DIABETES THINK TANK

Wednesday 5 June 2013

Meeting Room O, Portcullis House

2.30pm – 4.00pm

QOF: Delivering Better Care for Patients

Meeting Report

Introduction

On 5 June, the Diabetes Think Tank met to discuss the opportunities to reform the diabetes-specific indicators of the Quality and Outcomes Framework (QOF) in order to improve the health outcomes for people with diabetes. While the condition is extensively represented within the QOF, concerns have been expressed that the framework has become unwieldy and that the current diabetes indicators no longer offer effective incentives in driving improvements in diabetes care.

During the discussion, the Think Tank examined the ways in which the current indicators could be revised and considered the possibility for inclusion of additional measures that would drive care improvements in three key areas:

1) delivery of the nine key care processes;
2) integration of diabetes care; and,
3) diabetes screening.

The meeting was co-Chaired by Adrian Sanders MP, the Diabetes Think Tank's long-standing Chair, and Professor Roger Gadsby, who has played a key role in the development of QOF indicators in the past and possesses wide-ranging expertise in the area. The meeting was attended by Dr Jonathan Valabhji, the recently appointed National Clinical Director for Obesity and Diabetes and a number of leading diabetologists, GPs, diabetes specialist nurses and patient group representatives.

This report provides a record of the discussion that took place during the meeting and sets out a number of practical recommendations for the reform of the QOF. A copy of this report will be shared with key stakeholders, including Anna Soubry MP, Parliamentary Under-Secretary of State for Health with responsibility for diabetes care.

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Summary of Recommendations

Recommendation 1:
The QOF indicator for cholesterol levels should be lowered from ≤ 5.0mmol/l to ≤ 4.0mmol/l and separate indicators should be created to incentivise the achievement of appropriate cholesterol levels in type 1 and type 2 diabetes.

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Recommendation 2:
Further research, including pilot schemes, should be conducted to determine the exact wording of a new composite QOF indicator, comprising the nine key care processes. Such an indicator could be accompanied by individual indicators for care processes that require additional incentives to improve.

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Recommendation 3:
Retinopathy screening should remain part of the nine key care processes, to encourage attendance, even though it is delivered by the Diabetic Retinopathy Screening Service.

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Recommendation 4:
NICE should ensure that more detailed exception reporting is included in the QOF reporting regime to prevent undue penalisation of GPs for not performing checks on patients for whom they are not suitable.

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Recommendation 5:
Achievement of the structured patient education QOF indicator should be measured by the number of patients "completing" a programme rather than by "attendance".

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Recommendation 6:
Rather than incentivising the delivery of checks for diabetes-related foot complications, the QOF should incentivise the referral of patients, whose foot test results require specialist attention, in line with NICE recommendations.

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Recommendation 7:
NICE should consider the development of QOF indicators at a CCG level to encourage integration across the diabetes care pathway.

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Recommendation 8:
Patients who are diagnosed with a condition associated with a higher risk of diabetes should receive diabetes screening as standard practice. Where possible, this screening should be incentivised by the QOF.

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Recommendation 9:
A QOF indicator should be developed to incentivise the provision of diabetes-specific preconception advice where appropriate.

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Recommendation 10:
QOF indicators DM15 and DM16 should be removed and funding should be reallocated to indicators for diabetes preconception and pregnancy care.

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Background Information

QOF was introduced in 2004 as a voluntary incentive scheme open to GP practices across the UK. Its purpose is to incentivise participating GPs to meet best practice standards, measured by a nationally agreed set of indicators. Practices score "points" against these indicators and payments are awarded based on the number of points that are achieved. Payments are adjusted to reflect the size of the practice taking part and the local prevalence of the conditions in question.

Following a public consultation in 2008, the National Institute of Health and Care Excellence (NICE) took over the responsibility for administering the framework from the Department of Health (DH). This was to increase the transparency of the indicator development process and the scheme as a whole. NICE now undertakes the following roles with regard to the QOF:

- prioritising areas for new indicator development;
- developing and selecting new indicators;
- advising on indicator thresholds;
- ensuring consultation with individuals and stakeholder groups; and,
- recommending whether existing indicators should continue to be a part of the QOF.

Evidence regarding the QOF and potential new indicators is provided to NICE by an independent expert panel, which was first established in 2006. This evidence informs negotiations over changes, which take place between NICE, NHS Employers (representing the Health Departments of the four UK nations) and the British Medical Association's General Practitioners Committee. Any changes to the QOF should be agreed via these negotiations as they impact upon the General Practice Standard Contract. However, if the negotiations prove to be inconclusive, the DH can impose QOF changes on GPs. A number of changes that took effect from April 2013 were imposed in this manner after negotiations with the British Medical Association broke down.

When new QOF indicators are recommended, NICE requires a pilot scheme to take place prior to any nationwide roll-out. NICE works with partner organisations such as the University of Birmingham and the York Health Economics Consortium to pilot new indicators as well as to carry out cost-effectiveness and other analysis. NICE also works with the Health and Social Care Information Centre, which takes responsibility for QOF data management and the development of "business rules" for the QOF.

There are currently 16 QOF indicators relating to diabetes. Diabetes-specific indicators are listed below and cover areas including: the creation of a diabetes patient register; the delivery of the nine key care processes; and patient education. Three diabetes-related indicators were added to the 2013/14 QOF; one on patient education and two relating to erectile dysfunction.

Concerns have been raised about the continued effectiveness of the QOF in improving diabetes care. In particular, the National Diabetes Audit has identified that large numbers of patients are not receiving the nine key care processes or other NICE-recommended care standards. This led to the DH asking NICE to examine the possibility of developing a composite QOF indicator which comprises all nine care processes.

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It is unclear whether this will be adequate. A report published in 2013 by a broad range of diabetes stakeholders, *Best Practice for Commissioning Diabetes Services: An Integrated Care Framework* suggests that achieving patient-centric, integrated care is only possible "by moving beyond payment-by-results and QOF". NHS England has also expressed an interest in moving the NHS away from payment-by-results systems. The future of the QOF may therefore be uncertain.

Diabetes QOF Indicators 2013/2014

DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less
DM005. The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March
DM011. The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
DM012. The percentage of patients with diabetes, on the register, 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 in previous ulcer) or 4) ulcerated foot within the preceding 12 months
DM013. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register
DM015. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months
DM016. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months

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Meeting Notes

Introductory Remarks

The meeting was opened by Professor Gadsby who delivered a series of introductory remarks on the QOF development process and the history of the framework. He pointed out that the performance indicator data shows that the QOF has previously made a considerable impact on diabetes care. He suggested that diabetes care was improving prior to the QOF being introduced and the rate of improvement increased following the framework's introduction. However, from 2008 onwards, this began to level off. This suggests that the benefits derived have begun to dwindle and there is a case for the alteration and renewal of the current indicator set to re-incentivise further improvements.

Professor Gadsby highlighted that QOF indicators for diabetes have seen some changes since NICE took responsibility for the scheme in 2009. In particular, NICE has attempted to bring QOF indicators in line with NICE Clinical Guidelines, which has led to changes to QOF indicator DM13 (the indicator for macroalbuminuria levels amongst diabetes patients). Finally, Professor Gadsby noted that NICE requires all new QOF indicators to be piloted prior to any national roll-out and that a number of new diabetes indicators are currently being piloted.

Theme 1:
Delivery of Nine Key Care Processes

Effective management of cholesterol levels is one of the nine key care processes for diabetes. The National Audit Office and the House of Common's Public Accounts Committee have both recently published reports that criticise diabetes services for not meeting cholesterol targets of ≤ 4.0mmol/l. Currently, the QOF incentivises services to meet a cholesterol target of ≤ 5.0mmol/l. NICE Clinical Guideline 66 – Type 2 Diabetes (CG66) calls for a ≤ 4.0mmol/l target for high risk patients, rather than for all. This suggests that diabetes services have been judged harshly against existing guidance by the two reports mentioned above. Nevertheless, the Think Tank recommended that the QOF be brought into line with the more ambitious cholesterol target. However, if this recommendation is adopted, the Think Tank would suggest that separate QOF targets are created for type 1 and type 2 diabetes. This is due to the difference in cholesterol levels attained by patients with different types of the condition.

Recommendation 1:
The QOF indicator for cholesterol levels should be lowered from ≤ 5.0mmol/l to ≤ 4.0mmol/l and separate indicators should be created to incentivise the achievement of appropriate cholesterol levels in type 1 and type 2 diabetes.

The Think Tank discussed the possibility of introducing a "composite" QOF indicator, currently being developed by NICE. This indicator would incentivise practices to deliver all nine of the key care processes rather than the individual checks. It was noted that achievement levels are high for seven of the nine indicators, but testing for macroalbuminuria levels and retinopathy screening are relatively low. This presents difficulties for the introduction of a composite indicator, as a failure to achieve one care process could lead to an unfairly low completion rate for the whole QOF

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indicator. It was, however, suggested that macroalbuminuria testing achievement rates will improve in future as the QOF now incentivises urine testing rather than ineffective stick testing.

It has been suggested that retinopathy screening is another area that complicates the introduction of the composite indicator. This is because it is the only one of the nine key processes which retinopathy screening is commissioned from and delivered by the Diabetic Retinal Screening Service. The Think Tank discussed the possibility of removing retinopathy from a nine key processes composite indicator but ultimately decided that this would not be a positive step. Attendees felt that the role of primary care in treating diabetes was not necessarily about *providing* all nine care processes directly, but about *ensuring* that all nine are completed.

The Think Tank concluded that the development of a composite QOF indicator for the nine key care processes could be a positive development which could result in the more widespread delivery of all nine key care processes. However, the exact composition of the indicator is critical and requires further discussion.

The Think Tank considered a few options regarding the make-up of the composite indicator. It was proposed that the composite indicator could be introduced alongside selected indicators for individual tests. As part of this model, only some of the existing QOF points allocated for the delivery of each key care process would be allocated to the new composite indicator, with the rest of the individual indicators remaining in place with a reduced points total available.

As with cholesterol levels above, the Think Tank also recommends that NICE investigates the possibility of having separate composite indicators for type 1 and type 2 diabetes, to ensure that primary care physicians are incentivising standards that are appropriate for each disease type.

It was also noted that achieving the nine care processes would not be appropriate for all patients at all times. For example, it may not be appropriate to insist on regular testing for all vulnerable elderly patients in care home settings. For this reason, the Think Tank recommends that the QOF reporting regime includes more detailed exception reporting. This would ensure that patients continue to receive appropriate care while preventing practices from being financially penalised.

Finally, the importance of patient education was recognised by attendees. Patient education is already incentivised within the QOF but the Think Tank discussed the possibility of including education as a tenth key care process. It was also noted that the current education indicator incentivises referral but not completion of the programme. The Think Tank recommends that the QOF should incentivise completed education processes. It also recommends that completion is used as the measurement of achievement for the original nine key care processes.

Recommendation 2:

Further research, including pilot schemes, should be conducted to determine the exact wording of a new composite QOF indicator, comprising the nine key care processes. Such an indicator could be accompanied by individual indicators for care processes that require additional incentives to improve.

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Recommendation 3:
Retinopathy screening should remain part of the nine key care processes, to encourage attendance, even though it is delivered by the Diabetic Retinopathy Screening Service.

Recommendation 4:
NICE should ensure that more detailed exception reporting is included in the QOF reporting regime to prevent undue penalisation of GPs for not performing checks on patients for whom they are not suitable.

Recommendation 5:
Achievement of the structured patient education QOF indicator should be measured by the number of patients "completing" a programme rather than by referral.

Theme 2:
Integration of Diabetes Care

It is universally acknowledged that the delivery of integrated diabetes care not only improves patients' experience of care but also leads to better health outcomes. The Think Tank recognises that the QOF and incentive payment schemes have been key drivers for change within the NHS; however despite this positive impact, the Think Tank does not believe that the QOF is the appropriate lever with which to achieve integrated care for diabetes.

Members of the Think Tank identified a number of difficulties that are likely to be encountered when attempting to integrate diabetes care across primary and secondary care boundaries through QOF. The framework is said to be considered by secondary care providers to be "money for primary care". It is therefore difficult to capture providers' interest in working to achieve targets set by QOF indicators as they do not feel incentivised to do so. This limits the usefulness of the QOF as a lever in trying to achieve further integration. The Think Tank believes that without shared budgets and a move towards shared-decision making processes, workable integrated care for diabetes will not be achievable.

While acknowledging the limitations of the framework in driving further integration of diabetes care, the Think Tank made a number of recommendations for incremental steps that could be taken to incentivise integrated diabetes care using the QOF. It already incentivises screening programmes relating to diabetes however, it is also clear that these are of limited value on their own. The QOF should also be used to incentivise primary care professionals to refer patients to specialists if appropriate, encouraging the providers to collaborate. This step would also be in line with the Think Tank's call for the QOF indicators to measure completed care processes rather than only patient attendance.

Furthermore, the Think Tank noted that NICE Guidelines call for diabetes patients who are screened positively for complications to be referred to a diabetes multi-disciplinary team or to a specialist foot care team within 24 hours. The development of a QOF indicator for referrals that specifically incentivises the referral of patients to specialist teams could lead to diabetes services becoming compliant with NICE-recommended best practice. This would also encourage integrated

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care by incentivising primary care providers to work alongside secondary care beyond a simple referral mechanism.

Recommendation 6:
Rather than incentivising the delivery of checks for diabetes-related foot complications, the QOF should incentivise the referral of patients, whose foot test results require specialist attention, in line with NICE recommendations.

The Think Tank considered the possibility of developing "overarching" QOF indicators to incentivise integrated care at the CCG level. There are a number of diabetes-related complications, such as foot amputations, which are best treated using integrated care teams. However, as incidence levels for such complications will often be low when measured at individual practice level, a QOF indicator will not be effective in incentivising improved and integrated care for such conditions. A number of practices may not treat any diabetes patients who require amputation over a QOF period, meaning that it would not be possible to meet the indicator's achievement requirements and thus there would be no incentive for that practice to improve. A QOF indicator that encourages improved care for such complications, via integrated care, would need to incentivise CCGs rather than individual providers. The Think Tank therefore recommends that the possibility of developing CCG level indicators be investigated in order to encourage improved and more integrated care.

Recommendation 7:
NICE should consider the development of QOF indicators at a CCG level to encourage integration across the diabetes care pathway.

The Think Tank believes that patients can be effective advocates for change within the new commissioning system. Any patient education scheme for diabetes should equip patients with knowledge of the NICE guidance recommendation that treatment should be provided by a multi-disciplinary team where appropriate. This will encourage patients to demand access to multi-disciplinary teams, putting pressure on commissioners to provide an increasingly integrated service.

Theme 3:
Diabetes Screening

The Think Tank considers screening to be an important, and often neglected, part of the diabetes care pathway. GPs are already incentivised to take part in a number of screening programmes, including the NHS Health Check. This check is intended to screen those aged over 40 who present certain risk factors for a number of conditions, one of which is diabetes.

The Think Tank welcomes the provision of NHS Health Checks; however, it is not generally believed that there is sufficient evidence for wider screening amongst the general population. Nevertheless, the five yearly screenings offered by NHS Health Checks are not seen to be entirely sufficient. The Think Tank recommends that diabetes screening becomes part of standard practice for patients who are diagnosed with conditions associated with a higher risk of developing the disease. In particular, diabetes screening should be encouraged amongst those diagnosed with

cardiovascular disease, obesity, COPD, hypertension, dementia and mental health issues. This additional diabetes screening could also be incentivised using QOF indicators developed for these clinical areas.

Recommendation 8:
Patients who are diagnosed with a condition associated with a higher risk of diabetes should receive diabetes screening as standard practice. Where possible, this screening should be incentivised by QOF.

Other Recommendations:

The Think Tank discussed a number of other QOF-related issues. In particular, concern was raised that there has been little improvement in diabetes care during pregnancy and for women with diabetes during pre-natal care. The Think Tank was concerned that unplanned pregnancy is rarely taken into account by the preconception care offered to people with diabetes. Primary care services should discuss conception and preconception issues with people with diabetes where this is appropriate. The Think Tank recommends that people who seek advice relating to pregnancy and conception are asked if they have diabetes as standard practice and are offered advice where appropriate. As the Think Tank believes this care is best provided within a primary care setting, a QOF indicator should be developed to incentivise this behaviour.

Recommendation 9:
A QOF indicator should be developed to incentivise the provision of diabetes-specific preconception advice where appropriate.

Concerns were also expressed over the recent inclusion of QOF indicators DM15 and DM16 in the current diabetes QOF indicator set, relating to erectile dysfunction. It was noted that the diabetes community had suggested that these indicators were not priorities for inclusion during the last QOF consultation, especially when pregnancy-related indicators have yet to be included. The usefulness of an annual check for erectile dysfunction was also questioned by Think Tank members and similar concerns have previously been raised by the British Medical Association. Therefore the Think Tank recommends that DM15 and DM16 are removed and funding reallocated to preconception and pregnancy care indicators.

Recommendation 10:
QOF indicators DM15 and DM16 should be removed and funding should be reallocated to indicators for diabetes preconception and pregnancy care.

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List of Attendees

Adrian Sanders MP	Chair *Diabetes Think Tank* and *All-Party Parliamentary Group for Diabetes*
Dr Gary Adams	*Insulin Dependent Diabetes Trust*
Dr Mike Baxter	Consultant Adviser Diabetes *Sanofi*
Louise Brant	Government Affairs Manager *Sanofi*
Debbie Cook	Nurse Consultant *National Obesity Forum*
Rob Fuller	Secretariat *Insight PA*
Professor Roger Gadsby MBE	Associate Clinical Professor *University of Warwick*
Dr Martin Hadley-Brown	GP and Clinical Tutor *University of Cambridge*
Dr Rowan Hillson	Former National Clinical Director for Diabetes *Department of Health*
Fiona Kirkland	Diabetes Nurse Consultant *Staffordshire and Stoke on Trent NHS Partnership Trust*
Jan Maly	Secretariat *Insight PA*
Alistair McInnes	*College of Podiatry*
Philip Newland-Jones	Advanced Specialist Pharmacist for Diabetes and Endocrinology *University Hospital Southampton NHS Foundation Trust*
Karen Thomsett	Renal Dietetics Manager *East Kent Hospitals University NHS Foundation Trust*
Dr Jonathan Valabhji	National Clinical Director for Obesity and Diabetes *NHS England*

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Grace Vanterpool	Consultant Nurse *Diabetes Service Manager at NHS Hammersmith and Fulham*
Dr Chris Walton	Chair *Association of British Clinical Diabetologists*
Melissa Way	Senior Commissioning Manager *Portsmouth, Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups (CCGs)*
Lyndi Wiltshire	Head of Diabetes Care *Birmingham and Solihull Mental Health Foundation Trust*

About the Diabetes Think Tank

The Diabetes Think Tank has been meeting in Westminster since 2008. It brings together policy makers, patient group representatives and healthcare professionals from across the diabetes patient pathway and provides them with a platform to engage in an open discussion of current issues affecting care for people with diabetes.

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