A decade of the nGMS contract: Has it delivered for people with diabetes?

Colin Kenny
GP in Dromore, County Down, Northern Ireland

Around the start of the new millennium, GPs in the UK were becoming disillusioned (Huby et al, 2002). They saw that, increasingly, the focus of managing the rising burden of many chronic conditions, including diabetes, was shifting from secondary care to primary care. Resources were not following this, and practices were looking at static or falling incomes, a situation which threatened to become unsustainable.

GPs then participated in two ballots. The first ballot, in 2001, asked GP Principals to consider submitting an undated resignation, unless significant and acceptable changes were negotiated to the existing General Medical Services (GMS) contract (British Medical Association [BMA], 2001). They voted "yes" to this, and in so doing underpinned GPs' commitment to an NHS that was free at the point of contact. The BMA then entered into negotiations with the NHS Confederation on behalf of the Department of Health (DH), and by 2003 the new GMS (nGMS) contract had emerged. Almost 80% of GPs voted "yes" to this contract in a June 2003 ballot, and practices entered a preparatory phase of 9 months before the contract came into effect on 1 April 2004 (*The Guardian*, 2003).

Thus arrived into practices a thick, sky-blue A4 nGMS contract book, which rewarded careful reading about the Quality and Outcomes Framework (QOF), its details and the points to be allocated. This contract was innovative. Approximately one-third of practice income would come from payment for performance (P4P) across a range of evidence-based interventions. Ten common chronic conditions were selected. Diabetes accounted for 10% of the contract overall (18 clinical indicators), with additional resources for addressing important risk factors associated with the condition, including hypertension and cardiovascular risk (Kenny, 2005b).

A decade on from the upheaval of the nGMS contract, I ask: Has it altered the focus of diabetes care in the UK? And has it helped people with the condition?

Immediate outcomes

Preceding the nGMS contract, the four nations of the NHS had developed four National Service Frameworks (NSFs) for diabetes (Kenny, 2005b). These had placed an emphasis on patient-centred care and the development of a therapeutic relationship. The nGMS contract moved away from these NSFs and towards a more biomedical model of care, focusing on easily quantifiable targets. To facilitate these processes, primary care organisations invested considerable funds in information technology. These organisations had ownership of the computer hardware, but no direct control over the databases, and so to meet the looming challenge of QOF targets, many practices invested their income in staff and resources. A computerised template guiding patient encounters, examinations and interventions, and used by both practice nurses and GPs, thus emerged as being vital to the process of the chronic disease management of diabetes.

The negotiators of the contract were pragmatists who knew their GPs well, and it is important to remember that it did not arrive into a sterile or ill-prepared GP environment. Subsequent analysis has shown that primary care diabetes was improving before the contract, but that the contract accelerated this improvement and sustained its consistency across the UK (Campbell et al, 2005). One of the aspects of the contract was that it soon provided rich data that, when analysed, showed a rapid initial improvement in primary care diabetes (Kenny, 2005a). There is evidence that smaller practices improved most (Tahrani et al, 2008). In the pages of this Journal, and elsewhere, these data and achievement figures have been reported on (e.g. Khunti et al, 2007; Hilton et al, 2008).

The nGMS contract brought considerable funding into primary care. The Labour government in power at the time pledged £1 billion annually. There were differences in achievements between the four nations of the NHS initially (Kenny, 2005b), and these have persisted but are now less marked. The cost of the QOF scheme did, however, prove a great deal higher

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By the Editorial author

"England set the scene for contract negotiations when a deal was reached in November 2013. The agreement sees the removal of 341 points from QOF, and with it a reduction in the amount of so-called 'box ticking' in general practice. Diabetes-specific clinical indicators retired include albumin:creatinine testing, retinal screening and erectile dysfunction; 238 points will be transferred to core funding and another 103 to enhanced services. In effect, these alterations reverse most of the changes imposed in 2013–14."

On 1 April 2014, changes to the nGMS contract for the year 2014–15 came into effect

There are differences between the four nations of the UK, and a perspective on each nation is provided in sidebars to this editorial

For further details on changes to indicators and achievement thresholds in your nation, please refer to the documentation with which your practice should have now been issued

than had been expected. The DH had estimated that GP practices would achieve an average of 75% of the maximum "points" available under QOF in its first year. In fact, in that inaugural year, practices achieved 91.3% (and this rose to 96.8% by 2007–8; DH, 2008).

In short, GPs delivered more than was anticipated, and the scheme was therefore more expensive to run. It is worth observing, though, that primary care-based interventions are cost-effective – countries with strong primary care systems have lower healthcare costs and healthier populations (Starfield, 2001).

"Negotiations between the Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland General Practitioners Committee have concluded with an agreement for the 2014–15 nGMS contract. As was the case last year, we see evidence of the regional variation in the agreements reached, with what seems like a more equitable deal for GPs in Northern Ireland.

The good news for general practice in Northern Ireland is that there will be no new indicators introduced this year. The deal sees the recycling of 263 QOF points into core funding and the retention of the minimum practice income guarantee. The agreement will increase the value of QOF so that practices will receive an additional £1 million funding and be awarded a total uplift of 1% for pay and expenses (http://bit.ly/1hrW0Dh [accessed 09.04.13]). Although the DHSSPS follows NICE advice, this year's agreement sees NICE recommendations rejected in relation to QOF.

The lower threshold for 13 QOF indicators also increases by 20%. Thirty indicators are being removed across all areas, and we see retinal screening and dietary review disappear from the diabetes domain. Previously, two separate indicators covered erectile dysfunction, and these are now to be combined into one. There are some points reductions, threshold increases and timeframe changes in the mix of the new deal.

Northern Ireland's 'Transforming Your Care' NHS reform plans cover several clinical priority areas, which includes diabetes. The five local commissioning groups have progressed plans to map out the current diabetes pathway and aim to plug the gaps in, and overcome the obstacles to, good care provision. By planned reform we seek to improve the outcomes for the population with regard to diabetes, including prevention."

Nigel Campbell
GP, Lisburn, and Chair of the South Eastern Local Commissioning Group

Long-term outcomes

Impressive initial achievement levels are described above, but were they sustained?

Part of the problem with analysing the nGMS contract P4P scheme is that there is not a comparator, as the contract was almost universally adopted. Nor was this depth of data recorded before the contract started. It could be argued that other similar European nations offer comparisons, but they do not have the sophisticated data extraction that became available in the UK with the nGMS contract. A second problem is that the contract was not set in stone. QOF initially set out a lower and upper threshold for each indicator. All lower thresholds were set at 25%, and upper thresholds were set somewhere between 50% and 90%, depending on the estimated difficulty of achieving individual indicators (Kenny, 2004).

There was a sense, however, that the effect of incentives was wearing off and that performance had plateaued. Following good achievements, these thresholds were raised in 2006–07. For diabetes, the minimum thresholds were raised to 40% and upper thresholds were raised to 90%, with a few exceptions (NHS Employers and General Practice Committee, 2006). The contract then stayed unchanged until 2009, when NICE took over the annual QOF review process. In this edition of the Journal, Professor David Haslam (Chair of NICE), celebrates 15 years of the organisation and examines its current priorities regarding diabetes.

The most recent contract changes (NHS Employers, 2014) include reallocation of a quarter of QOF funding to core capitation payments and reduction in the share of remuneration linked to quality measures. Other items in the pages of this edition indicate that the need for ongoing contractual review persists into 2014–15, with arguments presented for inclusion among QOF indicators of gestational diabetes (in a piece on page 60) and preconception counselling (in an article starting on page 70).

Running parallel to the QOF review process have been the national (England and Wales) diabetes audits, and a similar process in Scotland. These audits have confirmed high achievement levels in

Richard Quigley

GP, Glasgow, and Treasurer of the Primary Care Diabetes Society

"The continuing disenchantment with operational QOF, one decade in, is as acute in Scotland as elsewhere in the UK. The Scottish General Practitioners Committee (SGPC) continues to engage in the helpful dialogue with Holyrood, spawned by the distant observation of an imposed contract for our English colleagues in 2013.

SGPC also faces a more local and, perhaps, more pressing challenge from Scotland's largest health board, who have offered GPs in Greater Glasgow and Clyde an administration-light 17c contract. On the face of it, this wipes out, at a stroke, almost the entire administrative burden of QOF.

For the first time, SGPC is negotiating exclusively with Holyrood, sporting a rolling ambition of reducing QOF complexity and securing a medium-term stability period featuring no changes year on year.

However, distant rumblings of 'bundled targets' for the following year, with the re-appearance of recently retired targets, are looking distinctly spanner-shaped and should give us all pause for thought."

diabetes care in these nations (Gadsby, 2013). It could be argued that elements such as diabetes prevention and more aggressive lipid control could be included in QOF, but this has not happened yet.

People with diabetes

It is unfortunate that people with diabetes have not been engaged more actively in consultations on the QOF domain for the condition. Individuals with diabetes living through these changes will have seen their experience of care delivery change. Primary care teams are now central to the process. From diagnosis, through initial referrals for education, to organising podiatry, retinal screening and influenza immunisation, primary care teams orchestrate care delivery. They initiate most of the antidiabetes drug regimens and complex cardiovascular risk reduction initiatives, as well as issuing smoking cessation advice. They use other encounters to populate templates and perform medicines reviews. All this activity has been reinforced by the nGMS contract and can only be of benefit to people with diabetes, even if softer and less easily quantifiable interventions are taken for granted. Assessors have found very little evidence of "gaming" of the system on the part of general practitioners (Doran et al, 2014), although the ethics of P4P schemes has also been critically appraised, emphasising the need for a patient-centred focus (Snyder et al, 2007).

The future is already here

William Gibson is famous for saying: "The future is already here – it's just not very evenly distributed." Back in the early 2000s, innovative GPs knew what was needed to achieve high-quality diabetes care. What the nGMS contract did was to provide a catalyst for change that saw high-quality models of diabetes care become more widely distributed. The utility of audit, the use of IT templates and the empowering of the primary care team were key elements, as was engaging actively with patients and encouraging compliance with complex therapies. Analysts have argued that P4P is not a magic bullet, but simply a useful tool in the armoury of addressing the burgeoning task that all national governments face in managing chronic conditions in general, and diabetes in particular (Roland, 2012). Also relevant is a recent activity survey, which has not really shown an improvement in GP morale (BMA, 2014).

Of course, incentives will change along with the nature of primary care, and, interestingly, there is some evidence that other countries may be adopting a P4P approach (Roland and Nolte, 2014).

The four nations of the NHS may evolve separately, but the model of primary care diabetes devised by the nGMS contract should endure for the overall benefit of people with diabetes. ■

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Pam Brown

GP, Swansea, and Welsh Representative of the Primary Care Diabetes Society

"In Wales, a major reorganisation to funding of general practice sees 344 QOF points removed, with the funding for 300 points ploughed back into the global sum. A new local development domain has been created worth 160 points, using 116 points from the existing Quality and Productivity element of QOF in Wales, and 44 points from other indicators. For this new domain, practices will work in clusters to develop and take part in schemes promoting early cancer detection and end-of-life and elderly care, with 30 points allocated to completion of the Clinical Governance Practice Self Assessment Tool. In the diabetes domain, those indicators which are embedded in practice are removed or their associated points decreased. Overall, this equates to a loss of 41 points across the diabetes domain compared with 2013–14.

The Diabetes Directed Enhanced Service will be reviewed to ensure that it incentivises quality care, including control of blood pressure, cholesterol and HbA_{1c}, and referral to structured education for newly diagnosed individuals. Three national priorities have been agreed for the Locality Development Service Programme, and clusters will decide how to address them: significant event audit and review of people with lung and gastrointestinal cancer; after-death analyses using a template; and medication reviews in people over 85 taking fewer than seven medications, aiming to reduce unscheduled admissions and falls.

Weekend working, the 'named GP' concept and care data have not been negotiated in Wales."