The Quality and Outcomes Framework: Where are we now? Where are we going?

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Article points

1. Full tables of Quality and Outcomes Framework (QOF) results for 2004/2005 from general practices in England, Wales, Scotland and Northern Ireland have recently been published.
2. The standard of data achieved makes it an outstanding national and international success.
3. Practices are now consolidating their data and trying to improve their performances against clinical indicators for another annual round.
4. The success of the QOF shows that the UK Government has facilitated an effective intervention in the diabetes population, and although the Framework may be modified, it is unlikely to change substantially.

Keywords

- QOF
- nGMS
- Disease prevalence
- Service redesign

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UK general practice recently witnessed the publication of the first set of results from the Quality and Outcomes Framework (QOF) of the new General Medical Services contract. In this article, Colin Kenny summarises the results and explains how the QOF may develop in the future.

General practitioners (GPs) in the UK were among the first to manage many aspects of diabetes care in their own practices (Wilkes, 1973; Thorn and Russell, 1973). By the new millennium many practices in the UK were providing systematic diabetes care (Pierce et al, 2000; Kenny et al, 2002). This activity in diabetes and other chronic diseases stretched ahead of what practices were being rewarded for and it impacted negatively on morale (Huby et al, 2002).

It is widely believed that the UK Government chose to invest in primary care for a number of reasons:

- to encourage evidence-based interventions
- because primary care is the most cost-effective healthcare sector for investment to achieve positive patient outcomes (Starfield, 2001; Snyder et al, 2003)
- because UK GPs have an excellent record of achieving targets
- because there was an urgent need to improve morale among GPs and their practices
- to reward primary care professionals directly for clinical activity through the new General Medical Services (nGMS) contract.

We now know that, despite initial scepticism (e.g. Shekelle, 2003), the Quality and Outcomes Framework (QOF) of the nGMS contract has been a considerable success across the ten disease categories in general, and also in the 18 clinical indicators specific to diabetes (Health and Social Care Information Centre [HSCIC], 2005a). The standard of the data achieved shows differences between the four nations in the NHS, but is still an outstanding success. Internationally, no other healthcare organisation has achieved comparable audit standards for diabetes care. UK GPs, through their detailed practice diabetes databases, have effectively become diabetes franchisees and have been financially rewarded, while providing a very cost-effective intervention for the NHS.

QOF data: 2004/2005

The QOF was introduced on 1 April 2004 as part of the nGMS contract. Full tables of results for 2004/2005 from practices in England, Wales, Scotland and Northern Ireland have recently been published (HSCIC, 2005a; NHS Wales, 2005; Scottish Health Statistics, 2005; Department of Health, Social Services and Public Safety, 2005; respectively). For England, the results are taken from the Quality Prevalence and Indicator Database (QPID), which in turn draws its data from the national Quality Management Analysis System (QMAS) used to calculate QOF achievement for general practices (HSCIC, 2005b). The published information is based on the period 1 April 2004 to 31 March 2005, and was extracted from the database at the end of June 2005 (HSCIC, 2005b).

Disease prevalence data in a selection of the ten

QOF clinical domains in the four countries are shown in *Table 1*. *Table 2* outlines the total points achieved overall for each country, as well as in the same four QOF clinical domains.

Resources

To facilitate these results, primary care organisations have invested considerable funds in IT. These organisations have ownership of the computer hardware, but no direct control over the databases, and so to achieve these results many practices have invested practice income in staff and resources. Although participation in the QOF was not compulsory in the nGMS contract, practices realised that non-involvement would mean a loss of about one third of their income – perhaps even making practices unviable (Hadley-Brown, 2005). As such, participation rates were very high (HSCIC, 2005b).

Looking ahead

Practices are now consolidating their data and trying to improve their performances against clinical indicators for another annual round. Suggestions for changes to the diabetes and other clinical indicators are being made to inform the contract negotiations beginning this autumn for implementation in 2006/2007 (National Institute for Health and Clinical Excellence, 2005). The success of the QOF shows that the UK Government has facilitated an effective intervention in the diabetes population, and although the QOF may be modified, it is unlikely to change substantially. A new Government white paper on primary care is imminent and may change emphasis and ownership of databases (Carvel, 2005).

Table 1. UK disease prevalence statistics as published in Quality and Outcomes Framework data for 2004/2005.

Disease area	England	Wales	Northern Ireland	Scotland
Coronary heart disease	3.60 %	4.27 %	4.10 %	4.50 %
Stroke and transient ischaemic attack	1.50 %	1.76 %	1.40 %	1.70 %
Hypertension	11.30 %	12.48 %	10.00 %	11.70 %
Diabetes	3.30 %	3.84 %	2.80 %	3.30 %

Based on data submissions in February 2005.

Sources: Health and Social Care Information Centre, 2005a; NHS Wales, 2005; Scottish Health Statistics, 2005; Department of Health, Social Services and Public Safety, 2005.

Uniform interventions

A growing evidence base for diabetes interventions informed the four diabetes National Service Frameworks (NSFs) in the UK (Department of Health, 2001; NHS Scotland, 2002; Welsh Assembly Government, 2002; Diabetes UK

Table 2. Quality and Outcomes Framework points achieved for 2004/2005.

	England	Wales	Northern Ireland	Scotland
Total QOF points achieved (%)	91.3	90.2	94.2	92.5
Average QOF total points achieved per practice	958.7	947.1	989.0	971.3
Diabetes total points achieved (%)	93.2	93.3	95.7	96.0
Coronary heart disease total points achieved (%)	95.3	93.4*	97.0	95.0
Hypertension total points achieved (%)	94.4	93.7	97.9	94.8
Stroke and transient ischaemic attack total points achieved (%)	92.0	91.2	95.9	94.3

**Includes left ventricular dysfunction.*

Sources: Health and Social Care Information Centre, 2005a; NHS Wales, 2005; Scottish Health Statistics, 2005; Department of Health, Social Services and Public Safety, 2005.

Northern Ireland, 2005). There is some evidence for the multifaceted interventions in the nGMS contract (Olivarius et al, 2001; Gaede et al, 2003). However, the softer, patient-focused options in the NSFs were largely ignored by the contract negotiators, who chose mainly pharmaceutical-based interventions, which could be applied in every practice in the UK. The NHS white papers (Secretary of State for Health, 1997; Secretary of State for Scotland, 1997; Secretary of State for Wales, 1998; Department of Health and Social Services, 1999) and subsequent NSFs were presented nationally and seemed to signal a fragmentation of the NHS. In contrast, the negotiators insisted that the nGMS would be the same throughout the four nations in the NHS, and, following the widespread uptake of the QOF, people with diabetes are receiving a uniform set of interventions throughout the UK.

GPs with a special interest in diabetes

Complementing, and running parallel to the nGMS contract has been the concept of GPs with a special interest in diabetes (GPwSIs; DoH, 2003). Primary care trusts have used these practitioners in areas of need, but unlike the almost universal coverage of the QOF, these initiatives have been poorly resourced. Without a model job description or remuneration, these posts are still evolving (Karet, 2005).

Clinical assistants, many of whom are GPs, continue to play an important role in hospital diabetes care. The rewards from the new contract have seen their remuneration fall behind comparable work based in general practice. Ultimately, they may move to work in more intermediate care settings, so as to benefit from the contract as well.

Conclusion

Both types of diabetes represent heterogeneous diseases, which do not respect age, gender or ethnicity and are relentless in their progression. The prevalence of type 2 diabetes is increasing markedly in the UK, and dramatically in other parts of the world with a different population mix. The diabetes clinical indicators in the QOF of the nGMS contract have provided very cost-effective interventions and have partially contained the costs associated with this epidemic.

People with diabetes deserve to be empowered by healthcare professionals to gain mastery of their condition. They should have their cardio–metabolic risk addressed, and they should be able to move, and be tracked, seamlessly between primary, intermediate and secondary care according to their individual needs and the complexity of the complications which inexorably follow this chronic condition. ■

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