QOF indicators for PAD: Have the cavalry finally arrived?

There are four words in the NHS lexicon that, when lingered over, project a positive image of a potentially bright future: "Quality and Outcomes Framework" (QOF). The bright and positive light of QOF is now being shone on peripheral arterial disease (PAD).

For too long PAD has been a neglected clinical consideration, under-diagnosed and under-treated (Tomson and Lip, 2005), but the cavalry – of sorts – have finally arrived for the management of PAD in the UK. It is formed of two columns: new NICE clinical guidance (due for publication in August 2012; NICE, 2012); and – arguably more importantly – four new QOF indicators (NHS Employers, 2012). While it will take some years to determine whether these two initiatives will positively impact clinical outcomes, it is encouraging that some real focus and money has finally been invested in primary care-led identification and management of PAD.

Background

Approximately 20% of people in the UK over the age of 60 have some degree of PAD (Fowkes et al, 1991). PAD is a recognised contributor to lower-limb ulceration – and ultimately amputation – and a marker for increased cardiovascular morbidity (Jude et al, 2001); people with PAD have a mortality rate of approximately 30% after 5 years (Halperin, 2002). Diabetes is among the strongest risk factors for PAD, with others including smoking, advanced age, hypertension and hyperlipidaemia (American Diabetes Association, 2003).

Despite this high burden on patients and the health service, PAD has historically had no NHS screening programme or early detection plan, no big charity support and no memorable national media campaign. This is in sharp contrast to its close circulatory cousin coronary heart disease. The work of the Vascular Society (www.vascularsociety.org.uk) and Target PAD (www.targetpad.co.uk) have gone some way to raising the profile of PAD, despite their relatively small sizes in the health charity and campaign group arena; the Vascular Society spends approximately £1 million annually, while the British Heart Foundation and Diabetes UK spend some £290 million and £26 million, respectively (data from the Charity Commission [www.charity-commission.gov.uk]). The relative "invisibility" of PAD has probably contributed to it being under-diagnosed and under-treated, and ultimately translating into poorer outcomes for patients.

QOF and the diabetic lower limb

Two process indicators – DM9 and DM10 – associated with the diabetic lower limb were included in QOF from its inception.

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DM9 related to the percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months, and DM10 to the percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months (NHS Employers, 2003).

Together, DM9 and DM10 created a large-scale interest in the diabetic lower limb in the primary care setting, where previously there had been little. As a result, year-on-year improvements were seen in the percentage of patients in whom these indicators were met: in 2004/5, 78.9% of participating practices achieved full points for DM9, while in 2008/9 the figure rose to 91.2% (The Information Centre, 2010).

In 2011, DM9 was retired and DM29 introduced. DM29 relates to the percentage of people with diabetes with a record of foot examination (including peripheral pulses) and risk classification (NHS Employers, 2011). Although DM9, and subsequently DM29, relate to peripheral pulses, this was as far as QOF took the issue of vascular disease of the lower limb. No incentives were put in place to improve the management of PAD – the very condition that the presence or absence of foot pulses is undertaken to assess.

PAD updates for QOF

It has taken 8 years of lobbying from groups such as Target PAD (www.targetpad.co.uk) to achieve the inclusion of indicators for the management of PAD in QOF. In 2011, six PAD-related indicators were included in the QOF consultation process (NICE, 2011a); four of those six indicators survived the process and have been included in the 2012/13 QOF (NHS Employers, 2012; *Table 1*).

These long-fought-for additions mean that general practices will be paid to establish a registry of patients with PAD, and for having 40% or more of those people receiving anti-platelet therapy, and for demonstrating that 40% or more have blood pressure and total cholesterol measurements below stated cut-offs. A threshold of only 40% for these indicators may appear low, but it has been deemed a reasonable starting point for a historically neglected condition. Over time, as better diagnosis and management of PAD become the norm in general practice, these thresholds will be reviewed and, in theory, increased.

Interestingly, one of the two proposed PAD indicators that failed the QOF consultation process related to confirming the diagnosis of PAD by ankle–brachial pressure index or referral for specialist assessment (NICE, 2011a).

NICE ID	QOF ID	Indicator 2012/13	Points	Threshold
NM32	PAD1	The practice can produce a register of people with PAD	2	–
NM33	PAD2	The percentage of patients with PAD with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken	2	40–90%
NM34	PAD3	The percentage of patients with PAD in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	2	40–90%
NM35	PAD4	The percentage of patients with PAD in whom the last measured total cholesterol (measured in preceding 15 months) is 5.0 mmol/L or less	3	40–90%

Table 1. Quality and Outcomes Framework (QOF) indicators for 2012/13† for peripheral arterial disease (PAD).

†NHS Employers, 2012.

Thus, points will be awarded for putting patients on a PAD registry but, looking at the small print (NICE, 2011b), PAD only has to be suspected for the patient to be included and diagnostic confirmation by clinical assessment or ankle–brachial pressure index is not required.

It remains to be seen how these PAD QOF indicators will work in practice. NICE estimates that these additions to QOF will cost the NHS £4 million per year to implement, with the cost off-set being long-term savings related to "serious vascular events" (NICE, 2011b).

Conclusion

The first QOF indicators for diabetic foot screening greatly helped in raising the profile of the diabetic foot in general practice, but were not linked to meaningful outcome measurements. In 2012, we need to ensure that the new QOF indicators for PAD are more than just a point-scoring activity; the opportunity has arrived for clinicians with an interest in vascular disease and the diabetic foot to collaborate with each other and their colleagues in general practice to ensure the early diagnosis and best management of PAD in our patients.

Ultimately, the inclusion of PAD in QOF should positively impact outcomes around amputation, wound healing and – perhaps far more importantly – cardiovascular morbidity and mortality. Achieving this would really deliver a brighter future for people with PAD and entirely justify the use of those four words – Quality and Outcomes Framework. ■

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