# Never mind the quality — count the points:
## the effectiveness of the nGMS contract

The Section of General Practice and Primary Care of Glasgow University hosted an afternoon conference with speakers from across the UK addressing issues to emerge from the nGMS contract. Delegates were treated to an interesting and sometimes controversial exchange of ideas.

Graham Watt, from the University of Glasgow, focused on the Scottish dimension, addressing 'Improving Quality — the West of Scotland Context.' With one of the highest rates of poor health and deprivation, staff here were struggling to keep their heads above water. The challenges facing future preventative measures, he argued, were around appropriate targeting, engagement, agreement, support and research, all underpinned by continuing professional development. Overall, the effect on GPs in deprived areas did not appear to be positive, a point later highlighted by Bruce Guthrie.

Martin Roland, director of the National Centre for R&D in Primary Care and expert advisor in the development of the QOF, presented 'Evidence Based Quality Markers', discussing the need and use of exception reporting. Despite initial scepticism that GPs would gather 'points' by overusing exception reporting, analysis of QMAS data suggested that this had not been the case. He highlighted the perverse effect that 48-hour access indicators had produced, resulting in patients being unable to forward book and plan an appointment, an effect which had apparently not been anticipated by the great brains advising Tony Blair, in a television programme during last year's general election.

Laurence Buckman, deputy chairman of the GP Committee and co-chair of the QOF review continued with an incisive and droll presentation on 'Quality in nGMS — present and future'. Although involvement with QOF is voluntary, almost every practice in the UK now contributes. Practices and patients have complied and there has been no evidence of 'cheating the system'. Incomes have improved, an evidence base has been recognised as necessary and a huge industry has evolved around raising quality. Despite all this, we have yet to see if mortality, morbidity, drug costs or intervention costs are reduced. Laurence put a new slant on the QOF by commenting that it was about paying practices for recording what they were doing, rather than doing anything new. Hence, someone who didn't monitor diabetic patients could still be in trouble with the GMC despite the monitoring appearing to be part of the 'voluntary' QOF.

'Meeting the IT Challenge' was presented by Kenneth Harden, clinical director of GPASS, who argued that when benefits to patients are resourced and evidence based, it will be the ease with which records are amended, data collected and analysed, and patient call and recall rigorously implemented, that will ensure success. For those among us who regularly buy airline tickets electronically it seemed this new software was a long time coming. Although it is too early to assess its impact, IT developments are not cheap. The benefits to patients must be tangible, therefore, but the Clinical Scenario Toolbox software developed by GPASS, and similar innovations from other software suppliers, should make it easier for clinicians to enter clinical information and do the right thing. However, those of us with memories going back at least a month will believe it all when we see it. 'Jam tomorrow but the system's down today' seems to be the mission statement of most IT systems providers.

Bruce Guthrie outlined current research on 'Implementing the Quality and Outcomes Framework.' Early data suggest that practices had generally embraced the contract, achieving high average points, partly because they felt they had to 'stay in the game', although there was uncertainty as to the true nature of that 'game'. Although GPs often cast the QOF as 'fair pay for work done' data demonstrate a shift in activity to nurses. However, most activity in general practice is still for non-QOF conditions, with evidence that consultation rates for depression and anxiety have fallen, suggesting this work is being crowded out by other financial incentives. Concluding that the nature of the 'game' was still evolving, with participation shifting from being (theoretically) voluntary to being required; there are worrying indications that important areas of care are not currently financially incentivised. Bruce highlighted the strange but true situation that a large practice with 100 diabetic patients will receive more in QOF payments than a smaller practice with the same number of patients achieving the same targets. Apparently a simple error in the formula but one that seems remarkably unfair to smaller practices.

The final presentation of the day was by Matt Sutton of the Health Economics Research Unit at the University of Aberdeen, who collated data to assess 'The Effect on Patient Care'. There has been much conjecture about how practices might manipulate the system for exception reporting — to be left with just one patient who was perfect in all respects. Although there was a degree of exception reporting, it appeared that practices with good underlying performance were excluding more patients than their less well-organised colleagues. So it appears that gaming is not taking place, possibly because those who know how don't need to. Interestingly, and substantiating Graham Watt's argument, those who gained fewer points generally came from deprived

areas. Clearly, if health inequalities are to be addressed the QOF is at best an imperfect instrument. Unsurprisingly to some, female GPs tended to score higher on organisational points!

The conference concluded with a discussion between delegates and presenters with many varied and often opposing points of view. There was universal agreement that a positive feature of the QOF had been the engagement of almost every practice in the country, with the consequent consolidation of infrastructure and activities to support high quality care. Having established the QOF, the next challenge is to continue to develop its content, reflecting the full range of clinical activity with the potential to contribute to the health improvement of our population. Several delegates suggested that they would return to their practices and use the evidence presented to re-examine and re-focus some of their clinical and organisational procedures. Reflecting on the QOF, however, with the use of exclusions, the effect of deprivation and the development of new indicators (for example, depression), it is perhaps time to plan the next innovation more strategically, based on emerging evidence.

**Sandra McGregor and Malcolm Campbell**

# *Flora medica*
# Richard Lehman

## From the journals, April–May 2006

***New Eng J Med* Vol 354**

**1567** Homocysteine is a tricky blighter: unstable in blood, linked with cardiovascular disease, lowered by several B vitamins — folic acid, pyridoxine and cobalamin. But the big Canadian HOPE 2 trial showed no protective effect from these vitamins in people with vascular disease or diabetes, although they did lower homocysteine.

**1698** 'I'm afraid there's nothing we can do to stop the poor mite vomiting', you say, carefully moving to a safe place and switching on the fan. Oh, but soon there will be. Ondansetron as a melting tablet reduced vomiting in children with gastroenteritis in a big placebo controlled US trial.

**1787** The amount of levothyroxine that people absorb is reduced if they carry *H pylori* or take regular omeprazole.

**1796** More bad news about the antioxidant vitamins C and E: they don't prevent pre-eclampsia in nulliparous women.

**1879** A self-expanding stent is what your patients need in their superficial femoral artery if it blocks, according to a trial comparing these with balloon angioplasty and conventional stenting.

***Lancet* Vol 367**

**1247** A new vaccine against human papilloma viruses 16 and 18 may prevent cervical cancer, even in those not vaccinated. Hurrah for herd immunity.

**1343** Your defective, one-sided view of amblyopia can be cured by a good *Lancet* review, just as the condition itself can by an hour or two of patch wearing a day, or even by a drop of atropine twice a week.

**1399** Marburg virus may no longer spell doom: a new filoviral virus not only prevents it in rhesus monkeys, but works even given after exposure.

**1412** If you want men to get fewer women pregnant, give them more testosterone. Pills, patches and implants switch off male gonadotrophic hormone and cause infertility which is fully reversible within 6 months.

**1503** Comparison with the gold standard of intra-arterial carotid angiography shows that ultrasonography is dependable at finding the occlusions that matter most — those between 70 and 99%.

***JAMA* Vol 295**

**1647** The Women's Health Study shows that unopposed equine oestrogen given to women without a uterus doesn't increase breast cancer but does increase deep vein thrombosis (DVT), slightly.

**1668** More good news about herd immunity: giving babies conjugate pneumococcal vaccine spreads protection even to unvaccinated babies (and vulnerable adults).

**1775** A randomised trial of mercury amalgam fillings versus non-mercury in American children finds no difference in measures of coordination or intelligence 5 years later.

**1824** A systematic review into why women get more migraines — the culprit may simply be oestrogen.

**1901** Shocking news about implantable defibrillators — they are prone to malfunction and this can be fatal.

**2037** If you're over 50 in England, you'll be paying half as much for your health care as the average American, and be quite a lot healthier in almost every way.

**2057** A systematic review of non-hormonal therapies for menopausal flushes confirms what you know: they don't work.

***Arch Intern Med* Vol 166**

**729** Once someone's had a DVT, should they have a 'thrombophilia screen' for Factor V Leiden and prothrombin G20210A? This systematic review suggests no: it doesn't change management.

**743** Fibrates may make a come-back following an analysis of 18 year results from a trial of gemzofibril, showing a marked reduction in events in obese patients with high triglycerides.

**869** If you feed chalk tablets to osteoporotic elderly women, be prepared to find that many don't take them, but that those who do get fewer fractures.

**909** Patients with high blood pressure should have an ECG — not for left ventricular hypertrophy but for a more predictive measure — the adjusted QT interval.

***Ann Intern Med* Vol 144**

**554** More evidence (from Japan) that caffeine prevents diabetes, taken as coffee or green tea.

**625** Laparoscopic adjustable gastric banding proves highly effective at reversing obesity in moderately fat Australians.

**Guest Journals: *Chest* (Vol 129) and *Thorax* (Vol 61)**

Much of general practice is chesty and thoracic, so these are useful journals. *Chest* reminds us (page 1282) that a common cause of death in cardiac patients is pulmonary embolism — how often do we miss it? *Thorax* discusses the evidence for preventing exacerbations of COPD (page 440) and carries a whooshy editorial: Got a match? Home oxygen therapy in current smokers (page 374).

**Plant of the Month: *Magnolia x wieseneri***

The spectacular flowers last a mere night or two, but fill your garden with an unearthly fragrance — plant it if you dare.