Is the Quality and Outcomes Framework achievement for diabetes set to fail? An English perspective

Martin Hadley-Brown
GP Partner in Thetford, Norfolk, and Clinical Tutor at Hughes Hall, University of Cambridge

Colin Kenny reviews the diabetes-related changes to the Quality and Outcomes Framework, and their potential implications, in full on **page 73**

You may have been preparing to face your friends again following hard-hitting criticisms of diabetes services by Diabetes UK (2012), the Commons Select Committee (2012) and the National Audit Office (2012). This has come while we have been receiving "huge bonuses" in the form of Quality and Outcomes Framework (QOF) payments for "just doing your jobs", according to at least one national newspaper. My recommendation is as follows: stay out of sight, for next year your QOF achievement will have fallen, your intended 1% pay rise will thus not have been achieved, and there will no doubt be headlines from the same old critics telling us how our clinical performance has dropped even further.

Fortunately, nearly all of the nurses, doctors, healthcare assistants (HCAs) and other clinicians involved in helping people with diabetes will continue to try to perform at their very best. I know that, having met so many during my time with the Primary Care Diabetes Society and more broadly in primary care. We keep trying to do our best, and to better that each year.

Indeed, from the very beginning of QOF, as part of the General Medical Services (GMS) contract in 2004, practices have consistently outperformed the expectations upon which the pricing was originally set. Hence, there have been continual efforts since to tighten the scheme, raise targets, add new indicators and cease payments for work now regarded as "standard practice". In addition, this year the QOF changes in England have simply been "imposed" after the Government broke off negotiations with the British Medical Association. Other nations within the UK have reached slightly differing, but agreed, settlements.

The 2013–14 QOF changes are among the more significant that there have been (NHS Commissioning Board et al, 2013), and to reflect this the whole rule-set has been rewritten rather than simply amended. There are few new indicators, but those which appear stand to make a significant impact. Changes to those relating to diabetes care are reflected on below.

NICE has now taken responsibility for determining QOF indicators. As one would expect, we are now seeing a more cohesive linkage between NICE (and SIGN) guidelines and QOF targets and thresholds. This is welcomed, together with the evidence base which it brings.

Clinical indicators in the diabetes domain

Indicator DM001 (all indicators have been rewritten in the new document with three-digit numbers to differentiate them from previous indicators) requires a register of all people with diabetes over the age of 17, classified by "diabetes type". It has been apparent for some time that classification of diabetes in primary care databases has often been inaccurate, and a very useful report jointly produced by the Royal College of General Practitioners and NHS Diabetes (2011) discussed this in depth and gave practical guidance. The ultimate aim for the Government is to identify separately spending on type 1 and type 2 diabetes. The importance for us is that the two conditions are managed differently in significant respects.

Indicators DM002 and DM003 set blood pressure targets of 150/90 and 140/80 mmHg, the intention being that the lower standard should be the generally applicable one, with 150/90 mmHg being reserved for those who cannot safely achieve it. Undoubtedly the evidence is strong for benefit in trial populations; in real populations, though, this can present tough challenges. In common with a number of other indicators, the achievement thresholds have been raised, in the case of DM002 to 93%. This figure is that previously achieved by only the top 25% of practices, thus "raising the bar" for maximum points.

Indicators DM004 and DM005 refer, respectively, to achieving cholesterol levels below 5 mmol/L and

checking albumin–creatinine ratios (ACRs), and there is little change here. However, I would like to make a personal point. Please perform a dipstick test before sending the (early morning) urine sample for analysis. This will not only detect those with urinary infections, whose ACR results will be inaccurate, but also give an excellent chance of detecting the earliest stages of bladder carcinoma. With postulated links between at least two available oral hypoglycaemic agent classes and bladder carcinoma, this is a test we cannot afford to neglect.

DM006 continues to stress the importance of using angiotensin-converting enzyme (ACE) inhibitors or angiotensin-II receptor antagonists in those with microalbuminuria or proteinuria, but again the threshold targets are raised. This brings up the issue of "exception reporting", to which I shall return.

DM007, DM008 and DM009 refer to the glycaemic targets. While these are unchanged, the necessary achievement targets have been raised dramatically, again to reflect the achievement of the top 25% of practices.

DM010 relates to influenza vaccination, DM011 to the arrangement of retinal screening and DM012 to foot examination, including a stratification of risk relating to circulatory, neuropathic and anatomical abnormalities.

DM013 requires that dietary advice be offered every 12 months, and by a professional compliant with at least "level one competence" as defined in the Diabetes UK competency framework for dietitians (Deakin, 2011). It is doubtful as to whether most practices are currently able to provide the skill or time to offer this service, and I regard it as odd that only 3 points are allocated to this domain. This contrasts to a total of 10 points dedicated to the detection and management of erectile dysfunction, which is dealt with in indicators DM015 and DM016.

Finally, the requirement to offer structured education to all people newly diagnosed with diabetes must be welcomed. This is indicator DM014. Definitions of "structured education" are set out in the GMS contract documents and are rigorous. Areas vary widely as to the provision they already offer for diabetes patient education. An "ad hoc" practice service will not meet this requirement, and so it will generally be necessary that such services are commissioned from a competent provider, often from Clinical Commissioning Group level. Where such a service is unavailable or inadequate, do note that the practice requirement is to "refer to", not to provide, this service. One hopes that, where necessary, practices will press for increased provision of what has to be a cornerstone of diabetes care.

A last word must be reserved for "exception reporting". So far, many practices have virtually ignored exception reporting if they achieve maximal points without it. The fact that patients being "exception reported" are removed from "adjusted practice disease figures" and thus reduce payments is a further deterrent. This is understandable, but probably unhelpful overall. It is entirely appropriate to use this tool to exclude people who, once offered a service or intervention, choose not to avail themselves of it. That may be, for example, by ignoring three invitations or by deciding specifically not to take a statin, ACE inhibitor or other intervention. There will be individuals for whom adverse reactions, contraindications or, indeed, a judgement of benefit against risk make groups of medications inappropriate, and "patient choice" surely still has some relevance. Unfortunately, as it is little used in many cases so far, it is difficult to know just what rate of exception is justifiable. However, with attainment targets now having been raised significantly, practices may face having to be more attentive to this aspect of QOF if they are to avoid unjustified losses of income.

Conclusion

Overall, there is much to be welcomed in this rewriting of QOF indicators. As to how it is being imposed by the Government in England, and manipulated to minimise the payments which will come from it, you don't need my opinion in addition to your own. ■

Commons Select Committee (2012) *The management of adult diabetes services in the NHS*. UK Parliament, London. Available at: http://bit.ly/SwrLKO (accessed 17.04.13)

Deakin T (2011) *An Integrated Career and Competency Framework for Dietitians and Frontline Staff*. Available at: http://www.dmeg.org.uk/Doccuments/Dietetic%20Competency%20Framework%202011.pdf (accessed 17.04.13)

Diabetes UK (2012) *Diabetes UK criticises "lost year" of diabetes healthcare*. Diabetes UK, London. Available at: http://bit.ly/14vfz7U (accessed 17.04.13)

National Audit Office (2012) *The management of adult diabetes services in the NHS*. The Stationery Office, London. Available at: http://www.nao.org.uk/wp-content/uploads/2012/05/121321.pdf (accessed 17.04.13)

NHS Commissioning Board, British Medical Association, NHS Employers (2013) *Quality and Outcomes Framework guidance for GMS contract 2013/14*. NHS, London. Available at: http://bit.ly/Xk1mq1 (accessed 17.04.13)

Royal College of General Practitioners, NHS Diabetes (2011) *Coding, classification and diagnosis of diabetes*. Available at: http://bit.ly/II4u85 (accessed 17.04.13)