Diabetes and the Quality and Outcomes Framework: 2005/06 data

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Article points

1. The reported prevalence of diabetes according to QOF data has increased in the last year.
2. Practices increased QOF points earned by 5% over the previous year.
3. Practices in more affluent areas are achieving more QOF points for diabetes than practices with deprived populations.
4. Results compare favourably with payment by results health systems in the US.

Key words

- QOF
- Prevalence
- Payment by results
- GP practices

Data are now available for the first 2 years of the Quality and Outcomes Framework among GP practices in the UK. In this article, Colin Kenny summarises the changes in the diabetes and cardiovascular disease results during the second year, and considers how the QOF is changing practice.

This journal has consistently highlighted the importance of the Quality and Outcomes Framework (QOF) in moulding the approach that primary care teams in the UK are taking to diabetes care (for example; Kenny, 2004). The initial confusion surrounding the number of complex interventions needed to fulfil the QOF requirements has given way to the realisation that by following this target-driven approach, teams have achieved outstanding success (Kenny, 2005a). This article reports the recently published data on the 2005/06 round of the framework scheme in the UK, outlines improvements and shows how the QOF data is highlighting regional differences in both diabetes care and in locality prevalences of the condition (The Information Centre, 2006a; Department of Health, Social Services and Public Safety, 2006; NHS National Services Scotland, 2006).

As part of a drive towards continuous improvement, the Department of Health has given an undertaking to publish annual QOF data online. This data is freely available and is not password protected. It allows all with an interest in quality care to track locality care and even find out the performance of individual practices (The Information Centre, 2006b). It was agreed that The Information Centre would publish QOF data for 2005/06 using a dataset extracted from the Quality Management and Analysis System at the end of June 2006. This was so that GP practices and primary care trusts (PCTs) could agree QOF achievement in the three-month period after the end of the financial year.

For practices whose 2005/06 QOF achievement was recorded as approved for payment, a validation exercise allowed PCTs to highlight specific local circumstances, and to provide some context for the published QOF achievement figures. For example, some practices provide primary care services to special population groups, such as the homeless, asylum seekers or drug users, and as a result population bias is introduced.

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Prevalence data

The data from the QOF scheme provides comprehensive information on the prevalence of the most common chronic conditions treated in UK general practice. The data is collected from 53 million people registered in UK general practices. Diabetes prevalence and the prevalences of the common conditions associated with cardiovascular risk are presented in *Table 1.*

The prevalence data on diabetes is consistent with the 2004/05 data across the four nations of the UK. It would appear that diabetes is showing the greatest increase in prevalence, with stroke and coronary heart disease relatively stable and a consistent higher prevalence of recording of hypertension. Wales remains the nation with the highest prevalence of diabetes at 4.1% of the population. It is felt that the high Welsh prevalence may reflect social deprivation and an older population. Prevalence is similar in Scotland and England although there are differences in prevalence across England with an apparent North–South divide and variation within London itself. There is a rising but lower prevalence in Northern Ireland, consistent with a lower population of ethnic minorities.

Diabetes achievement data

The achievement data outlined in *Table 2* show a consistent improvement over the 2004/05 data. Practices earned an average of 5% extra in QOF points on the previous year. Primary care teams scored an average of 1011 out of a possible 1050 QOF points (96%) up from 959 points (91%) in 2004/05. This activity is mirrored in diabetes activity, where there were consistent rises in the points achieved. Almost 10% of practices in England achieved maximum points this year compared with 3% in 2004/05.

There is now little doubt that the QOF has resulted in a sharp improvement in the quality of diabetes care. The standard of diabetes care was improving in the UK slowly from the millennium but the 2003 contract has provided an important catalyst for change and improvement. Many PCTs report increased prescribing of diabetes-related agents including anti-hypertensive and cholesterol-lowering drugs. There has also been a sharp improvement in clinical indicators from April 2004/5 when work towards the QOF began (Anon, 2006).

The introduction of more clinical indicators, with more complex targets, have led some commentators to urge caution about an increased improvement in indicators year-on-year. The target revisions introduced in 2006 such as chronic kidney disease, obesity and depression scoring have increased GPs workload, potentially making points harder to achieve. There has been no uplift on the remuneration per point so effectively this will place a potential freeze on practices' earning.

The QOF in context

The impact of the QOF scheme has been tracked by researchers since its initiation. It would appear that larger practices in more affluent areas have benefited more from the scheme. This appears to be reinforcing the inverse-care law for people with diabetes (Gutherie, et al, 2006) – that is the most deprived populations (those in need of most care) in smaller practices have benefited least. Other commentators have postulated

Page points

1. Wales remains the nation with the highest recorded prevalence of diabetes (4.1%).
2. Almost 10% of practices in England achieved all the QOF points.
3. Larger practices in more affluent areas have achieved more QOF points than practices with more deprived populations.

Table 1. UK disease prevalence statistics as published in the Quality and Outcomes Framework for 2004/5 and 2005/6.

Disease area	England		Wales		Northern Ireland		Scotland	
	04/05	05/06	04/05	05/06	04/05	05/06	04/05	05/06
Coronary Heart Disease	3.6	3.6	4.3	4.3	4.1	4.2	4.5	4.5
Stroke	1.5	1.6	1.8	1.9	1.4	1.6	1.7	1.9
Hypertension	11.3	12.0	12.5	13.4	10.0	11.1	11.7	12.4
Diabetes	3.3	3.6	3.8	4.1	2.8	3.1	3.3	3.4

Sources: The Information Centre (2006a); Department of Health, Social Services and Public Safety (2006a); NHS National Services Scotland (2006); Kenny (2005a); NHS Wales (2006a).

that the QOF is also being driven by mechanistic protocols, which suit diabetes care at a practice level but may be threatening individual-centered diabetes care (Greenhalgh, 2000). This balance is offset by the patient questionnaire introduced by the contract, giving patients the opportunity to comment on standards of care.

This high achievement data in diabetes has also placed the role of secondary care in diabetes management in context (Kenny, 2005b). The improving performance by individual practices, and the impetus towards primary care commissioning of diabetes by PCTs, is placing new pressures on diabetes secondary care, leaving the accepted role of hospital diabetes clinics in increasing doubt.

Have the results obtained in the QOF been noted internationally? Doran et al (2006) have attempted to put the diabetes QOF data into an international context. They drew attention to the QOF results and attempted to compare them with payment by result schemes in North America. Allowing for differences in scored indicators, length and timing of data collection and sampling, English practices compared very favourably with schemes such as the 'Veterans affairs' (McGlynn et al, 2003; Jha et al, 2005). The paper points to the relatively high incidence of exception reporting in the QOF, but most American managed healthcare schemes only look after selected subsets of that population. Only time will tell whether imitation of the QOF diabetes scheme internationally proves to be the sincerest form of flattery.

Conclusion

Another round of data extracted from the QOF results in diabetes 13 months after the previous data shows a small but significant rise in both the prevalence of diabetes and the individual practices achievements in the scheme. The QOF would appear to be driving up the quality of diabetes care in practices, although differences remain within PCTs aligned along practice sizes and social deprivation. In an international context, the data stands up robustly when compared with healthcare schemes in North America. ■

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Table 2. Quality and Outcomes Framework points achieved for 2004/5 and 2005/6.

	England		Wales		Northern Ireland		Scotland	
	04/05	05/06	04/05	05/06	04/05	05/06	04/05	05/06
Total QOF points (%)	91.3	96.2	90.2	95.6	94.2	97.9	92.5	97.7
Average QOF points/practice	958.7	1010.5	947.1	1003.3	989.0	1027.6	971.3	1026.2
Diabetes points achieved (%)	93.2	97.4	93.3	97.5	95.7	98.3	96.0	98.5
CHD points achieved (%)	95.3	98.3	93.4*	97.3*	97.0	99.2	95.0	98.7
Hypertension points achieved (%)	94.4	98.1	93.7	97.7	97.9	99.6	94.8	99.0
Stroke and TIA points achieved (%)	92.0	97.2	91.2	96.8	95.9	99.1	94.3	98.9

*Sources: The Information Centre (2006c); NHS Wales (2006b); Department of Health, Social Services and Public Safety (2006b); NHS National Services Scotland (2006) * includes left ventricular dysfunction*