

Position statement: The Future of the Quality and Outcomes Framework in England

February 2018

Key points

- The Quality and Outcomes Framework (QOF) provides a national framework for delivering quality clinical care in primary care settings. It has driven significant improvements for diabetes both in terms of treatment and data collection.
- Withdrawing QOF indicators carries a high level of risk that there will be a corresponding decline in measures of diabetes care.
- QOF should be retained in England, however it needs to reflect that the nature of primary care and the diabetes population is changing. Careful consideration should be given to reforming it through population stratification, to support more person-centred care and to avoid perverse incentives.
- If QOF is withdrawn and replaced, the alternative must sustain quality improvements in diabetes care and continue to support data collection.

What is the Quality and Outcomes Framework?

The Quality and Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices. It was introduced in 2004 and provides financial incentives to GP practices for the provision of 'quality care'. While participation by practices in QOF is voluntary, participation rates have been very high, with most Personal Medical Services (PMS) practices also taking part.

Since April 2013, QOF has been different across England, Wales, Scotland and Northern Ireland. In England, the Secretary of State for Health signalled his intention to remove QOF from the GMS contract in 2014. In March 2017, NHS England cited 'wide agreement that this particular approach has run its course, and is now partly a tick-box exercise'¹. It committed to agree a successor with stakeholders.

However, the British Medical Association's conference of Local Medical Committees has since carried a motion which stated disinvestment in QOF is no longer desirable because it has shown quality improvements and provides good data². The conference agreed that successful indicators should not be retired, and that new indicators should attract new funding when they are introduced.

The future of QOF in England is now uncertain. It has already been discontinued in Scotland, with all points being retired from the GP contract and payments transferred to core funding for practices. QOF has previously been suspended in both Wales and Northern Ireland.

This position statement concerns the future of QOF in England.

Diabetes indicators in QOF

In the 2017/18 GMS contract for England, 87 of the total 559 QOF points relate to diabetes care processes. These incentivise activities such as:

- maintaining a register of adult patients with diabetes;
- recording a set percentage of patients on the register that achieve the recommended targets for blood pressure, cholesterol and HbA1c (glycaemic control);
- recording that a set percentage of those who are newly diagnosed have been referred to a structured education programme within 9 months of entry on to the diabetes register.

The National Institute for Health and Care Excellence (NICE) is responsible for recommending changes to QOF indicators. In August 2017, NICE added four new diabetes indicators to the indicator menu for general practice³. Three relate to diabetes prevention, including an indicator for referring those newly diagnosed with non-diabetic hyperglycaemia to the NHS Diabetes Prevention Programme. The fourth concerns HbA1c testing for women who have had gestational diabetes. If agreed by NHS Employers and the BMA's General Practitioners Committee, these indicators would form part of QOF in the future GMS contract for England.

The effect of QOF on diabetes outcomes and care processes

Treatment targets

Comparing data from the most recent National Diabetes Audit (NDA) with the audit preceding the introduction of QOF shows that significantly more people are achieving the NICE recommended treatment targets since its introduction.

1 HbA1C

2003/04: 56% of people with diabetes achieved an HbA1c of less than 7.5%⁴

2016/17: 64% of people achieved this target⁵

2 Blood pressure

2003/04: 21% of people with diabetes achieved blood pressure of 135/75 mm/Hg or less

2016/17: 74% of people achieved a slightly less ambitious target of 140/80 mm/Hg or less

3 Cholesterol

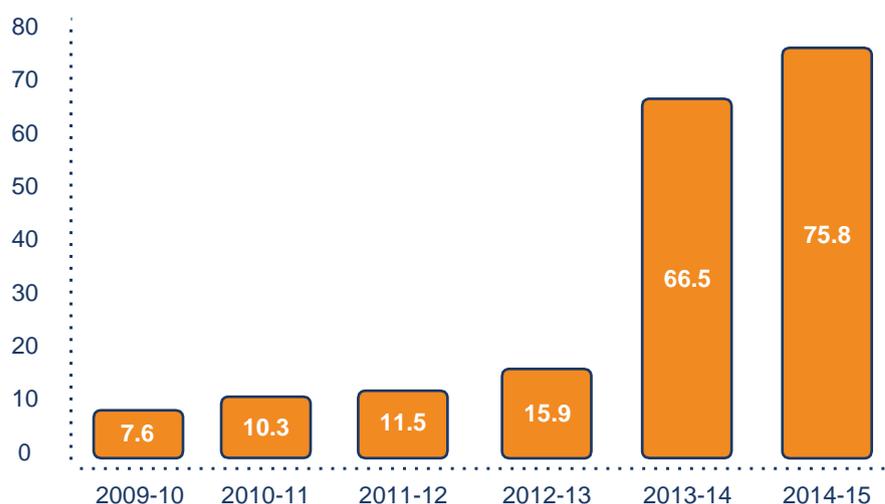
2003/04: 61% of people achieved the target of less than 5mmol/litre

2016/17: 76% of people achieved this target

Structured education referral

The QOF diabetes indicator DM014 incentivises referral to structured education programmes for anyone newly diagnosed with diabetes. It was introduced in April 2013 and is associated with a rapid rise in referral rates⁶.

Percentage of people newly diagnosed with diabetes being offered structured education in England and Wales by audit year



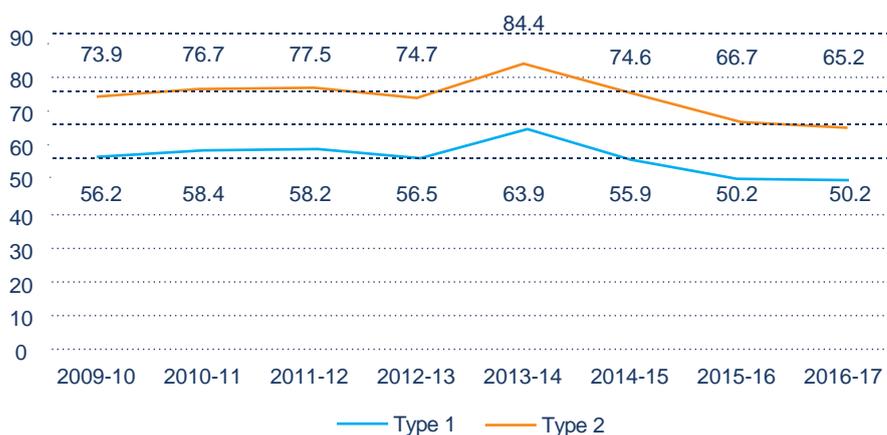
The effect of removing QOF indicators on diabetes care

NDA data shows a drop ranging from 10 to nearly 20 percentage points for care processes that are no longer incentivised through QOF.

Urine albumin:creatinine ratio (uACR)

The QOF indicator incentivising the recording of urine albumin:creatinine ratio (uACR) was retired from April 2014. The percentage of people receiving this care process has since dropped considerably⁷:

Percentage of people with diabetes in England and Wales receiving uACR check by diabetes type and audit year



Healthcare professionals have told us that retiring QOF indicators does not mean they simply stop seeing the value in carrying out care processes. However, without the additional financial incentive to reach a percentage of patients, it becomes too expensive to carry out additional work to ensure harder to reach patients get their checks, for example, by posting sample bottles to patients or sending these out with district nurses.

This is important because there is an association between receiving care processes and outcomes. People with diabetes who have had their annual diabetes checks regularly in the preceding seven years have a mortality rate which is half the rate of those who have not⁸.

BMI

The QOF indicator incentivising the recording of BMI for people with Type 2 diabetes was retired in April 2013. For the four years from 2009/10 to 2012/13, BMI recording rates for people with Type 2 diabetes varied between 90.5% and 90.9%. In 2013/14 this had fallen to 85.7%, and to 83.1% in the most recent audit⁹.

The effect of QOF on diabetes data collection

QOF has incentivised primary care to collect data used in the National Diabetes Audit (NDA). This provides a robust evidence base for quality improvement, and allows the audit to highlight variation and good practice across the whole population. This data includes those who are 'exempted' from QOF for payment purposes, for example because it would not be clinically appropriate for them to meet a treatment target due to other health conditions they have.

Since April 2017, it has been a contractual requirement for general practices to facilitate data collection for indicators that are no longer in QOF. As of July 2017 all GPs are also contractually required to allow collection of NDA data. However, as the above evidence on the recording of urine albumin:creatinine ratio and BMI for Type 2 diabetes shows, there is a clear correlation between discontinuation of a QOF indicator and reduced recording of data for that process.

Review of published evidence

A Department of Health funded review of the evidence about QOF in England concluded that there is only limited evidence that QOF improves healthcare quality¹⁰. However, the review's focus was QOF in general, rather than QOF and diabetes care. Three of the articles included in the review looked directly at the effect of QOF on diabetes care. These reported the following results:

- A longitudinal study of 148 general practices found that introduction of QOF incentives was associated with improvements in the recorded quality of diabetes care. They also found that variation in care between population groups diminished under the incentives (though remained substantial in some cases)¹¹.
- A retrospective analysis of the removal of the indicators for recording cholesterol (DM016) and HbA1c (DM005) from QOF found that performance levels were generally maintained¹². However, observed performance fell short of expectation, leading the authors to conclude that removing indicators is not without risk. Both removed indicators were also linked to other outcome indicators which remained in the QOF, meaning some financial incentive was retained. The results are therefore not generalisable.
- A study found a greater proportion of people with newly diagnosed diabetes are being initiated on medication within 1 and 2 years of diagnosis as a result of the introduction of the incentives for tight glycaemic control¹³.

International research further suggests that removing financial incentives for diabetes quality indicators produces a decline in related performance levels. Removing the payment for diabetic retinopathy screening at a Californian Kaiser Permanente facility was associated with a 7.6% fall in proportion of patients screened after four years¹⁴. These losses exceeded the gains made during the incentivised period.

Criticisms of QOF

The review¹⁵ summarises many of the criticisms that have been directed at QOF. These include:

- QOF has run its course. As many practices already derive maximum remuneration, there is no longer a drive to keep improving. There is therefore a risk that high performing services may revert to the mean.
- QOF may worsen inequalities because the patients who benefit most from it may be those who are easiest to manage. There is evidence that people from disadvantaged groups are more likely to be excluded from QOF diabetes indicators, and are less likely to achieve treatment goals¹⁶. International evidence also suggests that people with diabetes who have more complex needs and comorbidities are more likely to be excluded from payment-for-performance schemes¹⁷.
- The threshold nature of QOF may encourage perverse incentives.
- QOF is a process-driven 'tick-box' exercise. Some people living with diabetes report that this can create a barrier to holistic care, leading, for example, to the offer of structured education being made without clear explanation of its role in supporting diabetes management.

The future of QOF: Recommendations

Reforming QOF

QOF has given a national framework for delivering quality clinical diabetes care in primary care settings. It has driven significant improvements both in terms of treatment and data collection.

We therefore recommend that QOF is presently retained in England. However, careful consideration should be given to reforming the QOF indicators to ensure that they: remain effective in driving quality improvement; minimise perverse incentives; better reflect the changing nature of primary care, the diabetes population and prevalence; and encourage a more individuated, person-centred approach to delivering diabetes care within the primary care team.

We recommend that NHS Employers and the BMA support the new prevention and gestational diabetes indicators recommended by NICE in August 2017. The approach should ensure that their adoption does not undermine the effectiveness of the current clinical treatment indicators within the envelope of diabetes QOF points.

We also recommend that options for reforming diabetes QOF indicators should be thoroughly explored with a range of stakeholders, including general practitioners and practice nurses working with people with diabetes in primary care. Consideration should be given to addressing the criticisms raised above where there is evidence to support these, such as:

- Adopting a more individualised approach to HbA1c targets which reflects the progressive nature of diabetes, and/or stratifying HbA1c targets so they are more appropriate to specific populations, for example, people with frailty and people with comorbidities, as well as younger and newly diagnosed populations.
- Trialling incentivised indicators which reward progress for people who are very unlikely to meet the HbA1c target to reflect that some of the most complex cases involve people with very high HbA1c levels, and to counter the potential temptation to exception report these cases.
- Reviewing exception reporting practice to ensure that healthcare professionals are neither excluding people unnecessarily nor overtreating others to reach targets that are not right for them.
- Trialling incentivised indicators which support the delivery of more holistic care in addition to the current process and biomarker outcomes with person-centred outcomes¹⁸. This could include using goal-oriented outcomes, or the completion of care plans¹⁹.
- Avoiding perverse incentives, including the possible disincentive to support people into – and during – Type 2 diabetes remission²⁰ if this reduced income for GPs by taking patients off the diagnosed diabetes register. An option may be to introduce an incentive to help patients achieve remission and for continued monitoring and measuring of outcomes.

Withdrawing QOF

Withdrawing QOF indicators carries a high level of risk that there will be a corresponding decline in measures of diabetes care. If QOF is withdrawn, there must be an alternative which will at least sustain quality improvements in diabetes care and data collection, as well as a robust plan for how to transition to a new framework.

The approach to improving quality through GP clusters and peer-led review following the removal of QOF in Scotland should be carefully monitored and evaluated to ensure effective shared learning across the UK, with close attention paid to the impact of this on the quality of diabetes care and data.

Withdrawing QOF will make the need to implement effective drivers for quality diabetes care even more important. This includes:

- Urgent improvements in the level of healthcare professional education in basic diabetes care;
- Encouraging and supporting clinical leadership in diabetes in primary care across the country;
- Sustained investment in the transformation of diabetes services.

References

- 1 NHS England (2017) [Next Steps on the NHS Five Year Forward View](#), p. 21.
- 2 BMA (2017) [Conference News: Conference of Representatives of Local Medical Committees 18-19 May 2017](#), p. 13.
- 3 NICE (2017) [New indicators to be added to the NICE indicator menu for general practice](#).
- 4 Data for 2003/04 taken from [NHS Digital \(2005\) National Diabetes Audit 2003-04](#).
- 5 The NDA now reports separately on Type 1 and Type 2 diabetes. To facilitate comparison with pre-QOF data, these combined figures for people with Type 1 and Type 2 diabetes were calculated using data from NHS Digital (2017) [National Diabetes Audit Report 1 Care Processes and Treatment Targets 2016-17](#).
- 6 NHS Digital (2016) [National Diabetes Audit – 2013-14 and 2014-15: Report 1, Care Processes and Treatment Targets](#).
- 7 Data for 2009-10 until 2014-15 taken from NHS Digital (2016) [National Diabetes Audit – 2013-14 and 2014-15: Report 1, Care Processes and Treatment Targets](#); data for 2015-16 from NHS Digital (2017) [National Diabetes Audit, 2015-16 Report 1: Care Processes and Treatment Targets](#); data for 2016-17 from NHS Digital (2017) [National Diabetes Audit Report 1 Care Processes and Treatment Targets 2016-17](#).
- 8 NHS Digital (2017) [National Diabetes Audit, 2015-16 Report 2b: Complications and Mortality](#) (association between disease outcomes and preceding care)
- 9 NHS Digital (2017) [National Diabetes Audit Report 1 Care Processes and Treatment Targets 2016-17](#).
- 10 PRUComm (2016) Review of the Quality and Outcomes Framework in England. PRUComm.
- 11 Kontopantelis E et al. (2013) [Recorded quality of primary care for patients with diabetes in England before and after the introduction of a financial incentive scheme: a longitudinal observation study](#).
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- 13 Gallagher N et al. (2014) [Increase in the pharmacological management of Type 2 diabetes with pay-for-performance in primary care in the UK](#).
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- 17 Hsieh HM et al. (2016) [Effects of changes in diabetes pay-for-performance incentive designs on patient risk selection](#). *Health services research* 51:2.
- 18 Reuben DB, Tinetti ME (2012) [Goal-oriented patient care – an alternative health outcomes paradigm](#). *The New England Journal of Medicine* 366(9):777-779.
- 19 Hull S, Chowdhury TA, Mathur R et al. (2013) [Improving outcomes for patients with type 2 diabetes using general practice networks: a quality improvement project in east London](#). *BMJ Quality and Safety*.
- 20 Diabetes UK (2017) [Diabetes UK interim position statement on remission in adults with Type 2 diabetes](#).