The QOF: Quality outcomes or just framework?

Martin Hadley-Brown

Dr Martin Hadley-Brown is a GP in Thetford, Norfolk. He is a member of the founding steering group of the Primary Care Diabetes Society, and also of the Professional Advisory Council of Diabetes UK.

UK general practice has now had over a year of working under the 2004 version of its General Medical Services (GMS) contract with the Government, popularly known as GMS-2 (also known as the nGMS). As part of the contract, the Quality and Outcomes Framework (QOF; Department of Health [DoH], 2004) set a series of targets across ten clinical domains and a number of organisational ones. The QOF resulted from negotiations under which the Government needed to be able to demonstrate measurable achievement by primary care in return for increased investment. Achievement of QOF targets is linked to a large proportion of practice income, with the potential for rendering non-compliant practices financially unviable. The first review of the QOF and targets is now underway.

The QOF was only the latest in a series of initiatives and guidelines designed to influence the management of diabetes in primary and secondary care; the respected Scottish Intercollegiate Guidelines Network (SIGN) guidelines (SIGN, 2001) were followed by a delayed National Service Framework (NSF) for diabetes care (DoH, 2002) and by a series of publications from the National Institute for Health and Clinical Excellence (NICE). However, the QOF was the only one of these initiatives to carry significant funding and incentives. It also dealt mainly with aspects of diabetes which could at least be influenced by practice teams working with their patients in primary care. Most clinicians broadly supported the main thrust of what we were being asked to achieve, even if not some of the detail and methodology. As a result, practices put an immense effort into delivering high performance. In contrast, the NSF and NICE guidelines may remain largely ignored by practices other than those with specific interests. In the words of the acting chair of the Primary Care Diabetes Society (PCDS), Dr Colin Kenny, this has made GMS-2 and the QOF 'the only show in town' for delivering real improvements in diabetes care for the majority of patients.

However, the QOF is open to broad and significant criticism. Its focus is squarely on process and data collection. At best this can only be a crude measure of our management of patients, still less a measure of any care for or collaboration with them. Many primary care clinicians have complained of their frustration with a perceived emphasis on recording data for the computer rather than providing tailored advice and support for the individual patient sitting alongside them. With diabetes being just one of ten clinical domains included within the current QOF, some have feared for the attention paid to patients whose problems lie elsewhere. Fortunately, I and many others still believe that the professional and human values of UK primary care teams are largely protected against such cynicism.

Reassessing the QOF

So, now comes the first opportunity to modify at least the details, if not the fundamental structure, of the QOF for the year following April 2006. As might be expected, groups aggrieved that their specific topic of interest was not included in the initial QOF are campaigning for an increase in its scope. Patient and consumer groups, including Diabetes UK, are calling for wider and more challenging standards

to increase the service they expect of primary care clinicians. Academics and specialists in secondary care have strong interests too, and all expect to exert their influence.

The extraordinary success of practices in meeting the initial QOF targets has inevitably led some to argue that the standards set must be too low, and that the points should be harder to achieve. Fortunately, there is an agreed mechanism for determining QOF changes. The NHS Confederation requested submissions from any interested parties, asking that each be backed with appropriate evidence for inclusion. The closing date for such submissions was 30 May 2005. Diabetes UK made a full submission, parts of which were supported by the PCDS steering group members who sit on Diabetes UK advisory boards, to extend the challenges of the diabetes domain. Not supported was their suggestion that this could be achieved within the existing points score by reducing the points values of individual targets. Some of the possibilities supported by the PCDS steering group members are discussed below. Altogether, different interest groups have submitted some 60 proposals for changes to the diabetes domain of the QOF alone.

All submissions have now passed to groups of academics and experts for assessment. Those submissions which are supported, on the basis of evidence and effectiveness, will pass back to the DoH and general practice negotiators in late October. Then the process of negotiating the QOF, which we will work to from April 2006, starts. The principles of the QOF state that all indicators must be:

- achievable
- evidence based
- operationally deliverable by each participating practice
- fully resourced.

Another key point to bear in mind is the need to ensure that performance against the indicators can be reliably and simply measured. This explains the concentration on results and processes, rather than qualitative services such as provision of education and support for patients. As yet, robust mechanisms for assessing these within the QOF have not been demonstrated.

As an organisation committed to improving services for people with diabetes, and to supporting those in primary care who provide them, the PCDS supports developments of the QOF in pursuit of the discussed aims. Take a look at some of the steering group comments (see page 56). If you come to our inaugural national conference on 11–12 November (see pages 58–60) you will also have the opportunity to hear one of the senior GP negotiators, Dr Peter Holden of the British Medical Association, talk about the likely future developments in this area. ■

DoH (2002) *National Service Framework for Diabetes*. DoH, London. Alvailable at http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en (accessed 30.06.2005)

Department of Health (DoH, 2004) *Quality and Outcomes Guidance*. DoH, London. Available at http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONTENT_ID=4088692&chk=pPhvrh (accessed 30.06.2005)

SIGN (2001) *Management of Diabetes*. SIGN, Edinburgh. Available at http://www.sign.ac.uk/pdf/sign55.pdf (accessed 30.06.2005)

PCDS QOF recommendations

The deadline for the submission of suggestions for revisions to the new General Medical Services contract's Quality and Outcomes Framework (QOF; Department of Health [DoH], 2004), effective from April 2006, passed on 30 May. Soon afterwards the Primary Care Diabetes Society (PCDS) steering group discussed what actual changes might emerge from the 60 or so suggestions made regarding the diabetes domain. A number of the PCDS steering group had been involved, either individually or as members of Diabetes UK's Professional Advisory Council, in some of the submissions. It is inevitable that there will be pressure from the DoH for the inclusion of new indicators to be included at the expense of existing ones, which have either become standard practice or defunct, rather than bringing additional points and funding. How much of this we see will depend on the effectiveness of General Practice Committee negotiators.

The consensus from the PCDS discussions can be summarised as follows.

- Virtually all primary care practices now have disease registers, and points for possessing them might be moved to a new indicator.
- HbA_{1c} points targets of 10% and 7.4% may have led some to regard 7.4% and below as an optimal achievement. They are of course only payment trigger points; European guidelines suggest 6.5% as the optimal level, whilst American guidelines opt for 7%. Many, including the PCDS, strongly urge the inclusion of an 'improvement indicator' to reflect reductions in an individual's HbA_{1c} level of perhaps 1% over a year. This would emphasise the importance of achieving progress with patients who may still not achieve targets. Indeed, the absolute benefit of a reduction in HbA_{1c} of 1% from a starting point of 12% is significantly greater than that from 8%, yet currently the latter improvement would be rewarded.
- In the presence of multiple and disparate guidelines for optimum blood pressure levels confusion begins to reign. Whilst not supporting the adoption of the complexity of differing targets for type 1 and type 2 diabetes within the QOF, clarification of the difference between payment triggers and true target levels (which are lower) would be welcome.
- Microalbuminuria testing has been a point of contentious debate. Its value in type 2 diabetes is more as an indicator of vascular risk than of renal dysfunction. Since all people with type 2 diabetes should be regarded as having high vascular risk and be managed accordingly, and with angiotensin-converting enzyme inhibitors generally being favoured in the management of hypertension in people with diabetes, it is doubtful that the benefit of this measurement justifies the resources deployed.
- Over the next few years it is likely that routine creatinine measurements will be supplanted by estimation of glomerular filtration rate probably using the patients' age, gender and serum creatinine measurement. Expect to hear more of this, but not to see it altered in the QOF this time. The relevance is the difference in renal function between patients of different age and body habitus with similar absolute creatinine measurements, detectable using the new measure.
- Changes to cholesterol level targets might be expected, either to acknowledge the more accurate reflection of vascular risk by total cholesterol to HDL-cholesterol ratios, or perhaps concentrating on LDL-cholesterol rather than total cholesterol levels. Either way, recommended targets are being significantly reduced and the QOF could be expected to reflect this.

Additional indicators include the following.

- It is a principle of the QOF that, given adequate effort, any indicator should be generally achievable by all participating practices. Whilst we wish to see the universal provision of adequate support and structured education for people with diabetes, it is a role beyond the reach of many practices and perhaps best dealt with at primary care trust or locality level.
- With a growing recognition of the importance and potential benefits of earlier management of people at risk of diabetes we would support the inclusion of indicators encouraging detection and management of impaired glucose tolerance and, given a workable definition, metabolic syndrome.

No doubt speculation will be rife until details of the revised QOF emerge. Predictably, there will be tensions between those who favour pushing practices to and beyond their limits, even 'naming and shaming' those they call 'failures', and those who view the QOF as a means of rewarding aspects of excellence while incentivising all to achieve the best they can. The aim of the PCDS is to push the bounds of excellence in the care we provide to patients, whilst maximising support to all taking on the work. There is much to do. ■

The Primary Care Diabetes Society Steering Group

Department of Health (DoH; 2004) *Quality and Outcomes Guidance*. DoH, London. Available at http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONTENT_ID=4088692&chk=pPhvrh (accessed 28.06.2005)