General Medical Services contract changes for 2013/14: Is there a mismatch between past achievement and future support?

In this edition of the journal we analyse the planned changes to the Quality and Outcomes Framework (QOF) for 2013/14 and reflect on what it will mean for people living with diabetes and the primary care teams who organise their care. It would appear that the UK Government, intent on implementing austerity measures, has decided that the QOF "pay for performance" system is in need of reform. Through the four Departments of Health in the four nations that make up the NHS, an upheaval of the QOF system is being implemented that is the biggest since its inception in 2004.

This year's set of contract changes (NHS Commissioning Board et al, 2013) sees a substantial numbers of indicators replaced, a rise in the thresholds for payment for many indicators, and a re-evaluation of many QOF points. For the first time, considerable differences are emerging between the four nations of the NHS in the ways that the General Medical Services (GMS) contract is being implemented, and views from the different nations are presented alongside this editorial.

The General Practice Committee (GPC) of the British Medical Association (BMA) has been unable to agree with the UK government on its implementation approach, arguing that some of the Government's strategies risk damaging patient care, and have the potential to destabilise practices by under-resourcing them (e.g. BMA, 2013).

A long way in 10 years

Ten years ago, many practices were developing an interest in helping people with diabetes but were woefully under-resourced to deliver high-quality services (Pierce et al, 2000). This was affecting morale at a time when the Department of Health was seeking to implement clear evidence-based guidance on diabetes care (Huby et al, 2002). Primary care was seen as the most cost-effective healthcare sector for investment to achieve positive patient outcomes (Starfield, 2001). In the years following the then new GMS contract, great strides were made in primary diabetes care and primary care organisations invested considerable funds in practice clinical systems.

Although participation in QOF has never been compulsory in the GMS contract, practices soon realised that non-involvement would mean a loss of about one-third of their income (which had been redistributed to fund the QOF), and therefore it was almost universally adopted.

During the years after the implementation of the contract, this journal reported very high achievement levels in the QOF diabetes domain (Kenny, 2005). However, there was a sense that although performance had improved with the QOF incentive scheme, achievement levels appeared to plateau after several years.

When performance in diabetes care was analysed, there was a recognition that in the period leading up to 2004 contract, diabetes care was improving. After 2004, diabetes care showed a significant change that was well above the trend before introduction. However, the evidence was that this accelerated rate of improvement was not maintained after 2005 (Campbell et al, 2009). This led observers of primary care to a debate about the true purpose of QOF – was it just a payment mechanism for general practices or did it have a wider purpose as a quality-improvement tool?

This emerging evidence saw the Department of Health seek to overhaul QOF in 2009, by attempting to re-focus the scheme on patient outcomes rather than process-based targets. NICE then took control of the process of developing indicators. A key development for the new approach was the creation of a Primary Care QOF Indicator Advisory Committee. This committee did give individuals and stakeholder organisations a clear opportunity, through consultation, to contribute to

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"This year the Quality and Outcomes Framework (QOF) changes in England have simply been "imposed" after Government broke off negotiations with the British Medical Association. Other nations within the UK have reached slightly differing, but agreed, settlements.

Overall, there is much to be welcomed in this rewriting of the QOF indicators. However, as to how it is being imposed by Government in England, and manipulated to minimise the payments which will come from it, you don't need my opinion in addition to your own."

For a fuller reflection by Martin Hadley-Brown on this topic, see **page 66**.

the development of indicators (NICE, 2009). The committee of the Primary Care Diabetes Society contributed to this process. Ultimately, it has led to radical modifications to QOF being implemented in this year's contract change.

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

"A devolved healthcare administration across the four nations has led to variation in the General Medical Services (GMS) agreements reached. In Northern Ireland the negotiations went right to the wire, with the detail of the agreement still being studied. The retention of "minimum practice income guarantee" and 1.5% uplift in GMS funding are headline figures. GP negotiators feel that a fair deal has been reached.

At stake is the delivery of Transforming Your Care (TYC) – the biggest reform of Northern Irish healthcare provision in a generation. GPs and all others in primary care are needed now for the implementation of TYC to begin, and not just their goodwill. TYC requires that resources shift from secondary care to primary care with a much lower reliance on hospitals and much more care being delivered to people at home or close to them in a primary care setting. Primary care will need more facilities, an expanded workforce and a greater ability to work collectively if TYC is to succeed.

The term "shift left" captures the essence of TYC, even if some hate the phrase. Considering diabetes care, this works at two levels: firstly, we need to expand our capacity to care for many more people with diabetes in primary care and reserve the use of secondary care for those with complications; secondly, we need to intervene earlier in the pathway of diabetes, with greater emphasis on prevention, early diagnosis and aggressive treatment to prevent the long-term complications, which are costly and where too much of our activity is based at present. The challenge is great but can be met if we channel our efforts appropriately."

Fragmentation of the UK-wide GP contract

In the late 1990s, each of the four nations published individual diabetes National Service Frameworks (NSFs) and this seemed to signal the beginning of a fragmentation of the NHS's approach to diabetes care. In contrast, the negotiators insisted that the 2004 GMS would be the same throughout the four nations in the NHS, and, following the widespread uptake of QOF, people with diabetes received a uniform set of indicators throughout the UK.

In this round of the GMS contract update, negotiations in each of the four nations have taken different approaches. The Department of Health in England asked for considerable QOF changes, including removal of the organisational indicators. This is against a background of a minimal 1% pay rise for practices. North of the border, there has been more agreement on the GP contract with the Scottish GPC. Wales has also agreed a deal through the Welsh GPC. Finally, in Northern Ireland the GPC practised some brinkmanship but has eventually agreed the contract changes.

Tellingly, a BMA survey of GPs has reported an expectation of an increase in workload, on the back of these contract changes, to an unmanageable level that is likely to place a significant strain on GPs and practice staff (BMA GPC, 2013).

Targets beyond an evidence base

In the last edition of the journal we reported that UK general practice had some of the highest audited standards of diabetes care in the world (Kenny, 2013). This has not happened by accident. The 2004 contract was an important catalyst for change in diabetes care. In particular, the additional resources funded by QOF payments, and the considerable investment in information technology and staff development required, led practices to reassess their approach and increase their standards of diabetes care. Data extracted from practice clinical systems have allowed us to understand patterns in diabetes care throughout the UK. Practices became responsible for auditing their diabetes

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"In a move described as a "substantial amelioration" of the Quality and Outcomes Framework (QOF), the Scottish General Practice Committee (SGPC) and Scottish Government have reached a bipartisan settlement with substantial variation from the imposed arrangements in England. In a surprising but highly welcome manoeuvre, the Scottish Government approached the SGPC with an offer of talks following the breakdown of negotiations south of the border.

The input of primary care has been valued with respect to the utility of proposed changes, patient safety and workload (and stability). Therefore a substantial part of the QOF organisational domain (77 points) has been repositioned into core funding ("global sum"); "minimum practice income guarantee" is left unchallenged and no thresholds, in clinical domains, will breach 90%. Furthermore, many of the "unworkable" patient-centred proposals, highlighted in England, have been quietly dropped. In particular, the new blood pressure indicators surrounding physical activity, General Practice Physical Activity Questionnaire assessments and brief interventions (HYP003, HYP004 and HYP005) will simply not be implemented. Additionally, it has been made clear that no further training with respect to dietary advice for people with diabetes will be necessary (NM28) and that support of practice nurses is key. Exception reporting on structured education referral (NM27) is understood on both sides where the service does not exist. There was some appetite for repatriation of the entire contract, but the SGPC was keen to "tartanise" within the framework of a UK settlement, acknowledging the strengths of a UK-wide negotiating base.

From a Scottish perspective, then, it would seem that we can continue at the diabetes clinic untroubled by some new measures that seem needlessly bureaucratic and potentially harmful to care."

By the Editorial author

"The Wales General Practice Committee (GPC) has negotiated a revised contract similar to in Scotland. The new offer will help to protect GP practice income. The "minimum practice income guarantee" will not now be phased out as it will in England. Under the revised agreement, surgeries will have to match the performance of the top 50% of practices rather than the top 25%. GPs will also keep 59 of the 154.4 Quality and Outcomes Framework (QOF) points for organisational targets. The QOF review indicator will remain at 15 months, rather than dropping to 12, as will be implemented in England. Proposed higher thresholds for hypertension indicators will not be introduced, and money relating to the emergency department indicators in QOF will instead be put into practices' weighted global sum equivalent, as will payments for locum super-annuation. The overall impression is of a deal that takes local GP shortages in Wales into account, supporting practices in more rural parts of Wales."

care, and it would appear that they have striven to maintain high-quality diabetes services, against the background of a considerable rise in diabetes prevalence. It is very disappointing that these remarkable achievement figures, when portrayed in an international context, have not been recognised by successive Governments. It is also regrettable that the current Government is seeking to destabilise this high-quality service for people with diabetes, by undermining the resource that makes it possible, and apparently allowing it to fragment across the four nations, while setting achievement targets that are for the first time are not truly evidence-based. This risks potential patient harm if current planned thresholds are implemented. ■

Further information

Readers seeking further information on this topic are directed to: http://bma.org.uk/practical-support-at-work/contracts/gp-contract-survival-guide (accessed 29.04.13).

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