Will changes to QOF affect diabetes care?

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ACCORD Study Group, Gerstein HC, Miller ME et al (2011) Long-term effects of intensive glucose lowering on cardiovascular outcomes. *N Engl J Med* **364**: 818–28

Currie CJ, Peters JR, Tynan A et al (2010) Survival as a function of HbA1c in people with type 2 diabetes: a retrospective cohort study. *Lancet* **375**: 481–9

Holman RR, Paul SK, Bethel MA et al (2008) 10-year follow-up of intensive glucose control in type 2 diabetes. *N Engl J Med* **359**: 1577–89

NHS Employers (2011) *Changes to QOF 2011/12.* NHS Employers, Leeds. Available at: http://bit.ly/hiit7Q (accessed 14.03.11)

NICE (2009) *Type 2 Diabetes: The Management of Type 2 Diabetes.* NICE, London

NICE (2011) *Quality Standards Programme: Diabetes in Adults.* NICE, London. Available at: http://bit.ly/gocJli (accessed 04.04.11)

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The lowest HbA_{1c} indicator in the QOF has been raised from ≤7% (≤53 mmol/mol) to ≤7.5% (≤58 mmol/mol) (NHS Employers, 2011). The change was due to concerns raised by the increased mortality in the intensively treated group in the ACCORD (Action to Control Cardiovascular Disease in Diabetes; ACCORD Study Group et al, 2011) study, combined with the results of the Currie et al (2010) retrospective cohort study, which showed that mortality rates in those with type 2 diabetes followed a U-shaped curve with the nadir at HbA_{1c} of around 7.5% (58 mmol/mol). However, many primary care teams would argue that this is a retrograde step. Those of us who achieved the more stringent target of 50% of our patients with an HbA_{1c} level of ≤7% (≤53 mmol/mol) would argue that this was achieved safely by careful segmentation of our patient population, focusing on early diagnosis, and tight glycaemic control for those who had had diabetes for a shorter duration and younger people.

The UKPDS (UK Prospective Diabetes Study; Holman et al, 2008) long-term follow-up study demonstrated a beneficial effect on macrovascular outcomes at 10-year follow-up in the group tightly controlled early in the course of their condition, despite no difference in levels of control between the intensive and standard treated groups in the follow-up period after the study ended (the so-called "legacy" effect). It is important to remember that the UKPDS recruited newly diagnosed people and managed them largely as they would be managed in a conventional primary care setting.

In direct contrast, the ACCORD study took a group of people with advanced and poorly controlled type 2 diabetes (with an average HbA_{1c} level of 8.2% [66 mmol/mol]) and attempted to rapidly control hyperglycaemia, aiming for HbA_{1c} levels of <6% (<42 mmol/mol), compared with 7–7.9% (53–63 mmol/mol) in the standard therapy group. This is not a pattern of care usually replicated in the management of diabetes in primary care, where sequential addition of therapies takes place at a slower rate, following NICE (2009) recommendations.

I agree that it is important for NICE to review QOF indicators in all disease areas and modify them in light of emerging evidence. However, I believe that in choosing to update indicator DM23 to provide a target of achieving HbA_{1c} of ≤7.5% (≤58 mmol/mol) in 50% of people with diabetes, they have missed an opportunity to incentivise the implementation of their own guidance on type 1 and type 2 diabetes, and the new diabetes in adults Quality Standards (NICE, 2011), which continue to recommend individualised targets with the 7.5% (58 mmol/mol) target as the upper level rather than the average. I believe NICE has also missed the opportunity to use the evidence to encourage tighter control earlier in the course of type 2 diabetes, where it has been shown to have benefit, thus retaining the ≤7% (≤53 mmol/mol) indicator in this group, with the less stringent ≤7.5% (≤58 mmol/mol) indicator reserved for older people and those with longer diabetes duration.

The new Quality Standards published on 31 March 2011 again highlight the importance of individualisation of glycaemic targets (NICE, 2011). Standard 4 states that: "People with diabetes agree with their health professional a documented personalised HbA_{1c} target, usually between 6.5% and 7.5% (48 and 58 mmol/mol) and receive an ongoing review of treatment to minimise hypoglycaemia".

QOF indicators are just that – indicators of treatment targets. Let's not throw the baby out with the bathwater – many people with diabetes will already have been carefully (and safely) controlled to HbA_{1c} levels between 6.5 and 7% (48 and 53 mmol/mol), and it would seem prudent to maintain this control as long as their condition allows, provided that the levels are achieved without triggering significant hypoglycaemia. I have faith in my primary care colleagues' desire and ability to deliver quality diabetes care, and to safely and appropriately agree individualised targets with their patients. I am therefore confident that this new QOF indicator will make little impact on the high standards of care already being delivered. ■