

be added to the avoidance by the patient and care givers. We have very recently run a study to explore views of healthcare professionals and patients on end-of-life decisions, and found that both sides were not comfortable in talking about end-of life or even filling in a questionnaire on this topic. This remains as a challenge to overcome.

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Why all GPs should be bothered about Billy

The 2014–2015 QOF overhaul¹ retires three critical cardiometabolic indicators from the severe mental illness (SMI) domain, keeping only blood pressure. Yet cardiovascular disorders, rather than suicide, remain the single biggest contributor to 15–20 years reduced life expectancy. Two decades of cardiometabolic risk prevention has successfully reduced cardiovascular mortality

in the general population but sadly eluded those with SMI.²

Potentially modifiable cardiometabolic risks, often appearing within weeks of commencing antipsychotics, ultimately translate into 1.5–3-fold increased rates of diabetes, obesity, and dyslipidaemia than in the general population. By age 40 years metabolic syndrome becomes four times commoner and about 40% of individuals are biochemically at high risk of diabetes. Furthermore the National Audit of Schizophrenia³ found only 29% of 5091 patients from across England and Wales had cardiometabolic risk adequately assessed in the previous 12 months (weight, smoking status, glucose, lipids, BP). Weight was unrecorded in 43%. Moreover when cardiometabolic complications are discovered, too often these are ignored in clinical practice particularly when compared with patients without mental illness.

Responding to this evidence of inequalities in care, the Lester Positive Cardiometabolic Resource⁴ embraced these to-be-retired QOF measures with the message 'Don't just screen, intervene'. This was endorsed by the RCGP/RCPsych/RCP/RCN/Rethink/Diabetes UK and recommended by NICE (NICE CG 155) and the Schizophrenia Commission. The resource's lead author, the late Professor Helen Lester, key scientific advisor to the QOF until her death this year, challenged us to be 'Bothered about Billy'⁵ in the RCGP James McKenzie Lecture 2012.

QOF aims to universalise good quality care. The challenge is in its translation from checklist to the human being in front of us. Has anyone explained to a real person with SMI or their relatives why these indicators are being removed? Ultimately our responsibility is to First do no harm and provide a service that makes sense. This decision does neither.

We would ask the 2014–2015 GP contract negotiators to join us in being bothered about Billy too.

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Competing interests

David Shiers is a current member of the Guideline Development Group for NICE guidance for adults with psychosis and schizophrenia; David Shiers and Carolyn Chew Graham are members of NCCMH board

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Improving out-of-hours handovers

As a recently qualified academic GP working out-of-hours (OOH) shifts, I read with interest the debate and analysis section of the October *BJGP* dedicated to the problem of OOH service provision. How should urgent primary care be provided? Who are the key players and how should they form an effective OOH team? Dr Drinkwater pointed out the two key areas where patients can actively help in alleviating pressure on OOH services: self-management and information. Dr Greenhow emphasised creating a national quality contract running through all providers to ensure coherent clinical governance. Professor Mason