ABCD Spring Meeting

What is the evidence that QOF has improved the lives of people with diabetes?

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Former Chief Medical Adviser (Primary Care) Diabetes UK
and RCGP Clinical Lead for Diabetes.

Independent Commissioning Consultant

Doctors get 20% pay rise just for doing their jobs

By Michael Day

DOCTORS are getting 20 per cent pay rises for doing simple tasks "they should always have done," it was claimed last night.

Health economists, including Government advisers, say that under their new contracts GPs are being paid huge bonuses to meet "easy" targets that do little to improve patients' lives.

Such is the level of concern over the value for taxpayers that ministers are already meeting doctors' leaders in order to set tougher goals.

The move comes just weeks after the Government boasted how most GPs had met the targets for performance-related pay.

But Alan Maynard, professor of health economics at York University, said yesterday: "It's quite ridiculous. The Government's spent all this money and has given GPs 20 per cent more just to try and get them to do what they should always have done.

"Now they're being paid extra to look out for people with high blood pressure, which causes heart attacks and strokes, and to monitor and treat them - but they should have been doing that all along. It's not rocket science."

There have already been two Whitehall meetings after the disclosure last month that, on average, GP practices achieved 91 per cent of the available performance-related bonuses under the new contract.

After achieving bonuses, average earnings of a practice surged by £15,300 while the salary of the average GP partner rose to £106,000 a year. The first meeting to set tougher targets came within a week of the announcement. The second was held last week.

One BMA negotiator, Leeds GP Richard Vautrey, said: "We are looking at making amendments, but at present we're not in the position to say exactly what these are.

"We would expect the revised framework to be ready by the end of the year."

Apart from blood pressure, other target areas have been singled out as too modest. Chris Ham, professor of health policy and management at Birmingham University, said: "My view is that, in principle, the new GP contract is a good thing - GPs are being paid on the basis of how well they treat patients and not just according to how large their list size is.

"But the fact so many of them met the targets in the first year suggests they were too easy."

A BMA spokeswoman denied the targets were too easy. "They demonstrate the vast majority of doctors are already providing high-quality care for their patients," she said.

Simon Williams, director of policy at the Patients' Association, said, however: "The BMA would trumpet the GPs' performance. It's a trade union, it's there to represent doctors not patients."

A spokesman for the Department of Health said: "These excellent results show the new contract is giving GPs a real incentive to improve the quality of care."

GP on home visits

Good care should look like this

Safe

Timely

Efficient

Effective

Equitable

Evidenced-based

Patient-centered

And not this..

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21 February 2012 Last updated at 05:10

More than 1.3 million diabetes patients not offered vital tests

By Julian O'Halloran
Reporter, BBC File on 4

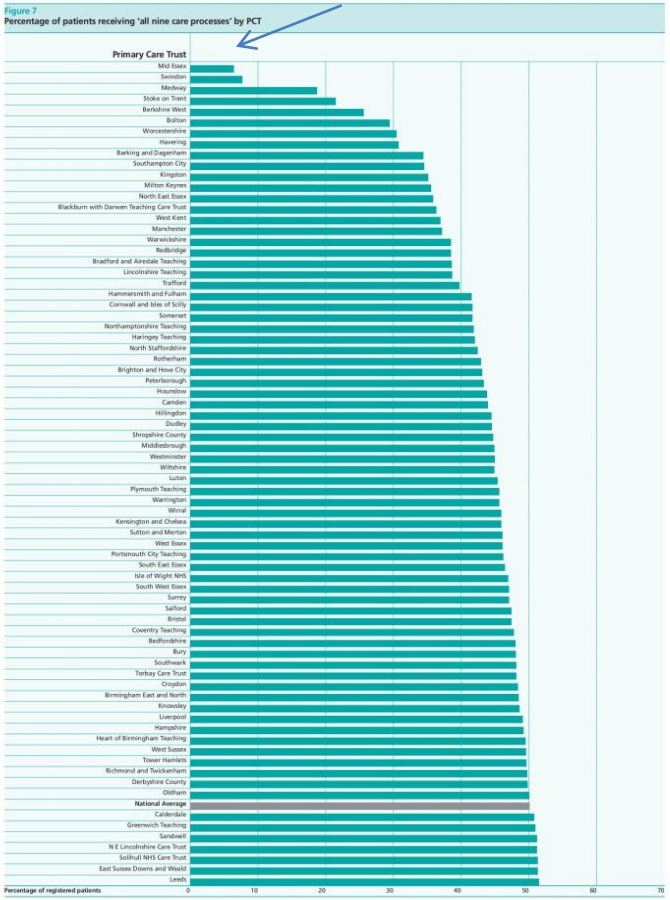
An estimated 1.3 million diabetes patients are missing out on vital and potentially life-saving health checks, the BBC has learned.

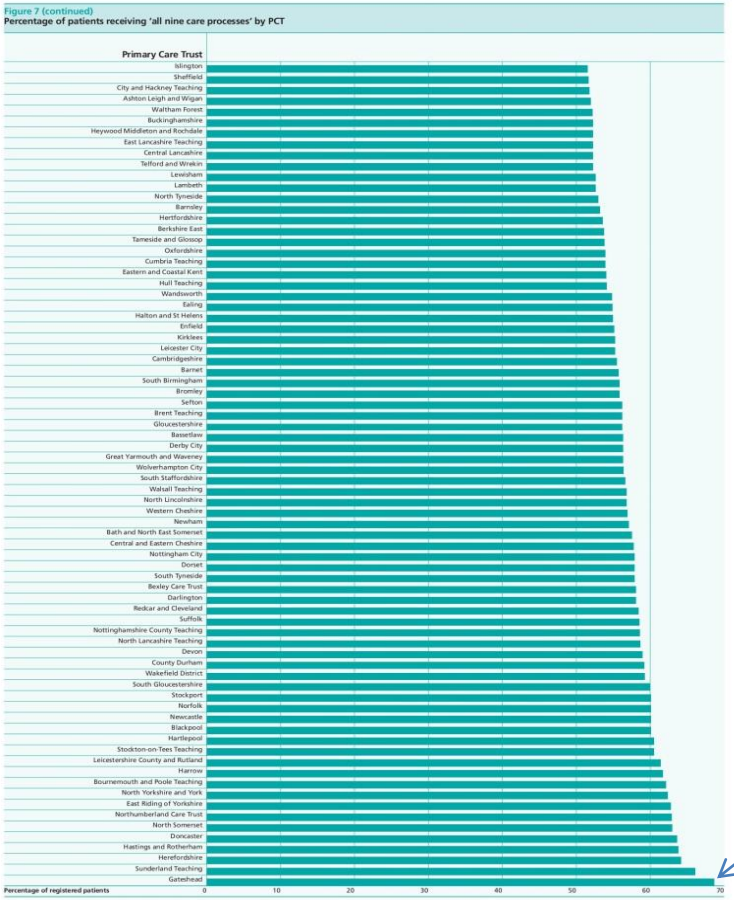
NHS figures reveal fewer than 10% of patients are offered the full series of tests in some areas of England.

Health Minister Paul Burstow said the situation was "outrageous" and "unacceptable".

At least its measurable!

Mid Essex

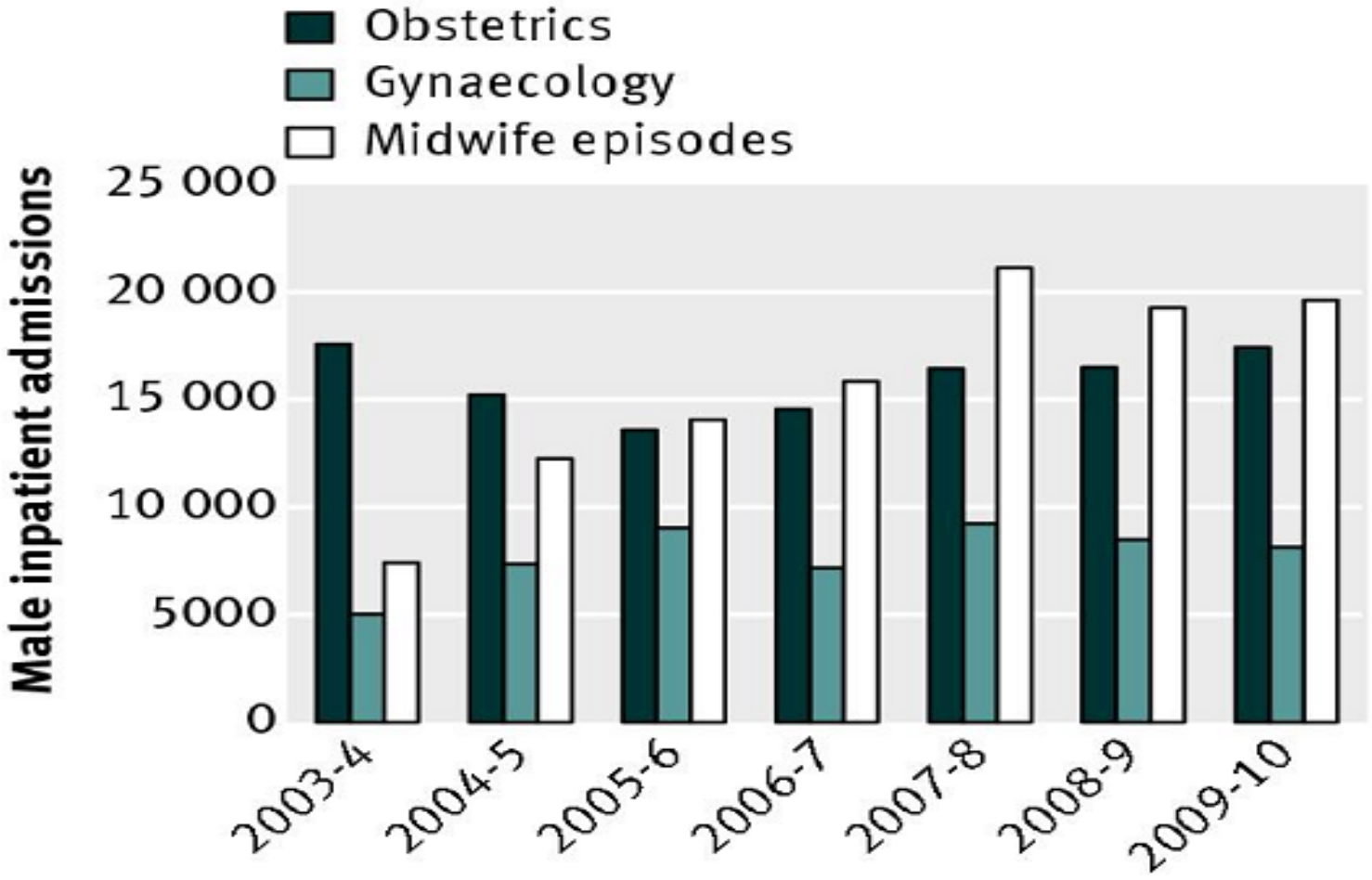




Gateshead

http://www.ic.nhs.uk/diabetesaudits

We all make mistakes !



Brennan L et al BMJ2012;344:e2432

THE INDEPENDENT

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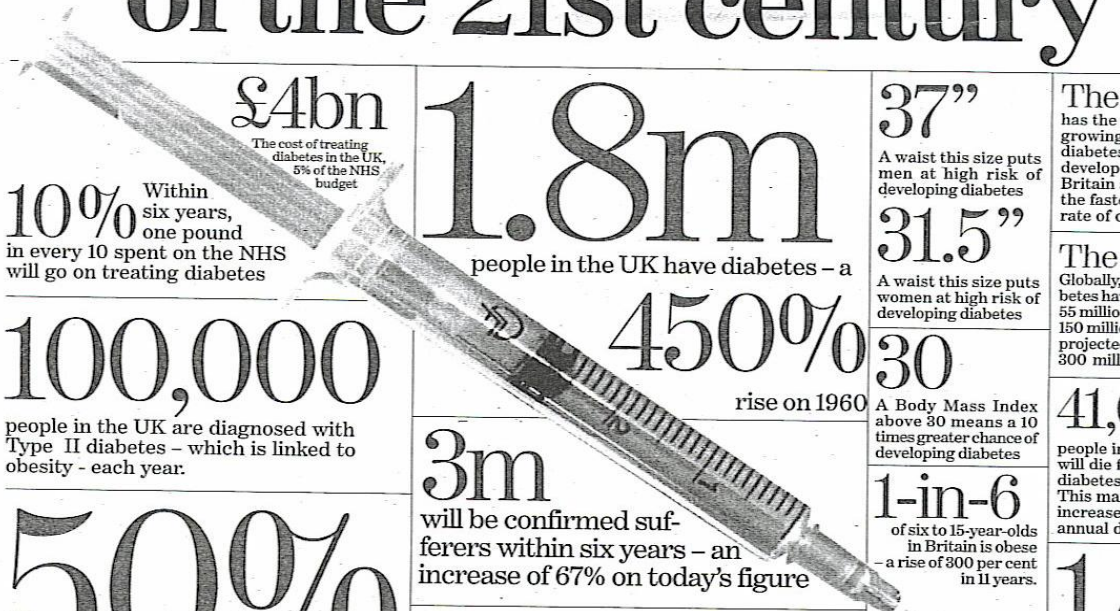
Today
.education & careers
56-page supplement

'I mean, it would be useful to know who is the father...' BRIDGET JONES'S DIARY
Page 37

World health body raises alarm over modern-day disease

Diabetes: health crisis of the 21st century



£4bn
The cost of treating diabetes in the UK, 5% of the NHS budget

10% Within six years, one pound in every 10 spent on the NHS will go on treating diabetes

1.8m
people in the UK have diabetes – a **450%** rise on 1960

100,000
people in the UK are diagnosed with Type II diabetes – which is linked to obesity - each year.

3m
will be confirmed sufferers within six years – an increase of 67% on today's figure

50%
More than 50% of British children could be obese by 2020, according to the Royal College of Physicians

1m more are estimated to have diabetes – but don't even know it

Sources: World Health Organisation, Diabetes UK, and the Royal College of Physicians

Full report and analysis, page 2

37"
A waist this size puts men at high risk of developing diabetes

31.5"
A waist this size puts women at high risk of developing diabetes

30
A Body Mass Index above 30 means a 10 times greater chance of developing diabetes

1-in-6
of six to 15-year-olds in Britain is obese – a rise of 300 per cent in 11 years.

80%
The ratio of men over 30 who will be overweight by 2015 in the UK, according to the World Health Organisation

The UK
has the fastest growing rate of diabetes in the developed world. Britain also has the fastest growing rate of obesity

The World
Globally, cases of diabetes have risen from 55 million in 1955 to 150 million in 2004, projected to grow to 300 million by 2025

41,000
people in the UK will die from diabetes in 2015. This marks a 25% increase on today's annual death rate

1/2
or more of all diabetes cases would be eliminated if weight gain in adults could be prevented.

So what are the big questions

- *Has QOF increased the quality of care (or just the quantity)?*
- *Does QOF make diabetes care too rigid?*
- *Do practitioners make inappropriate clinical decisions to attain QOF targets?*
- *Exception reporting. Is there too much?*
- *Could QOF be used to improve the quality of care further?*
- *What other areas might be useful in the diabetes domain of QOF?*

Lets look at QOF

- New contract introduced 1 April 2004[1]
- Voluntary[1]
- Significant proportion of income related to performance (pay for performance)[1]
- Promoting and rewarding better quality care[1]
- In 2009/10, 8486 practices in England took part, covering 99.5% of NHS-registered patients[2]
- Costs £1 billion per annum[3]

1. The NHS Information Centre (2005) *Introduction to QOF*. Available at: http://tiny.cc/hh7u4
2. The NHS Information Centre (2005) *National Quality and Outcomes Framework Statistics for England 2004/05*. Available at: http://tiny.cc/celho
3. NICE (2010) NICE indicator programme – frequently asked questions. Available at: http://www.nice.org.uk/aboutnice/qof/qoffaq.jsp

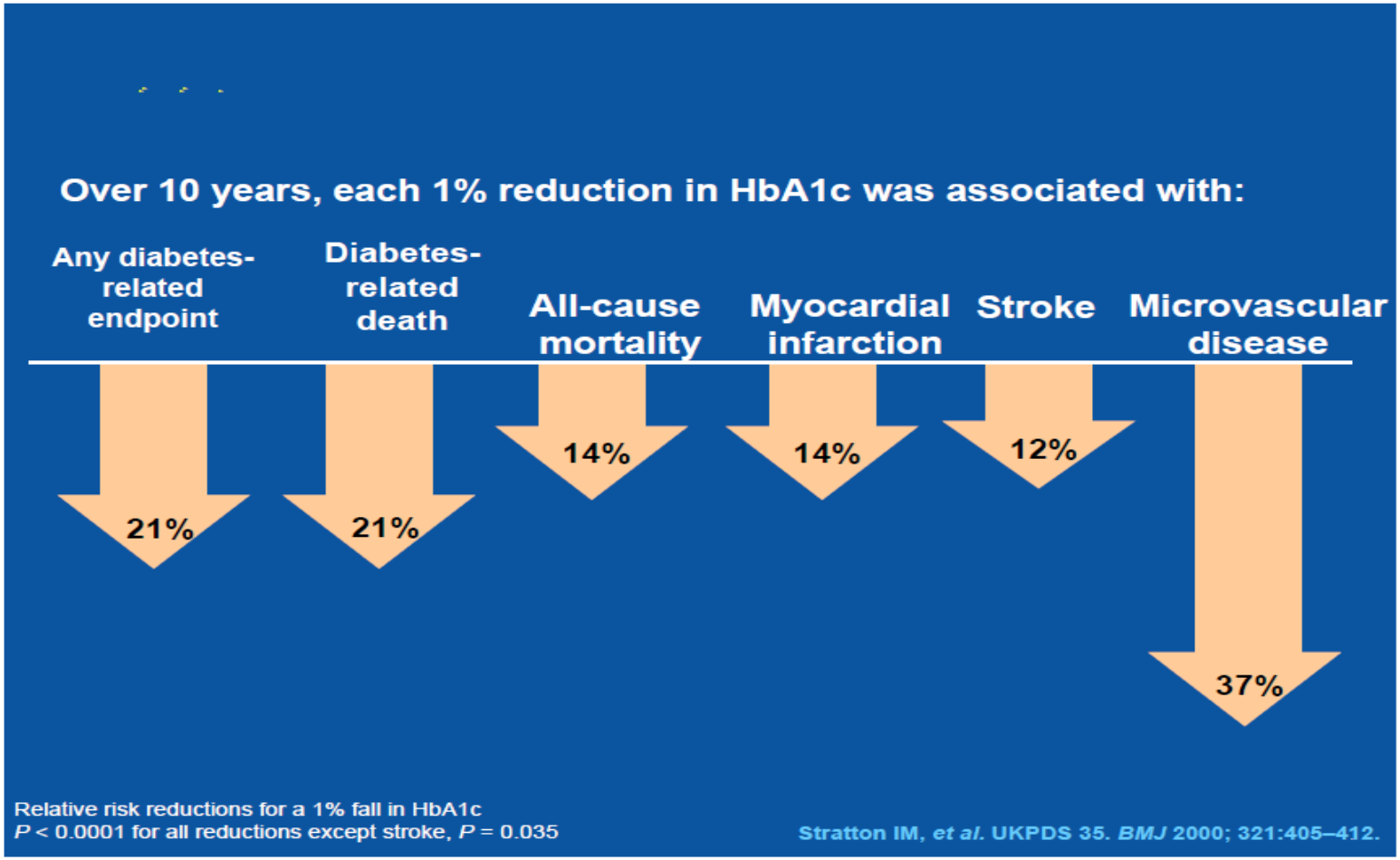
Diabetes indicators recorded in last 15 months

Indicator	Points	Target
• Practice register (type)[1]	6	
• % record BMI[1]	3	90%
• % HbA_{1c} ≤7.0%[1] (≤53 mmol/mol) (<59 for 2011/12)	17	50%
• % HbA_{1c} ≤8%[1] (≤64 mmol/mol)	8	70 %
% HbA_{1c} ≤9%[1] (≤75 mmol/mol)	10	90 %
% retinal screen[1]	5	90%
% microalbumin checks	3	90%
• % record neuropathy testing [1]	3	90%
• % of patients who have recorded foot risk classification	4	90%

Total diabetes points 92/803.5 (11.4%) Priced @ £130.51 per point

1. NHS Employers (2011) *Quality and Outcomes Framework guidance for GMS contract 2011/12*. Available at: http://tiny.cc/hs4a0 Department of Health, Social Service and Public Safety – Detailed List of All Indicalors. Available at: http://www.dhsspsni.gov.uk/qof-indicators.pdf (accessed 10.4.12)

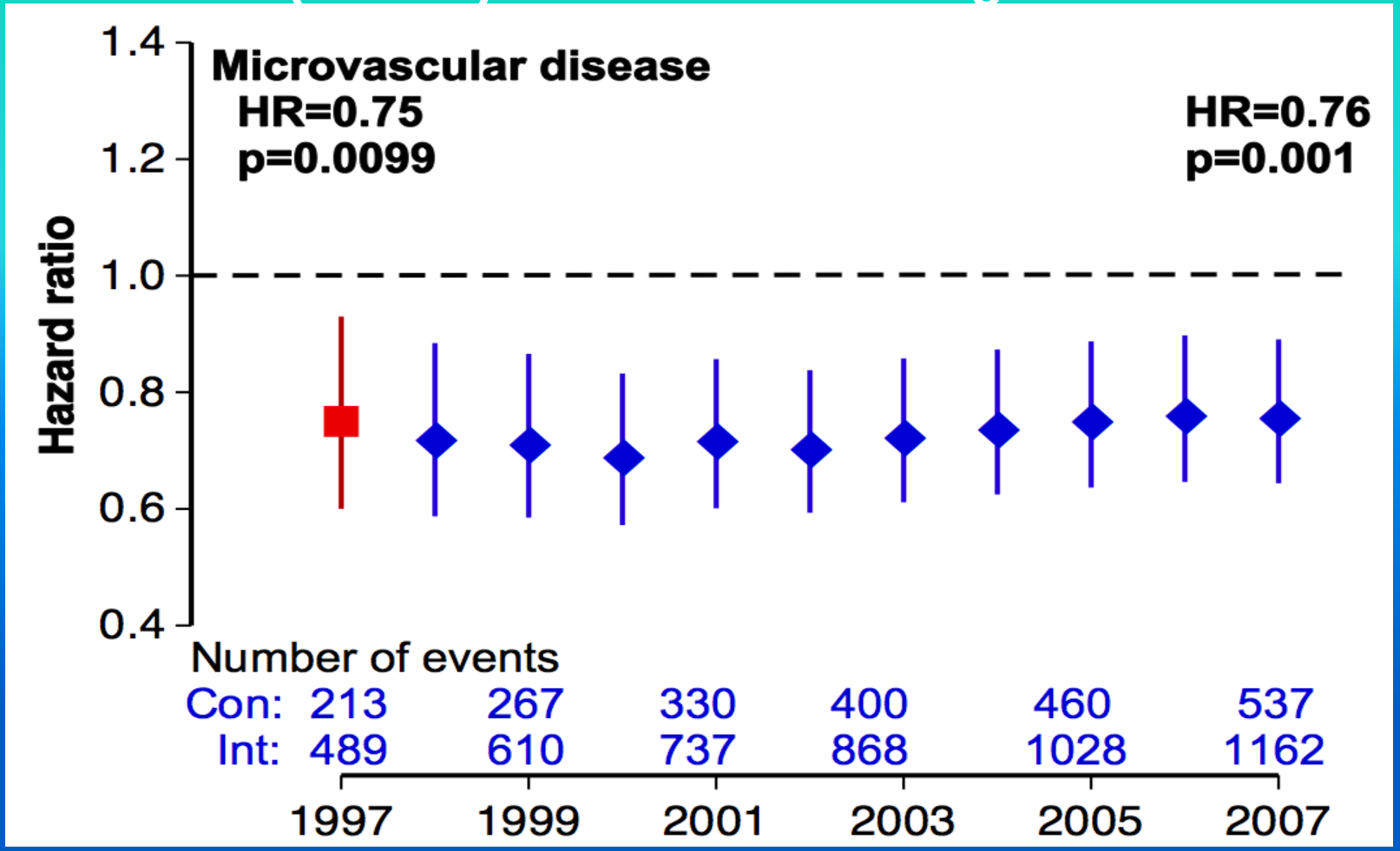
Why do we bother reducing HbA1c?



Microvascular Disease Hazard Ratio

(photocoagulation, vitreous haemorrhage, renal failure)

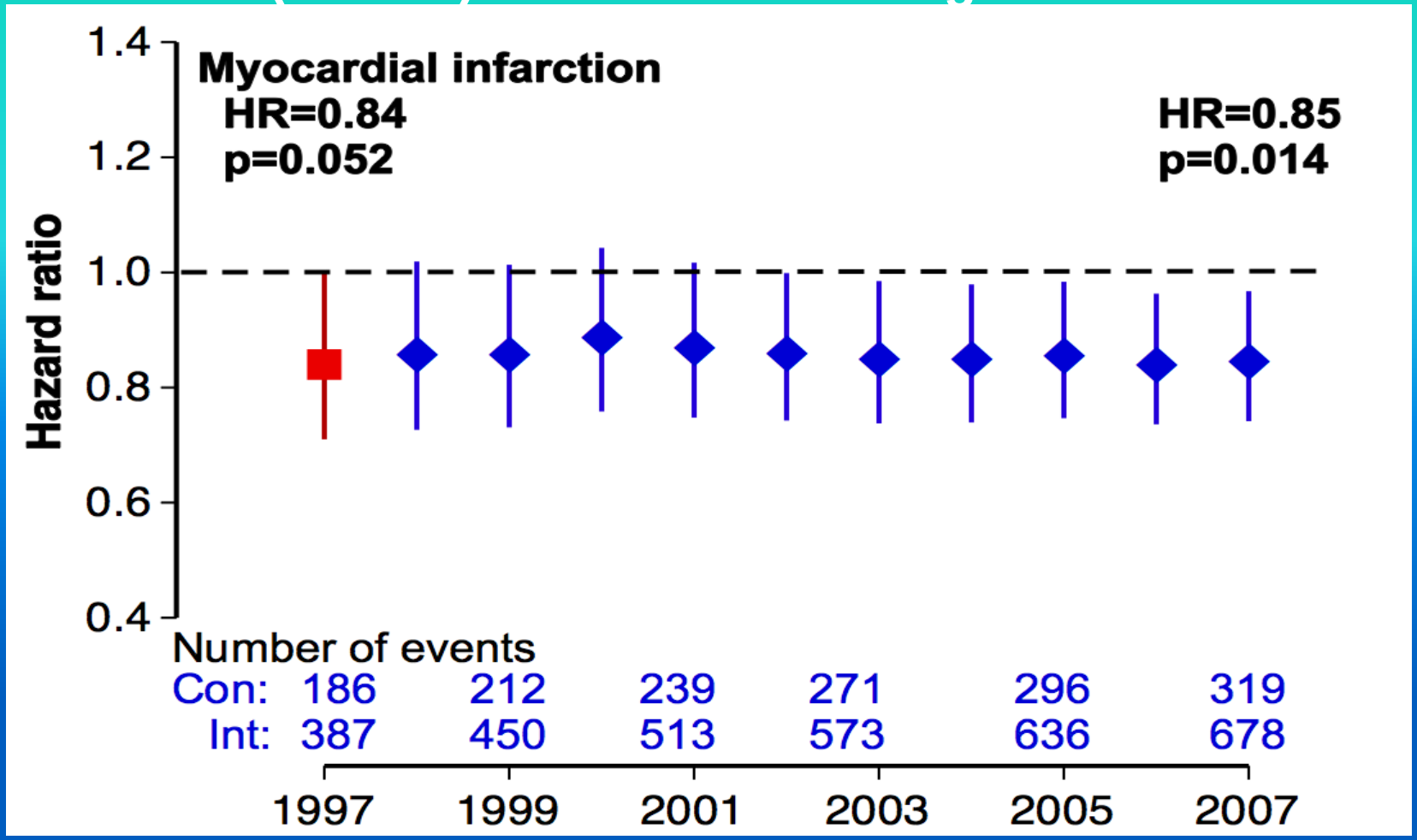
Intensive (SU/Ins) *vs.* Conventional glucose control



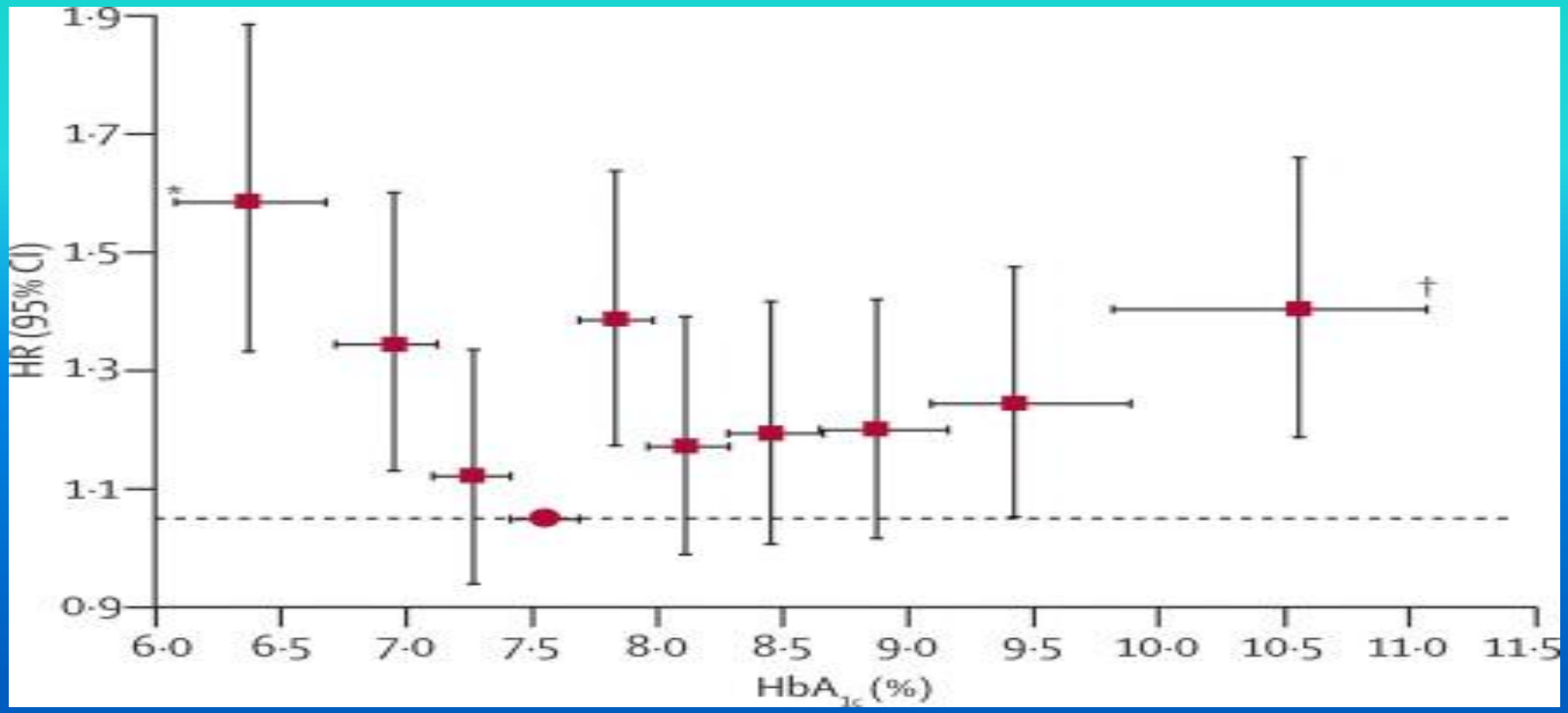
Myocardial Infarction Hazard Ratio

(fatal or non-fatal myocardial infarction or sudden death)

Intensive (SU/Ins) *vs.* Conventional glucose control



But……Recent data…



Hazard ratios for progression to first large-vessel disease event by HbA_{1c}

Currie et al (2010) *Lancet* 375;9713:481

What NICE says

- Involve the person in decisions about their individual HbA_{1c} target level, which may be above that of 6.5% set for people with type 2 diabetes in general.
- Encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life.
- Offer therapy (lifestyle and medication) to help achieve and maintain the HbA_{1c} target level.
- Inform a person with a higher HbA_{1c} that any reduction in HbA_{1c} towards the agreed target is advantageous to future health.
- Avoid pursuing highly intensive management to levels of less than 6.5%.

NICE (2008) *Type 2 Diabetes – National clinical guideline for management in primary and secondary care (update)*

Risks of low HbA_{1c} in the elderly

- Major vascular events:
  - Stroke
  - Myocardial infarction
  - Acute cardiac failure
  - Ventricular arrhythmia
- Impaired consciousness and convulsions
- Falls and bone fracture
- More likely to have hypo-unawareness (diabetic autonomic neuropathy)

Zammitt & Frier (2005) *Diabetes Care* 28:2948–61

Legacy Effect of Earlier Glucose Control

After median 8.5 years post-trial follow-up

Aggregate Endpoint		**1997**	**2007**
Any diabetes related endpoint	*RRR:*	12%	**9%**
	P:	0.029	**0.040**
Microvascular disease	*RRR:*	25%	**24%**
	P:	0.0099	**0.001**
Myocardial infarction	*RRR:*	16%	**15%**
	P:	0.052	**0.014**
All-cause mortality	*RRR:*	6%	**13%**
	P:	0.44	**0.007**

RRR = Relative Risk Reduction, P = Log Rank

Quality and Outcomes Framework

"..an initiative to improve the quality of primary care that is the boldest such proposal on this scale ever attempted anywhere in the world"

Shekelle P BMJ 2003;326:457-8.

Quality and Outcomes Framework (2004)

- **Incentives to improve quality and reflect workload**
- **Up to 25% of practice income linked to performance**
- **156 indicators with graduated scales**
  - **76 for chronic disease**
  - **15 for diabetes**
- **‘Evidence-based’**

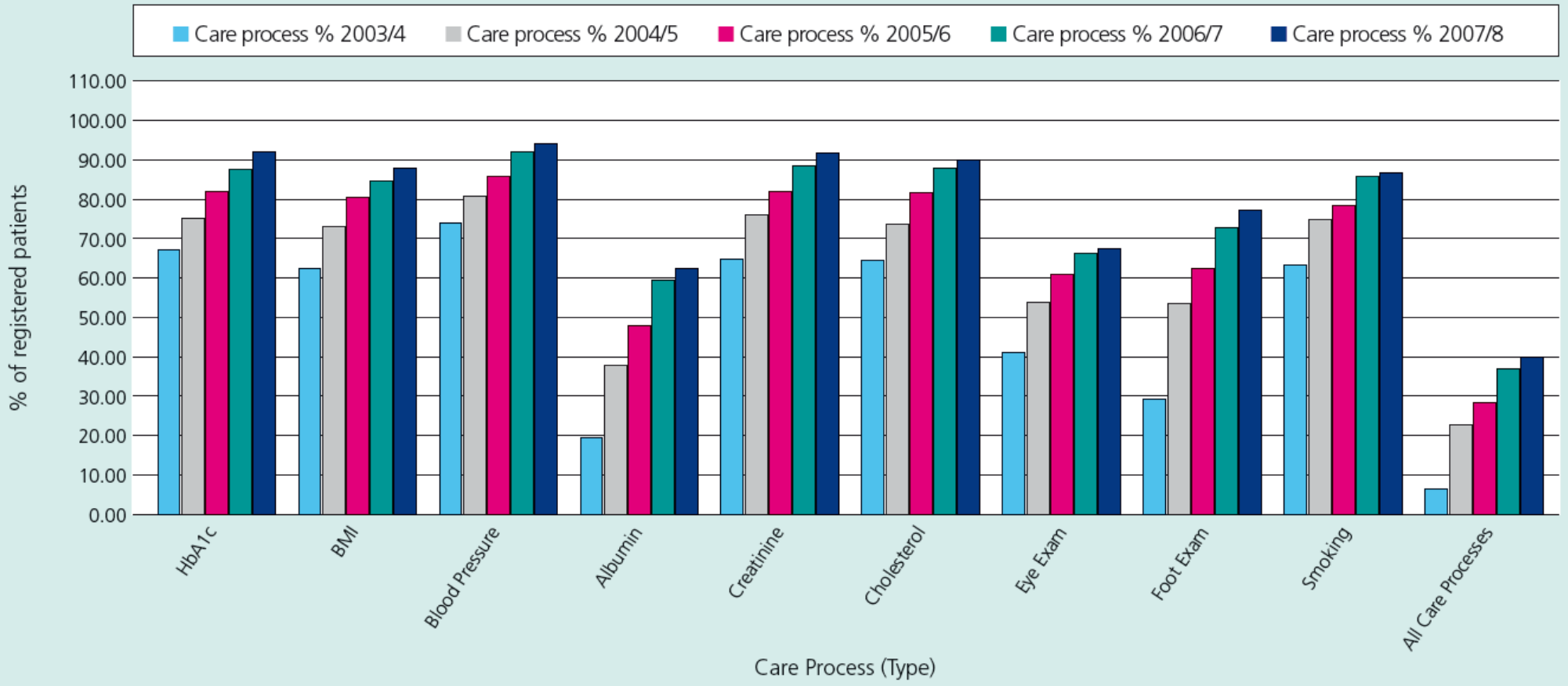
QOF effectiveness

- Care for people with diabetes improved more rapidly when QOF was introduced Campbell S et al NEJM 2009;361:368-378

- QOF reduced the inequality gap between practices in areas of high and low deprivation Doran et al Lancet 2008;372:728-736

Has care Improved too?

Figure 5: Percentage of people with diabetes in England achieving key care processes, over the 5 audit periods



Has QOF worked in Practice ?

- Observational study in 26 South London General Practices 2000–2005 (n = 1441)

	Median practice-specific % achieving target				
Clinical indicator	2000	2001	2002	2003	(QOF) 2005
HbA_{1c} recorded	**60**	**72**	**80**	**78**	**95**
HbA_{1c} ≤7.4% (≤57 mmol/mol)	**22**	**32**	**37**	**38**	**57**
BP recorded	**75**	**84**	**87**	**89**	**98**
BP ≤145/85mmHg	**38**	**40**	**47**	**50**	**70**
Chol recorded	**50**	**65**	**71**	**77**	**93**
Chol ≤5.0mmol/l	**23**	**34**	**36**	**47**	**72**

Gulliford MC et al. *Diab Med* 2007;24:505

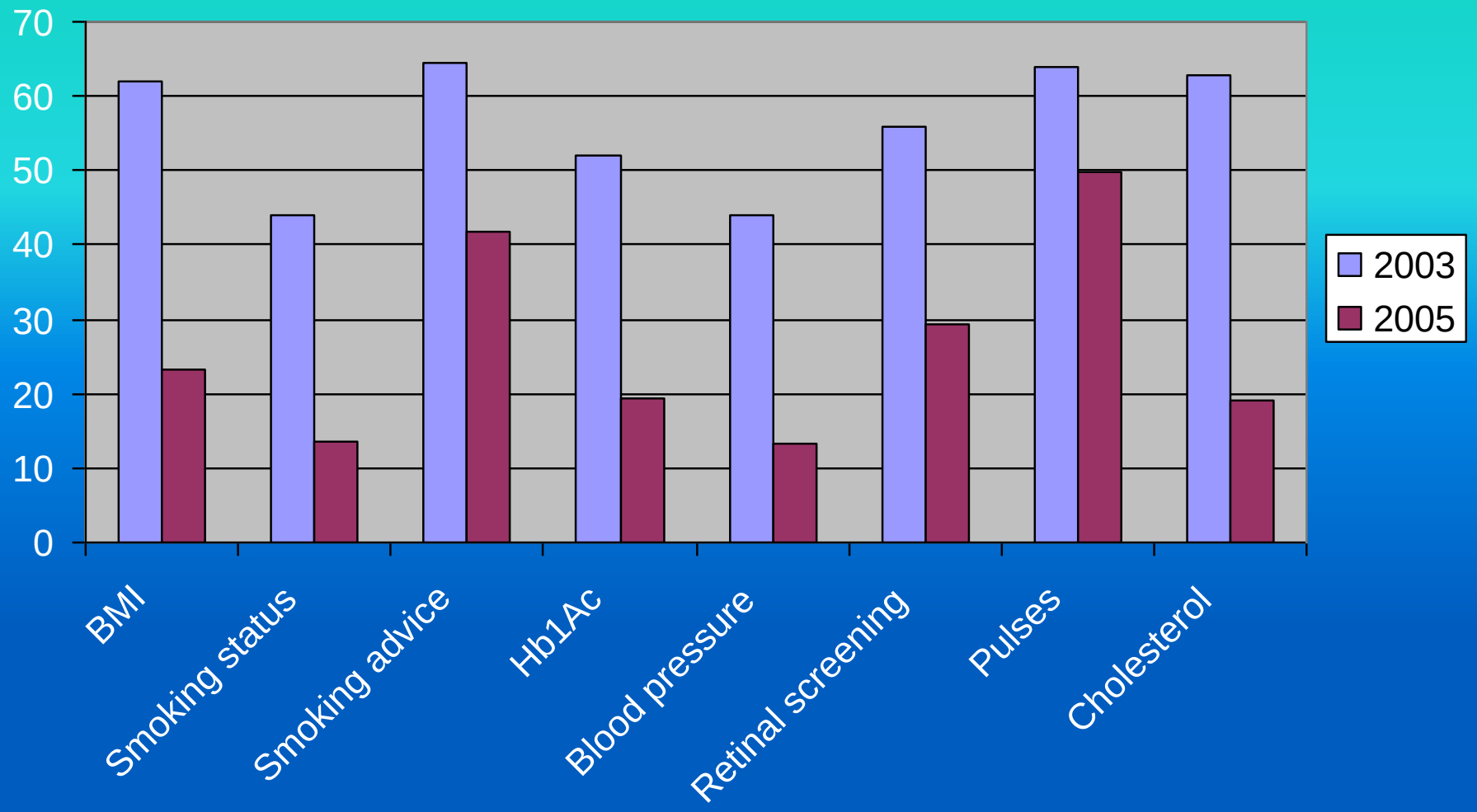
And more data

- Observational study in thirteen Nuneaton General Practices 2004-2005

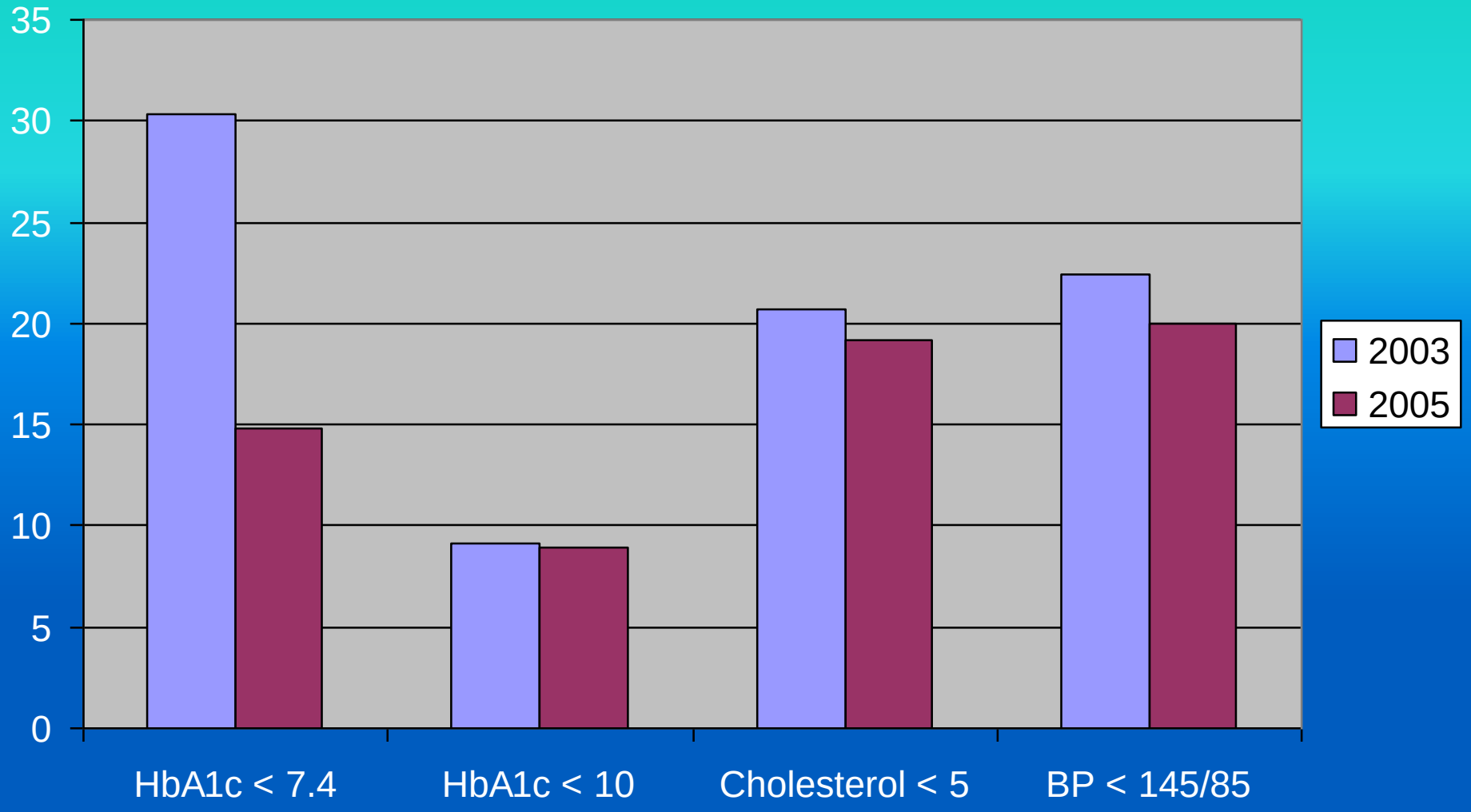
	% of patients for whom target achieved		
Clinical Indicator	2004 (n~3200)	2005 (n=3200)	P-value
HbA_{1c} recorded	**85**	**91.6**	**0.049**
$HbA_{1c} \leq 7.4\%$	**43.9**	**65.8**	**<0.0001**
BP recorded	**79.9**	**96.1**	**0.009**
BP ≤ 145/85mmHg	**50.2**	**65.9**	**0.001**
Chol recorded	**74.5**	**89.1**	**0.001**
Chol ≤ 5.0mmol/l	**47**	**68**	**<0.0001**

Jaiveer PK et al. *Br J Diabetes Vasc Dis* 2007;6:45

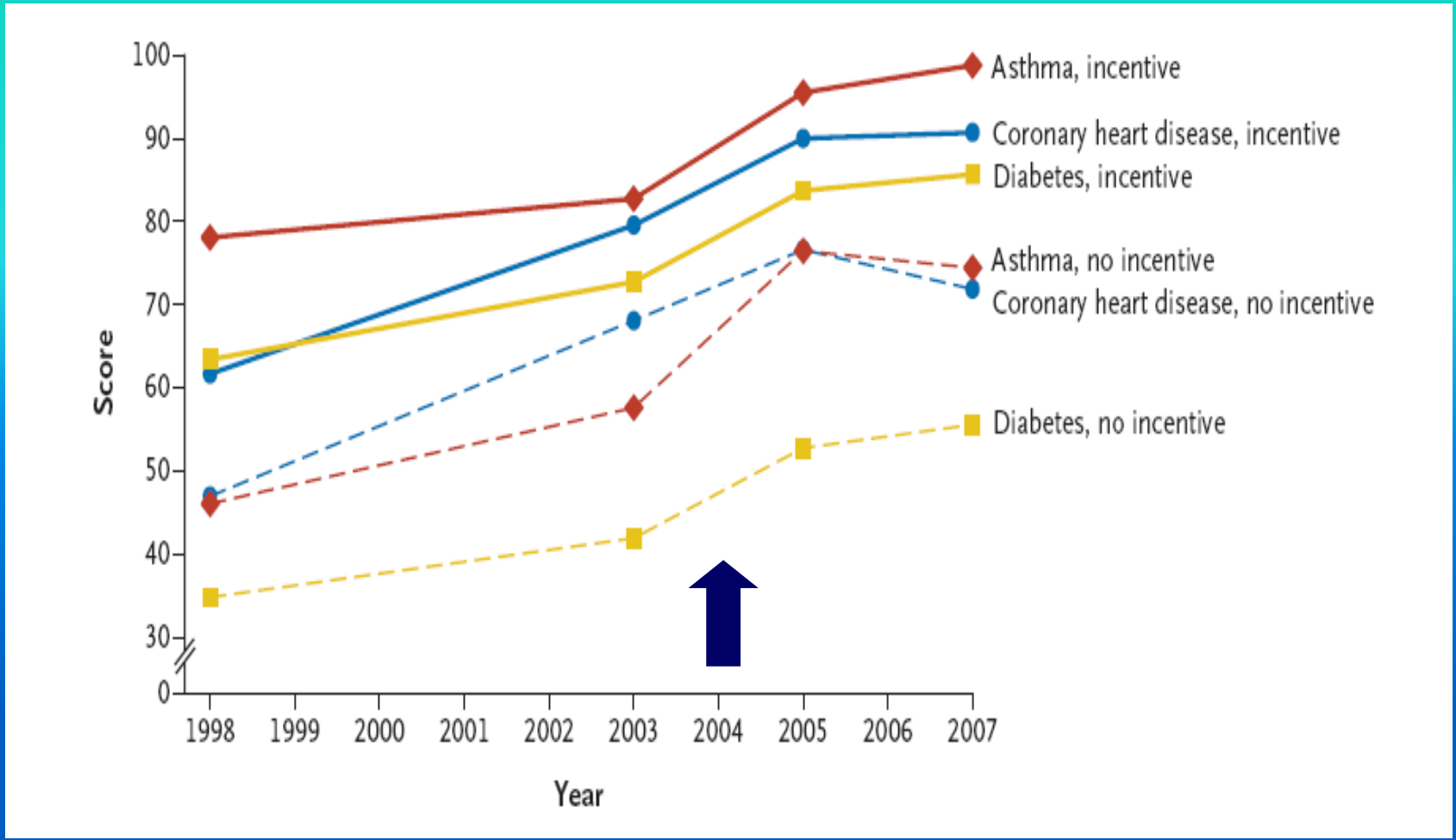
GMS quality indicators (process) - 10th/90th centile range



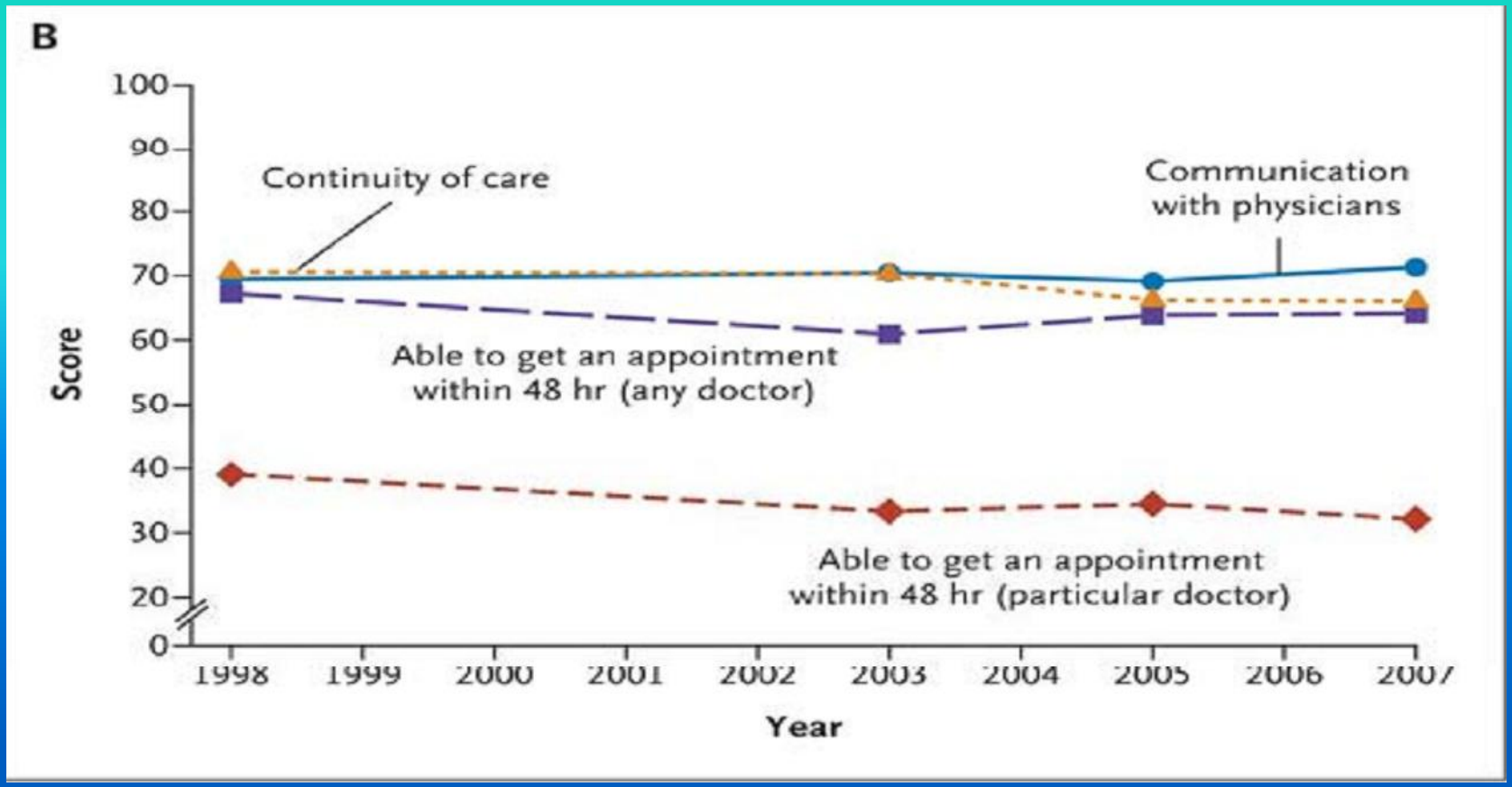
GMS quality indicators (outcomes) - 10th/90th centile range



Adverse impact



But compare this



Campbell SM, et al N Engl J Med 2009; 361:368-378

US vs NHS process and outcome of care

	US Commercial (Mean)	US Commercial (Best)	NHS
HbA1c in 12 months	87.5	92.1	95.6
HbA1c <9%	70.4	79.0	81.0
Retinal screening in last 12 months	54.7	73.2	73.7
BP ≤130/80	29.9	42.2	30.1

What about patients?

- QoF data for England has been available for patients to search since September 2005 via a patient-friendly site produced by the Information Centre (IC). The site enables patients to access their own practice's results, compare them with last year's results and compare both against other practices in the local area and against national scores.
- Overall, visitors to the centre's website increased by almost 100% in the year to January 2007, with the site now attracting more than 1000 hits per day and 48,000 visits in January

http://www.ehiprimarycare.com/news/

Exception reporting in England

Effective exception rate for diabetes

6.01%	2005/06[1]
6.34%	2006/07[1]
6.00%	2007/08[2]
5.65%	2008/09[2]
6.44%	2009/10[3]

- Effect of exception reporting likely to be small
- QOF monitoring process – practice visits by QOF teams

1. The Information Centre (2007) *National Quality and Outcomes Framework Exception Reporting Statistics for England 2006/07*.
2. The Information Centre (2009) *Quality and Outcomes Framework Exception Data 2008/09*.
3. The Information Centre (2010) *Quality and Outcomes Framework Exception Data 2009/10*

NICE Quality standards in diabetes

1. **Structured Education**
2. **Advice on nutrition and Physical Activity**
3. **Care Planning**
4. **Personalised HbA1c target 48-58mmol/mol**
5. **Regular medication reviews**
6. **Structured support for insulin management**
7. **Contraception and preconceptual advice**
8. **Annual risk and complication review**
9. **Annual psychological review**
10. **At risk foot assessment and referral**
11. Inpatient care
12. DKA follow up
13. **Hypo follow up**

http://www.nice.org.uk/media/FCF/87/DiabetesInAdultsQualityStandard.pdf

Whats next

- New title- *QOF Quality and Productivity (QP) Indicators*
- *Peer review (initially for prescribing)*
- *Care pathways*
- *Improvement plans*
- *Reduce unscheduled admissions*
- *COF*

The **Commissioning Outcomes Framework** to set direction and accountability

Organised around 5 national outcome goals / **domains** covering the breadth of NHS activity

These will help the public and Secretary of State for Health to track:

How **EFFECTIVE** the care provided by the NHS is
What the patient **EXPERIENCE** is like
How **SAFE** the care provided is

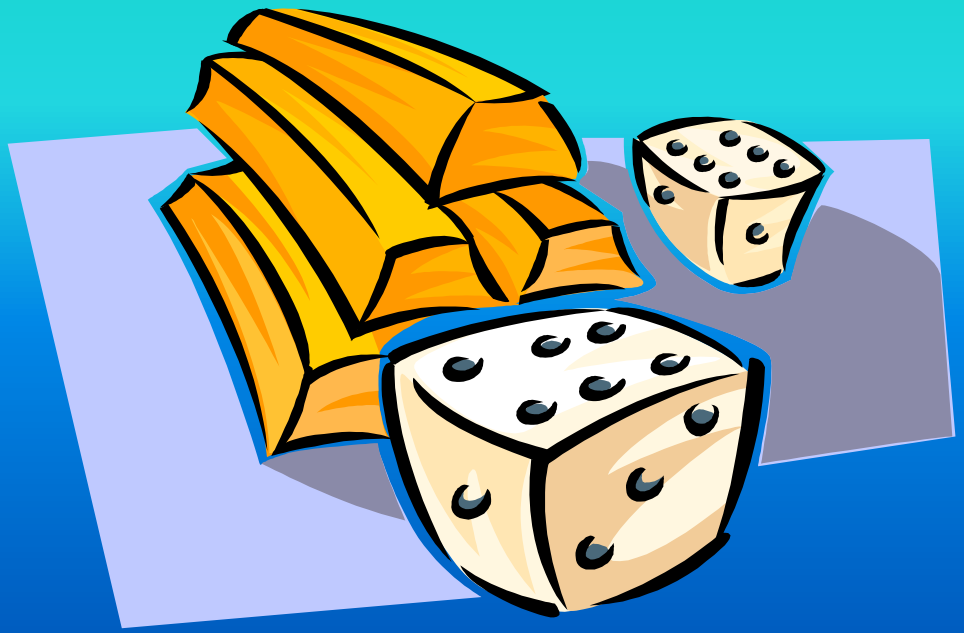
Domain 1	**Preventing people from dying prematurely**	**Effectiveness**
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**Patient experience**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**	**Safety**

And the indicators for Diabetes are..

- 7 on structured education
- 2 on DKA
- 1 on amputation rates
- 1 on complications
- 1 on hypo admission rates
- 1 on all 9 care processes

Incentives work!

Prof Martin Rowland (N Engl J Med 2004;351:1448-54)



- Better data collection
- More practice nurses
- Increased specialisation in primary care
- Increased biomedical orientation
- Improved health outcomes

QOF is a multi-faceted intervention

“Multifaceted professional interventions and organisational interventions that facilitate structured and regular review of patients are effective in improving the process of care.”

Renders CM et al. Cochrane Database 2001

Limitations of QOF

- Still some variations in care
- Target gaming by government
- Incrementally small benefits
- Areas not in QOF may be ignored
- Continuity of care may be affected.
- Not evenly applied

Other countries considering adopting QOF

- US
- New Zealand
- Australia
- European countries (France, Spain)

Even the Consultants support it!

BMJ 2005;331:1340 (3 December), doi:10.1136/bmj.331.7528.1340-a

Letter

Diabetes and the quality and outcomes framework

Integrated care is best model for diabetes

EDITOR—The Association of British Clinical Diabetologists (ABCD) welcomes Kenny's editorial on the impact of the quality and outcomes framework on diabetes management and supports his plea for supporting and strengthening secondary (specialist) care diabetes services.[1]

The implementation of the updated contract for general medical services (GMS2) has resulted in a welcome increase in the monitoring of patients, especially those with type 2 diabetes, who have been comparatively neglected in the past. However, the need to improve glycaemic control to meet the target value of 7.5% for HbA_{1c} has had some unforeseen consequences. In most specialist centres, referrals of patients treated with tablets for consideration of insulin treatment have increased, and many general practices do not feel confident with this. Simultaneously, it is not only extremely difficult for secondary care to attract additional resources, but there is actual "downsizing" of some specialist units by local primary care trusts, in line with the government's desire to transfer most, if not all, of chronic disease management from secondary to primary care.

This is one of the main reasons for the increasing frustration and discontent among diabetologists, which has led to a decline in recruitment into the specialty and many unfilled consultant posts. If as a result specialist services

In summary….

- At a time of increasing prevalence of diabetes
- Evidence of large variations in care and poor quality prior to QOF
- QOF has improved proxy outcomes for most but not all
- Proved the value of targeted incentivisation
- Increasingly aligned with care standards
- Patient experience is included
- Evidence led
- Evolving after 8 years
- Other opportunities
  - Sampling frame for:
    - clinical trials
    - epidemiological & genetic studies
    - health policy & health services research
    - supporting health economics

So.. Has QOF improved the lives of people with diabetes?

Simples!

Thanks for listening !