

Quality and Outcomes Framework data: Primary and secondary considerations



Colin Kenny

Diabetes prevalence in the UK has risen more quickly than that of any other chronic condition over the past decade and is predicted to rise further by 2010 (International Diabetes Federation, 2005). In 2003, through the new General Medical Services (nGMS) contract, the UK government chose to invest in evidence-based interventions in primary care. Data recently made available show that the Quality and Outcomes Framework (QOF) of this nGMS contract has been a considerable success across the ten disease categories, in general, and the 18 diabetes clinical indicators, specifically (Department of Health, Social Services and Public Safety, 2005; Health and Social Care Information Centre, 2005; NHS Wales, 2005; Scottish Health Statistics, 2005; see *Tables 1 and 2* on page 115).

'The QOF data give the most comprehensive and detailed information on the prevalence, process and quality of care of diabetes across the UK.'
Roger Gadsby, GP, Nuneaton

Although this large investment in primary diabetes care has been welcomed, and has been a catalyst for considerable change, it has left those working in secondary diabetes care

feeling beleaguered (Munro et al, 2005). There has been no similar investment in secondary diabetes care, and intensive micromanagement in hospital trusts has also weakened morale (Lancet, 2005). This has resurrected the debate as to who holds the primacy in diabetes care (Hampton, 1998).

A secondary care elite needs to be nurtured and rewarded to inform decisions, facilitate research and lead nationally. Inpatient diabetes care remains vital, and new diabetes drugs becoming available are complex in their action and may have only secondary care licenses.

'No other country in the world can boast such accurate disease-related information and quality assurance mechanisms.'

Neil Munro, GP, Claygate

Practices participating in the QOF can now show detailed process and outcome audit and have engaged actively with patients through satisfaction questionnaires. They may also soon be subject to league tables. This process has been very educational for primary care teams. In general, secondary care centres do not demonstrate these detailed audit data. If primary care organisations extend commissioning of diabetes care, this may impact on hospital-based diabetes clinics, which will have to show cost effectiveness through comparable data.

Rewarding chronic diabetes care through clinical indicators in the QOF

of the nGMS has proven to be an effective intervention, by shifting costs to

'I want to pay tribute to the work of primary healthcare teams, who have achieved such outstanding QOF results. However, we should not be complacent; greater support is needed for practice teams to improve care even further.'
Mayur Lakhani, Chairman, RCGP

primary care, and may partially contain expenditure associated with this epidemic.

Colin Kenny

Acting Chair, PCDS, and GP, Dromore, County Down

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Primary Care Diabetes Europe Conference

Athens, 10–11 September 2005



Eugene Hughes

Primary Care Diabetes Europe's (PCDE's) 8th International Conference took place on 10–11 September 2005 at the Divani Caravel

Hotel in Athens, Greece.

The keynote lecture on day 1 was given by Christos Lionis (Greece), who gave us a guided tour of Mediterranean countries, highlighting the disturbingly high prevalence of diabetes in each region. He suggested that the so-called 'Mediterranean' diet did not exist, having been largely supplanted by the fat- and glucose-rich fast food culture of more northern European countries.

His message was reinforced by Kamlesh Khunti (UK), who highlighted the need for collaborative research in primary care diabetes across Europe. Drawing on existing research findings, he presented interesting statistics about consultation rates and the ever-worrying fact that, on average, a target level for HbA_{1c} of 7.5% was only achieved in 42.5% of people with diabetes.

Alain Golay (Switzerland) gave a stimulating presentation titled 'From Obesity to Diabetes'. He demonstrated clear financial benefits for surgical management of obesity, suggesting that the cost gain would be as much as €14 000 per patient.

He pointed out that a 5 kg weight reduction halved the risk of developing type 2 diabetes, whereas a 5 kg weight gain doubled the risk. A 10% weight loss is associated with a 30% reduction in diabetes-associated mortality.

Martina Kelly (Ireland) was the poster prize winner at the 2004 PCDE conference. She gave an uplifting presentation about the diabetes interest group that she had established in

her region. A network of interested practices now exists, which is starting to move away from purely audit-based activity towards 'active management' of the condition.

Lena Insulander (Sweden) delivered a thought-provoking presentation on behavioural change and motivational interviewing. She stressed the necessity of determining with the patient the readiness and the perceived benefits of change.

Her message was echoed in the final presentation of the day from Ghislaine Hochberg (France), who focused on empowerment and therapeutic patient education, highlighting the pitfalls of the biomedical model of management.

Day 2 of the conference was dedicated to presentations from the European Association for the Study of Diabetes' newly formed study group on primary care research in diabetology. The day was chaired by Guy Rutten (Netherlands) and the speakers were as follows.

- Xavier Cos (Spain) outlined the work of the growing Spanish Primary Care Research Network.
- Philip Evans (UK) described the mechanism used in developing a questionnaire on the attitudes of GPs to diagnosis and management of impaired glucose tolerance (the PA_TH questionnaire).
- Kees Gorter (the Netherlands) presented some elegant data on the increased risk of infection in people with diabetes.
- Lika Tsutskiridze (Georgia) described the first attempt to use 'metaplans' for the education of medical students in her country.

- Anne Karen Jenum (Norway), who was this year's poster prize winner, described an impressive community intervention project promoting physical activity, which had led to lower cardiovascular risk factors in a low-income urban district.
- Imre Rurik (Hungary) asked if our older patients with diabetes keep to their diet. The answer, perhaps predictably, was 'sometimes'.
- Per Wändell (Sweden) reported on the effects of a higher prevalence of diabetes in the immigrant population of Sweden.
- David Whitford (Ireland) reported on the sustainability of diabetes care in primary care in Ireland.

The future of the new research group looks very promising indeed.

The conference was closed by the new chairman of PCDE, who thanked the outgoing chairman, Neil Munro, for his dedication and achievements over the past 5 years. We now look forward to 2006, where PCDE aims to be present at three separate conferences and to be represented by its own publication.

*Eugene Hughes
Chairman, PCDE, and
GP, Isle of Wight*



Eugene Hughes (left), the new chairman of PCDE, and Neil Munro (right), the outgoing chairman.

Cardiovascular disease in type 2 diabetes



Miles Fisher

The most common cause of morbidity and mortality in people with type 2 diabetes is cardiovascular disease.

Accelerated coronary heart disease, diabetic cardiomyopathy and diabetic autonomic neuropathy contribute to this burden, and the mortality from coronary heart disease is doubled in people with diabetes.

Lipid lowering

Reduction of cardiovascular risk requires a multifactorial intervention, based on the results of several large intervention trials (e.g. Gaede et al, 2003). This should include aggressive lipid lowering with statins, aggressive blood pressure lowering based on inhibition of the renin-angiotensin system, and appropriate use of antiplatelet agents.

There is now convincing evidence that the use of statins is beneficial for primary and secondary prevention in diabetes (Collins et al, 2003; Sever et al, 2003; Colhoun et al, 2004). The exact age at which therapy should be started is not clear. Patients over 40 years of age were included in the studies; it is not clear if statin therapy should be started in younger patients. The possible role of fibrates should become clearer later this year when the Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) study results are published.

Blood pressure lowering

Both ramipril and perindopril have been shown to reduce cardiovascular events separate from a blood pressure-lowering effect (Heart Outcomes Prevention Evaluation Study Investigators, 2000; Fox et al, 2003), and the use of these drugs should

form the cornerstone of the treatment of hypertension in diabetes. Many patients, however, will require multiple agents to reach target blood pressure readings, and diuretics or calcium-channel blockers are a suitable addition. Beta-blockers should be reserved for patients not controlled with these other drugs, or for patients with symptomatic coronary heart disease.

Antiplatelet agents

In a meta-analysis (Antithrombotic Trialists' Collaboration, 2002), aspirin reduced events when used as secondary prevention in diabetes, but the benefit for primary prevention is unproven, and is the subject of a large trial being run through the clinical trials unit in Oxford.

Glycaemia

The control of glycaemia should initially be based on treatment with metformin, but newer drugs may have some advantages. In particular, the recent PROspective pioglitAzone Clinical Trial In macroVascular Events (PROactive) trial demonstrated that pioglitazone 45 mg added to current cardiovascular therapies reduced deaths, myocardial infarctions and strokes in patients with type 2 diabetes and macrovascular disease, as described at the *European Association for the Study of Diabetes 41st Annual Meeting* (see page 154; www.proactive-results.com [accessed 23.09.2005]). The main side effects were oedema and an increase in hospitalisation for heart failure, but this was counterbalanced by a reduction in infarctions and strokes.

The best method of controlling glycaemia following acute myocardial infarction remains uncertain, and the Diabetes Mellitus Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) 2 study has not clarified this issue (Malmberg et al, 2005). The immediate treatment should be with intravenous insulin, and thereafter

treatment should be aimed at obtaining tight control of glycaemia using whatever glucose-lowering treatment is required.

Miles Fisher

Consultant Physician, Glasgow

Dr Fisher will be talking on cardiovascular risk and emerging therapies at the PCDS Conference at The Belfry, Warwickshire, 11–12 November 2005

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