Implications of the GMS contract for secondary care

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Introduction

At Worthing Hospital the diabetes team regularly evaluates all working practices for both quality and cost effectiveness. A high priority is given to workforce planning, which includes looking at future trends in epidemiology as well as predicted demands on the diabetes service. It is with this in mind that the diabetes team have investigated the potential impact of the new General Medical Services (GMS) contract on services already provided in secondary care.

Implementation of the new General Medical Services (GMS) contract will begin in April 2004. The extra investment proposed under the new contract signifies the importance the government attaches to primary care services (DoH, 2003). The Department of Health believes that the new contract will see many more patients treated to an improved service by their GP. There are 18 quality targets for diabetes. These targets or quality indicators will be based on the United Kingdom Prospective Diabetes Study (2000), and National Institute of Clinical Excellence and National Service Framework guidelines (2003). Achieving these targets will be a huge undertaking. GP's pay will depend upon the quality of the services they provide. The contract also proposes that the more NHS work GPs do, the higher their rewards will be (DoH, 2003).

Who does the GMS contract cover?

GPs have always been self-employed practitioners who are paid on the basis of the number of patients on their books and who receive extra payments for specific activities, such as vaccinations and maternity care. There are two systems of GP practice operating at present in the UK. Three-quarters of GPs work under the GMS contract, whereas the remaining GPs are employed under the personal medical scheme (PMS). The new contract covers those under the GMS contract but will affect the other GPs particularly in terms of achieving quality targets (*The Guardian*, 2003).

Linking performance and pay

The provision of incentives and rewards to primary care physicians has been shown to improve the quality of care provided to patients. One such example is the Primary Care Clinical Effectiveness (PRICCE) Programme conducted in East Kent in April 1998 (Allen et al, 2003). The intention of the programme was to give practices incentive payments to provide high quality evidence-based care to their practice populations across a number of disease areas simultaneously. PRICCE has served as an unofficial but highly successful pilot for the quality and outcomes framework of the new GMS contract (Allen et al, 2003).

Blackpool primary care trust (PCT) launched a pilot scheme with seven practices in 2000, which provided GPs with incentive payments related to meeting specific diabetes targets on HbA_{1c} and blood pressure. Results from this initiative demonstrated a 59% increase in patients with an HbA_{1c} of 7 or less, and an 18% increase in those

ARTICLE POINTS

1 Implementation of the new GMS contract will begin in April 2004.

2 The provision of incentives and rewards to primary care physicians has been shown to improve the quality of care provided to patients.

3 However, fears have been raised that as payment is related to achieving targets an over zealous approach to the use of standards may be used.

4 The new GMS contract could improve quality of care for patients, however, the potential for the increase in demand for secondary care services does not seem to have been considered.

5 Primary and secondary care will need to work collaboratively to consider new ways of working to innovate quality patient centred care.

KEY WORDS

- GMS contract
- GPs
- Quality targets
- Incentive payments
- Diabetes services

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1 GPs and nurses with an interest and experience in management of diabetes may be difficult to find.

2 The proposed implementation of the GMS contract has raised concern that the role of secondary care will be limited to educating and training health professionals in general practice and treating selected groups, such as pregnant women, young children and acute emergencies.

3 Fears have been raised that as payment is related to achieving targets an over zealous approach to the use of standards may be used (Cosgrove et al, 2003).

4 There are also concerns that drug budgets will spiral, fuelled by polypharmacy in aiming to achieve targets amongst patients with chronic diseases

with a blood pressure of 135/80 mmHg or less (Griffiths, 2003).

Identifying gaps in knowledge

With as much as a fifth of GP pay resting on meeting quality targets (Mead 2003), to survive and prosper practices will depend upon teamwork with more people doing increasingly specialised work. However, GPs and nurses with an interest and experience in management of diabetes may be difficult to find.

Indeed, before the Blackpool pilot scheme could begin an in-depth analysis of each pilot practice highlighted a lack of diabetes knowledge and management amongst practice nurses and GPs. In addition, liaison between primary and secondary care was inadequate and diabetes management was inconsistent between practices. Gaps in service provision were identified for dietetic and podiatry intervention. To overcome these issues a series of educational meetings were arranged for GP and practice nurses with the diabetologist and diabetes specialist nurses working in secondary care. A primary care pathway for diabetes was also introduced in partnership with secondary care colleagues, and the pilot was co-ordinated by a specialist practice nurse facilitator (Griffiths, 2003).

Planning services

The proposed implementation of the GMS contract has raised concern that the role of secondary care will be limited to educating and training health professionals in general practice and treating selected groups, such as pregnant women, young children and acute emergencies (Myers, 2003). Secondary care needs to review its current service provision and plan service developments within its resources.

In Worthing, diabetes education for professionals is currently based in secondary care. The existing courses in diabetes may not have sufficient places to cover demands. The extra resources required to provide the continual educational support and to assess competencies against agreed standards need to be considered.

Potential impact of the new contract

Fears have been raised that as payment is related to achieving targets an over zealous approach to the use of standards may be used (Cosgrove et al, 2003). The impact on secondary care could be huge if patients who were not meeting targets were automatically or over-referred to secondary care (Scarpello, 2003). There are also concerns that drug budgets will spiral, fuelled by polypharmacy in aiming to achieve targets amongst patients with chronic diseases (Cosgrove et al, 2003). Non-compliance with oral medication could be exacerbated as more tablets are given to achieve targets. Pharmacists may need to help with patient education and with increasing compliance. This would need to be co-ordinated, with consideration given to resourcing this appropriately.

The quality and outcomes framework in the new GP contract is described as data hungry (Allen et al, 2003). We will need to produce a system for communicating information between primary and secondary care to prevent duplication of tests ordered and treatments prescribed and to improve information sharing. In Worthing, we have some joint trust and PCT appointments in information technology to facilitate this process. The time clinicians spend actually inputting all of the required data and then analysing it should also be noted because all these expenses and the clinician's time will need to be included in business plans.

Worthing diabetes team

In Worthing the diabetes team have all of the skills and expertise required to educate and support GPs and practice nurses in obtaining extra skills that may be required to run their clinics. The hospital team have already embraced

new ways of working and now educate patients with regards to self-management in group sessions and are keen to share knowledge and skills with our primary care colleagues. However, without extra resources this cannot be achieved. The development of a care pathway is an example of collaborative working between primary and secondary care to share knowledge and skills. Extra support generated from the implementation of the new GMS contract would need to be ongoing and would need to be provided on top of services already in place.

Conclusion

The Department of Health believes that the new GMS contract will improve the quality of care for patients, however, the potential for the increase in demand for secondary care services does not seem to have been considered. Secondary care is not able to undertake unresourced service developments, instead primary and secondary care will need to work collaboratively to consider new ways of working to innovate quality patient centred care. ■

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