

How changes to the QOF will affect diabetes care

Colin Kenny

Article points

1. Changes to the Quality and Outcomes Framework will come into effect on 1 April 2006.
2. The lower indicator for HbA_{1c} will move from 7.4% to 7.5%.
3. The bottom threshold for payment for most indicators will move from 25% to 40%.
4. New indicators for chronic kidney disease, obesity and depression will be introduced.

Key words

- Quality and Outcomes Framework
- New General Medical Services contract
- Indicators

This journal has charted the importance of the Quality and Outcomes Framework (QOF), as well as recording the considerable success that primary care teams have achieved through it (Kenny, 2005). Subtle regional differences in performance between the four nations in the NHS have also been highlighted (Kenny, 2005). Primary care teams have been able to answer any perceived criticism of the quality of their diabetes care by pointing to the high standard of audited data (Department of Health, Social Services and Public Safety, 2005; Health and Social Care Information Centre, 2005; NHS Wales, 2005; Scottish Health Statistics, 2005). This article outlines the changes introduced to the QOF for 2006/2007 that are relevant to diabetes care (British Medical Association, 2006b).

As primary care teams approach the end of the second year of the Quality and Outcomes Framework (QOF) of the new General Medical Service contract, there is a realisation that the QOF was intended to be a dynamic structure to enable practices to be paid to deliver high-quality care. Reviews were built into the process and were intended to identify clinical indicators that had gained or lost evidence, matters for which the legal status had changed, and items that the NHS no longer wished to purchase (Buckman, 2006).

Part of the impact of the QOF has been to encourage professionals with an interest in diabetes to apply evidence-based medicine. The first QOF (QOF1; Department of Health, 2004) was based almost entirely on evidence or good practice. To ensure that this principle was maintained, the QOF negotiators appointed the University of Birmingham and the Royal College of General Practitioners to act as independent assessors of all the primary care evidence, both old and new. There was a call to submit evidence for review by 30 May 2005. Five hundred and

fourteen submissions were received, across all the clinical indicators, from Government departments, academic institutions, learned societies, patient groups and practices (British Medical Association [BMA], 2006a).

Changes to the diabetes indicators

Primary care teams are currently working to maximise QOF points for the year end (31 March 2006), before turning to the revised QOF (QOF2), which will be assessed at the end of March 2007 (BMA, 2006b; for changes relating to diabetes see *Table 1* for key points and *Table 2* for fuller details; see *Table 3* for a full list of diabetes indicators in QOF2).

From 1 April 2006, the QOF is going to be worth 1000 points. The negotiating parties agreed changes to the QOF, which include several new or revised clinical areas and higher thresholds. One hundred and sixty-six points have been recycled, of which 138 have been allocated to new areas and 28 have been incorporated into existing indicators. The value of each point remains at the levels set out for 2005/2006.

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Table 1. Changes to the Quality and Outcomes Framework for April 2006 to March 2007 that are relevant to diabetes care: Key points.

- Ninety-three, rather than the previous 99, points will be available for diabetes indicators.
- The lower indicator for HbA_{1c} will move from 7.4% to 7.5%.
- The bottom threshold for payment for most indicators will move from 25% to 40%.
- There will be slight changes to the top thresholds for payment.
- New indicators for chronic kidney disease and obesity will be introduced.

Quality Management and Analysis System (QMAS) reports in England, and their equivalents in the other nations, have shown very high achievement rates of indicators in QOF1 (BMA, 2006a), so it has been agreed to raise the payment threshold from 25% to 40% for most indicators in QOF2. Most upper limits have been set at 90% unless evidence suggests that it is unattainable or inappropriate.

Ninety-three points are now available for diabetes (Table 3), down from the previous

99. Eight smoking points from the previous diabetes indicators have been consolidated into a total smoking indicator, rather than awarding the same points across five clinical indicators (diabetes, hypertension, coronary artery disease, chronic obstructive pulmonary disease and smoking) as before. Two new points to augment the HbA_{1c} and hypertension clinical targets have been added, recognising the difficulty in achieving these outcomes. In the case of hypertension, the upper payment threshold has been set slightly higher.

Table 2. Changes to diabetes indicators in the Quality and Outcomes Framework for April 2006 to March 2007.

Previous DM 1	The practice can produce a register of all patients with diabetes mellitus.
New DM 19	The practice can produce a register of <i>all patients aged 17 years and over</i> with diabetes mellitus, <i>which specifies whether the patient has Type 1 or Type 2 diabetes.</i>
Previous DM 6	The percentage of patients with diabetes in whom the last HbA _{1c} is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months.
New DM 20	The percentage of patients with diabetes in whom the last HbA _{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.
Previous DM 8	The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months.
New DM 21	The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months. <i>(The change of number is due to the change of READ code; practices will need to demonstrate that patients have received screening.)</i>
Previous DM 14	The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months.
New DM 22	The percentage of patients with diabetes who have a record of <i>estimated glomerular filtration rate (eGFR)</i> or serum creatinine testing in the previous 15 months.

Table 3. Diabetes indicators for the Quality and Outcomes Framework for April 2006 to March 2007.

Indicator	Points	New payment stages	Former payment stages
<i>Records</i>			
DM 19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes.	6	–	–
<i>Ongoing management</i>			
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months.	3	40–90 %	25–90 %
DM 5. The percentage of diabetic patients who have a record of HbA _{1c} or equivalent in the previous 15 months.	3	40–90 %	25–90 %
DM 20. The percentage of patients with diabetes in whom the last HbA _{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.	17 (1 extra point)	40–50 %	<i>Indicator changed</i>
DM 7. The percentage of patients with diabetes in whom the last HbA _{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.	11	40–90 %	25–85 %
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months.	3	40–90 %	25–90 %
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.	18 (1 extra point)	40–60 %	25–55 %
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria).	3	40–90 %	25–90 %
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months.	3	40–90 %	<i>Indicator changed</i>
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists).	3	40–80 %	25–70 %
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months.	3	40–90 %	25–90 %
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 mmol/l or less.	6	40–70 %	25–60 %
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March.	3	40–85 %	25–85 %
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months.	5	40–90 %	<i>Indicator changed</i>
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months.	3	40–90 %	25–90 %
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months.	3	40–90 %	25–90 %

Disease registers

An important feature of QOF has been the establishment of disease registers. In the case of diabetes, to achieve the same points as before, practices will now have to stratify their patients with diabetes into type 1 and type 2. Accurate READ coding should help with this exercise. In addition, while insulin use is common to the two types, there are several typical differences, which are outlined in *Table 4*. It is worth noting that other clinical areas have seen the points diminish for forming such registers.

HbA_{1c} levels

Primary care teams may be surprised to see that the lower indicator for HbA_{1c} levels has gone from 7.4% to 7.5%, at a time when many organisations are urging a lowering of HbA_{1c} targets to 7.0%. There would appear to be more pragmatism than science here on the part of the negotiators.

The evidence for the lower HbA_{1c} indicator comes from the Diabetes Control and Complications Trial (DCCT), which found few microvascular complications in those with HbA_{1c} below 7.5% in people with type 1 diabetes (DCCT Research Group, 1993). The authors of the National Institute for Health and Clinical Excellence (NICE; formerly the National Institute for Clinical Excellence) guidelines on blood glucose control in type 2 diabetes use this to argue for HbA_{1c} levels below 7.5% in people with type 2 diabetes (NICE, 2002).

eGFR

Based on the rationale that estimated glomerular filtration rate (eGFR) is reported to be a better method than serum creatinine for detecting and monitoring early renal disease – as it takes plasma creatinine, sex, age and weight into consideration – it has been included in diabetes indicator 22. In the long term, eGFR should be easier for people with diabetes to understand because log

transformation is not needed to assess change in renal function.

Exception reporting

There have been no changes to the rules around exception reporting. However, there has been some speculation that primary care organisations may publish exception reporting within practices in a primary care trust.

New indicators relevant to diabetes

The process of deciding on the new areas of work to be introduced in QOF2 involved appraising the submitted evidence and then prioritising their clinical importance in primary care. There were 138 points available for new indicators, which were allocated based on supporting evidence (*Table 5*).

Chronic kidney disease

Diabetes nephropathy is the leading cause of kidney disease in people requiring renal transplant (Gross et al, 2005). In the Western world, type 2 diabetes is the most common condition in people with kidney failure (International Diabetes Federation [IDF], 2006). Primary care teams will recognise that there is considerable overlap between the chronic renal failure registers and their diabetes registers. New indicators for chronic kidney disease are shown in *Table 6*.

Obesity

As with diabetes and chronic kidney disease, there will be considerable overlap between diabetes and obesity. The risk of developing type 2 diabetes increases progressively with the level of obesity (IDF, 2004). Over a 10-year period, relative to people with a BMI <22kg/m², those with a BMI >35kg/m² are up to 80 times more likely to develop the condition. With a BMI >30kg/m², people are up to ten times more likely to get diabetes.

In QOF2, the new 8-point indicator for obesity is:

Page points

1. Changes to the Quality and Outcomes Framework should be carefully scrutinised by primary care teams.
2. They will recognise that there have been subtle but important changes to the indicators for diabetes and other clinical areas.
3. New indicators have been introduced, some of which overlap with the diabetes indicators.

'The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.'

Primary care teams may be relieved that they are not being judged on their abilities to reduce the prevalence of obesity. These registers may prove useful, though, if targeted screening for diabetes is proposed by the National Screening Committee, and eventually this indicator may be revised to include waist-to-hip ratio measurements.

Depression

For some time it has been recognised that there is an increased incidence of depression in people with diabetes, estimated to be between 11 and 15% (Anderson et al, 2001). Several trials have shown that depression can be adequately treated in patients with diabetes and depression (Lustman et al, 1998; Lustman et al, 2000). New indicators for depression are shown in Table 7.

NICE (2004) guidance on depression suggests that 'screening should be undertaken in primary care [...] for depression in high-risk groups' and that 'screening for depression should include the use of at least two questions concerning mood and interest,' such as the following.

- 'During the last month, have you often been bothered by feeling down, depressed or hopeless?'
- 'During the last month, have you often been bothered by having little interest or pleasure in doing things?'

Primary care teams will want to examine the guidance carefully and decide how best to assess their patients with diabetes. A mixed strategy of opportunistic screening and systematic application of questionnaires may well be used. A more difficult judgment will be whether to add an antidepressant to the overall pill burden of patients with diabetes.

Summary

Changes to the QOF should be carefully scrutinised by primary care teams. They will

Table 4. Typical differences between type 1 and type 2 diabetes.

Type 1 diabetes	Type 2 diabetes
Sudden onset	Gradual onset
Recent weight loss	No weight loss
Lower body mass index	Higher body mass index
Ketosis	No ketosis
Autoimmunity	No autoimmunity

recognise that there have been subtle but important changes to the indicators for diabetes and other clinical areas. New indicators have been introduced, some of which overlap with the diabetes indicators.

While there has been quite a lot of speculation about what might be in QOF2, the overall impression seems to be one of relief that most of the diabetes clinical indicators remain the same. With a systematic approach to the indicators, most teams should be optimistic of achieving as high levels as were previously attained. ■

Table 5. How the 138 points available for new QOF indicators have been allocated.

Area	Points
Dementia	20
Depression	33
CKD	27
Atrial fibrillation	30
Obesity	8
Palliative care	6
Mental health	9
Learning disability	4
Records 21	1

CKD, chronic kidney disease. Obesity and learning disability points are for the presence of registers only. Records 21 is the indicator for recording ethnicity.

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‘With a systematic approach to the new Quality and Outcomes Framework indicators, most teams should be optimistic of achieving as high levels as were previously attained.’

Table 6. New chronic kidney disease indicators for the Quality and Outcomes Framework for April 2006 to March 2007.

Indicator	Points	Payment stages
<i>Records</i>		
CKD 1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).	6	–
<i>Initial management</i>		
CKD 2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months.	6	40–90 %
<i>Ongoing management</i>		
CKD 3. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less.	11	40–70 %
CKD 4. The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded).	4	40–80 %

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Table 7. New depression indicators for the Quality and Outcomes Framework for April 2006 to March 2007.

Indicator	Points	Payment stages
<i>Diagnosis and initial management</i>		
DEP 1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions.	8	40–90 %
DEP 2. In those patients with a new diagnosis of depression, recorded between the preceeding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care.	25	40–90 %