*Eugene Hughes*

# The new GMS contract: could do better…

Well, here we are in July, three months into the new GMS contract. After all the initial fuss, the articles, and the practice meetings, we are all collecting the necessary data and smugly counting our points. Hurrah for the Quality and Outcomes Framework (QOF)!

Except it has nothing to do with quality. Or outcomes.

Lest we forget, the mind-numbing, READ-code-obsessed, number-crunching exercise we have all (well, nearly all) signed up to is about data collection. It is a system of payments, and a pretty crude system at that.

If it were about quality, it would use an evidence base that could support it. If it were about outcomes, it would relate to existing outcomes, and the interventions that underpinned them.

## $HbA_{1c}$

Let's take $HbA_{1c}$ as an example: where does the 7.4% figure come from? The generally accepted guideline is that 6.5% or less represents 'good' control, 7.0% is 'acceptable' and over 7.5% is 'poor'.

## Blood pressure

Even before the recent British Hypertension Society guidelines came out, 140/80 mmHg was the figure suggested by the experts. Now, it seems that for most people with diabetes, 130/80 mmHg should be the target, whereas the GMS contract suggests a target of 145/85 mmHg.

## Cholesterol

The Heart Protection Study (HPS), and more recently, the Collaborative Atorvastatin Diabetes Study (CARDS; announced at the ADA, but not yet published), would seem to support the view that all people with diabetes should be on a statin, except pregnant women and those with contraindications. Current estimates suggest that only 50% of those who should be on a cholesterol-lowering agent actually receive a prescription, and of those only 50% are treated to the 'target' cholesterol level of 5 mmol/l.

## A disturbing trend

Alright, I know I'm being picky, and I know that my own results would not stand up to close scrutiny, but it highlights a disturbing trend that has become obvious when I speak to groups of people around the country: namely the acceptance of the GMS 'indicator' levels as 'target'. They are not. They are the absolute bare minimum we should be aiming for. Adopting a mentality that leads to articles such as 'How to get your patients to 7.4%' risks doing a disservice to people with diabetes.

The parameters featured in these indicators are for the points police and the auditors – not for our patients. My concern is that once these barely-acceptable indicator levels are reached, no further efforts will be deemed necessary to improve metabolic control.

The contract, and indeed the QOF, are dynamic concepts – they are subject to change and modification. Although there will be cries of 'Unfair!' if the thresholds are made more difficult, there must be some homage to new evidence. As we scramble to label the 'exception reported', let us not forget that it is just this group who may need the most intensive attention and care, even if they 'earn' us nothing.

Get the points by all means, but let us not forget the real targets. Or the evidence. ■

## Letters

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