with ED are offered an assessment of contributory factors and a discussion of treatment options if applicable. Risk factors for ED include sedentary lifestyle, obesity, smoking, hypercholesterol[a]emia and metabolic syndrome. The guideline also recommends that men who need treatment could be offered phosphodiesterase type 5 (PDE-5) inhibitors, which can be prescribed on the NHS for men aged 18 or over with diabetes."

ED=erectile dysfunction.

be enough dietitians in the country to cover the extra demand. Under such circumstances, then, a pragmatic interpretation of this wording may be most sensible.

Retired diabetes indicators

Three diabetes indicators have been retired:

1 The percentage of patients with diabetes with BMI recorded in the preceding 15 months.
2 The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months.
3 The percentage of patients with diabetes who have a record of estimated glomerular filtration rate or serum creatinine testing in the preceding 15 months.

With regard to point 1, and as noted earlier in this article, indicator OB001 remains in place: "The contractor must establish and maintain a register of patients aged 16 or over with a BMI ≥30 kg/m^2 in the preceding 12 months." However, since the retired diabetes indicator covered the recording of *all* BMIs, it might appear that its removal leaves a gap where insufficient attention is paid to the issue of elevated BMIs approaching 30 kg/m^2 in people with type 2 diabetes. On the flip side, though, the amount of clinical benefit there may be from simply maintaining a register – compared with action-based indicators – has been questioned. Balancing these factors, then, there may well not be substantial consequences of its retirement.

Finally, the points released by retiring these indicators have been used in other ways.

Rise in thresholds and reduced periods for diabetes review

Most QOF indicators reward practices according to the proportion of eligible patients who benefit from the indicator and have upper and lower payment thresholds based on percentages of patients. Practices do not earn points until they exceed the lower threshold. All the threshold ranges for the new diabetes indicators are set at 40–90%. The DH judged that national average achievement is currently above the upper thresholds for all indicators, suggesting that there was no incentive for practices to improve the range of their diabetes care. The DH proposes, therefore, that the evidence of what is practically achievable should be based on the latest data available on achievement of the 75th centile of practices. The DH has also removed overlapping time-periods from most indicators' measuring processes or intermediate targets, by reducing these periods from 15 to 12 months or from 27 to 24 months. Practices should be aware that there are variations among the four nations in how these thresholds and time periods have been agreed and are advised to seek guidance from their local primary care organisations.

Conclusion

There is much for practices actively managing people with diabetes and obesity to consider for this new QOF year. Practices will want to recognise that this latest round of changes to QOF is the biggest upheaval in its 9 years. There are new diabetes risk indicators. Thresholds for payment and overall timings are reduced from 15 to 12 months. In spite of a representative survey of BMA members pointing out many flaws, and very reasoned arguments by the GPC of possible patient harm, the DH is pressing ahead with changes that will have a considerable impact on practice workload, as well as significantly impacting on the lives of people with diabetes and obesity. ■

"Practices will want to recognise that this latest round of changes to the Quality and Outcomes Framework is the biggest upheaval in its 9 years."

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