Quality and Outcomes Framework (QOF) Update 2011

Background

Introduced in 2004 as part of the General Medical Services Contract, the QOF is a voluntary incentive scheme for GP practices in the UK. The Quality and Outcomes Framework (QOF) identifies where practices have achieved set quality measures, financially rewarding them where they are able to demonstrate that they have met that level of quality. This provides incentive to provide good patient care, and a financial reward that can be reinvested into the services provided by the practice.

There is a clinical section of the QOF which is broken down into a number of condition specific areas, and diabetes is one of these. Within each area there are a number of indicators. Where a practice can demonstrate they have made achievements against an indicator they receive a certain number of points and these are then translated into a financial reward. The number of points to be gained within each indicator reflects the amount of work needed to achieve the standard set.

An example of an existing diabetes indicator is:

"The percentage of patients with diabetes who have a record of glycated haemoglobin (HbA1c) or equivalent in the previous 15 months"

The QOF is divided into four areas:

Clinical - linked to the care of patients with long terms conditions, such as heart disease, diabetes or asthma
Organisational - relating to records, information, management and training etc
Additional services - such as cervical screening, maternity and contraceptive services
Patient experience - based on patient surveys and consultations[1]

A public consultation process, managed by NICE (National Institute for Health and Clinical Excellence)[2] is held to inform the development of the clinical indicators of the QOF.

The official consultation process is three fold:

1. submitting new topic areas that could lead to the development of new indicators
2. commenting on existing indicators
3. commenting on potential new indicators that have been tested out (piloted)

There are two, four week opportunities to make new topic suggestions for future versions of the QOF. Separate consultations are also held on new indicators that have been developed and piloted. Comments on existing indicators can be made throughout the year without deadline. NICE also make recommendations about indicators that can be retired from the QOF. For more about the QOF and NICE process visit: http://www.nice.org.uk/aboutnice/qof/qof.jsp

Summary of Diabetes UK proposals on 2012/13 and 2013/14 QOF

This submission summary outlines Diabetes UK's submissions to the consultation for new topic areas. Some of these topics have been phrased as the potential indicators would be, informed by the way existing indicators have been written.

Diabetes Area of the QOF

"All people with diabetes to receive information about their condition, tailored to their individual needs, which includes information about local and national sources of support"

"Percentage of patients who have achieved a decrease in HbA1c as individually agreed with the person with diabetes (measured in mmol/mol) and at individually agreed intervals"

The indicator could also include recognition of the optimal treatment targets.

"Percentage of people with diabetes who have received a dietary review and assessment by a suitably competent professional in accordance with the relevant NICE guidance for Type 1 or Type 2 diabetes, in last 15 months"

Coronary Heart Disease Area of the QOF

"Percentage of people with CHD not known to have diabetes assessed for diabetes."

Suggestion to create a new area in the QOF called CVD Risk Assessment

Practice to produce a register of all people assessed as being at risk of diabetes via NHS Health Checks, and those at high risk of diabetes according to the following risk factors:

The person is white and over 40 years old, or is Black, Asian or from a minority ethnic group and over 25 years old and has one or more of the following risk factors:

- A close family member has Type 2 diabetes (parent or brother or sister).
- A person is overweight or their waist is 31.5 inches or over for women; 35 inches or over for Asian men and 37 inches or over for white and black men.
- A person has high blood pressure or has had a heart attack or a stroke.
- A woman with polycystic ovary syndrome and overweight.
- A person has been told they have impaired glucose tolerance or impaired fasting glycaemia.
- A woman who has had gestational diabetes.
- A person has severe mental health problems.

Percentage of patients on this register assessed for diabetes and Impaired Glucose Regulation (IGR)

Practice can produce a register of people diagnosed with IGR in accordance with World Health Organisation (WHO) criteria.

Percentage of patients with a record of IGR who have had a test for diabetes at least annually in accordance with WHO criteria

Percentage of patients with a record of IGR offered lifestyle intervention on diagnosis

All people over the age of 40, or over the age of 25 from the South Asian community who have had their waist circumference and BMI measured in the previous 15 months.

All people with a record of BMI over 25(Kg/m2) and over 23 for people from the South Asian community (Kg/m2) and a waist circumference of ≥ 94 cm (White and Black men) ≥ 90cm (South Asian men) and ≥ 80cm in all women who are offered weight loss support in accordance with NICE guidance.

Depression Area of the QOF

"Percentage of people with diabetes identified with depression who are provided with individually tailored appropriate support and intervention."

Organisational Area of the QOF

"Practices to participate in national and local audit and specifically the National Diabetes Audit"

Actively involving service users in service planning, design and review

All clinical practice and community staff involved in the provision of diabetes care and attached to the practice, to provide evidence of up to date training (within personal development plans) in diabetes.

Patient Experience Area of the QOF

"To assess patient experience and outcome measures identified as important by patients, using a range of tools available, administered in ways that enable people to participate. These tools could possibly include specific measures such as the ADDQOL, DQL, the Diabetes Health Profile. "

"The percentage of patients who report feeling they have been engaged in their own care"

"The percentage of patients who report feeling information about managing diabetes has been effectively communicated"

Consultation on new indicators for the 2012/13 QOF

Diabetes UK is pleased with the potential inclusion of new diabetes indicators for dietary review, structured education and interventions to support people who are registered obese following our recommendations that these should be included as future indicators for the QOF.

Summary of 2011/12 changes to the QOF

A summary of the changes to the QOF for 2011/12 is available from http://www.bma.org.uk/images/summarygofguidance2011_v3_tcm41-204734.pdf

The following changes are of immediate relevance to diabetes:

- The retirement of indicators relating to the measurement of HbA1c, blood pressure and cholesterol:

"The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months"

"The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months"

"The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months"

- A change to the HbA1c lowest target indicator, increasing it to 59mmol/mol (7.5 % in old DCCT values), and an amendment to the others to convert the way in which indicators are reported from DCCT values to mmol/mol IFCC values.

- A change in the neuropathy indicator to bring it in line with NICE guidance:

"The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4) ulcerated foot within the preceding 15 months"

- A change to the blood pressure indicator, introducing two new indicators

"The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less in the preceding 15 months" (for those with signs of complications)

"The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less in the preceding 15 months"

- An amended indicator which will help detect undiagnosed diabetes among people with severe mental illness

"The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose level in the preceding 15 months"

- A new indicator which will help detect undiagnosed diabetes among people with dementia

"The percentage of patient with a new diagnosis of dementia from April 2011 to have FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register "

Diabetes UK's view

While Diabetes UK greatly welcomes improvements to the foot assessment indicator, and those to help pick up undiagnosed diabetes among people with severe mental illness and dementia, we have grave concerns about other changes.

The new, higher, blood pressure target for those with complications is particularly perverse. It could discourage practitioners from proactively working with these individuals to reduce their risk of worsening complications. If the QOF is to deliver improvements in the quality of care then its indicators must reflect evidence based recommendations and quality of life considerations.

The change to the HbA1c indicator underscores the need for individualised HbA1c targets, and we believe achievement of a drop in HbA1c would be a better indicator. The purpose of the QOF is to drive quality improvement. Including such an indicator would bring the QOF in line with the NICE Quality Standard for diabetes.

We are also disappointed that diabetes process measures have been removed from the QOF. Recent figures in the NHS Atlas of Variation reveal a post code lottery of access to key diabetes checks. It is doubtful that all these processes are so well embedded in practice that their retirement from the QOF is not a risk.

Further new indicators have also been added, focussed on improving quality and productivity. These include prescribing practice, outpatient referrals to secondary care, and assessment of emergency admissions. It is important that these indicators do not focus on cost savings at the expense of quality care. We believe people with diabetes should have access to a choice of clinically effective treatments based on individual need and appropriateness, and be involved in making decisions about their care in partnership with their healthcare professional. Service re-design based on an integrated and partnership approach that involves the relevant multidisciplinary professionals and patients is welcome. Ultimately people with diabetes must receive the right care, from the right professional, at the right time.

Diabetes UK will maintain a watching brief on the impact of these changes to the QOF and how they affect access to, and quality of, care for people with diabetes and those at risk of developing the condition.

Policy and Care Improvement Team

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1. http://www.bma.org.uk/images/qofguidancefourthversion2011_tcm41-205262.pdf
2. http://www.nice.org.uk/aboutnice/qof/qof.jsp