The new GMS contract QOF update – hot tips and political hot potatoes

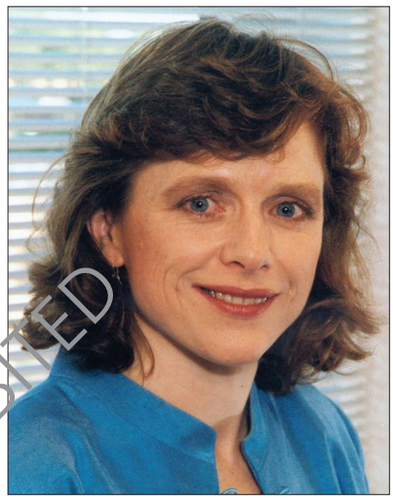
Submissions are in and now the real lobbying can begin. Scarcely a year after the implementation of the Quality and Outcomes Framework (QOF) of the new General Medical Services (GMS) contract,[1] the first review is already well underway and due to come into effect on 1st April 2006. All the existing domains and indicators will be reviewed. Submissions for potential new inclusions were due by 30th May 2005. To stand a realistic chance of inclusion, proposals must be supported by evidence which is published, peer-reviewed, applicable to primary care and preferably emanating from the UK.

So can cardiovascular disease expect any more attention? Certainly it received a disproportionate emphasis in the original QOF, with 257 of the 550 clinical points awarded for management of coronary heart disease (CHD), stroke, transient ischaemic attack (TIA), hypertension and left ventricular dysfunction. Another 99 points were awarded for management of diabetes – a condition now recognised as a CHD risk equivalent.[2]

But while cardiovascular disease (CVD) is the biggest killer in the UK – accounting for 37% of premature deaths among men and 27% among women[3] – there are many other major disease areas which have been completely ignored, or recognised only by a token few points, in the current QOF.

The huge emphasis on CVD reflects the determination of the General Practices Committee (GPC) to ensure that targets for the QOF were evidence-based and objectively quantifiable on computer. CVD is awash with objective evidence which other disease areas, such as mental health and gastroenterology, are never likely to match. Champions of these conditions can be expected to put up a strong argument for their conditions to be included – and the number of new targets which can be included is limited.

Despite the impressively (and, for the government, unexpectedly) high average achievement of QOF points by primary care in the 2004–2005 financial year, the QOF targets have a long way to go before they really reflect excellence in quality of care. The GPC negotiators openly admit that they were designed to be achievable by all practices with an organised system of ongoing care for patients with chronic diseases – with the consequence that most have been set well below the targets of other recognised national guidelines (see table 1). If the GMS contract really is to encourage consistently high standards of patient care (rather than minimal competence), some of the existing targets must be made more stringent. In addition, there are other areas associated with CVD which



Sarah Jarvis

Table 1. Targets for QOF payments compared to other recognised national guidelines

Blood pressure
QOF target blood pressure for hypertensive patients without diabetes – 150/90 mmHg
NSF for CHD target blood pressure for hypertensive patients without diabetes[4] – 140/85 mmHg
NICE target blood pressure for patients with diabetes but no microalbuminuria – 140/80 mmHg[5]
QOF target blood pressure for diabetic patients (with or without microalbuminuria) – 145/85 mmHg
NICE target blood pressure for patients with diabetes and microalbuminuria – 135/75 mmHg[5]
Cholesterol
QOF target total cholesterol for high-risk patients – 5 mmol/L
BHS-IV target total cholesterol for high-risk patients – 4 mmol/L[6]
QOF target LDL-cholesterol for high-risk patients – no target
BHS-IV target LDL-cholesterol for high-risk patients – 2 mmol/L[6]

Key: QOF = Quality and Outcomes Framework; NSF = National Service Framework; CHD = coronary heart disease; NICE = National Institute for Clinical Excellence; BHS = British Hypertension Society; LDL = low-density lipoprotein

have been entirely unrecognised and for which submissions have been made for inclusion in the revised QOF.

Existing targets – raising standards

There are several ways in which existing targets might be altered to encourage higher quality care. They include:

- Tightening up targets for blood pressure and cholesterol to reflect those of the National Service Framework for Coronary Heart Disease (NSF for CHD) and the latest British Hypertension Society guidelines (BHS-IV) (table 1).
- Adding a differential tighter blood pressure target for patients with diabetes who have microalbuminuria (table 1).
- Adding low-density lipoprotein (LDL) cholesterol as well as total cholesterol targets – the supporting documentation of the GMS contract accepts that "…future guidance may relate to reduction of LDL-cholesterol, which is the more important component".[7]
- Increasing the maximum number of patients reaching target to qualify for full points – maximum points at present are payable for achieving a target blood pressure of 150/90 mmHg in 70% of patients with CHD, stroke and TIA, and target blood pressure of 145/85 mmHg in 55% of patients with diabetes; and for achieving the target cholesterol of 5 mmol/L in 60% of all high-risk patients.

Peripheral arterial disease

Peripheral arterial disease (PAD) is recognised by the NSF for CHD as one of the biggest risk factors for CHD – on a par with diagnosed CHD, TIA and stroke.[4] Patients with PAD are at equal risk for CHD as those with angina,[8] and most (60%) will die from myocardial infarction, while a further 12% will die from stroke.[9]

All the QOF indicators for patients with stroke/TIA (smoking status and cessation advice, blood pressure recording and control, cholesterol recording and control, antiplatelet therapy and influenza vaccination) are equally relevant to those with diagnosed PAD. Its omission from the original QOF is illogical and evidence for its inclusion in the review compelling.

Obesity

The UK is on the brink of an obesity epidemic. The incidence of obesity (body mass index [BMI] over 30) in the UK has increased from 14% to 22% in the last 10 years alone, with more than half of women and two thirds of men now obese – the fastest growing rate in the Western world. The annual estimated costs of obesity to the NHS are £1/2 billion and to the UK economy £2 billion. A diagnosis of obesity is associated with a shortening of life expectancy of about nine years, with morbidity and mortality largely attributable to CHD, type 2 diabetes, hypertension and osteoarthritis.[10]

Table 2. International Diabetes Federation criteria for metabolic syndrome[12]

- Central obesity (waist circumference ≥ 94 cm for Europid men and ≥ 80 cm for Europid women, with ethnicity-specific values for other groups)
- Plus any two of:
  - Raised TG (≥ 1.7 mmol/L) or treatment for raised TG
  - Low HDL cholesterol (≤ 1.03 mmol/L for men and 1.29 mmol/L for women) or treatment for low HDL
  - Raised blood pressure (systolic BP ≥ 130 mmHg or diastolic BP ≥ 85 mmHg) or treatment for raised blood pressure
  - Raised fasting plasma glucose (≥ 5.6 mmol/L) or previously diagnosed type 2 diabetes

Key: TG = triglycerides; HDL = high-density lipoprotein; BP = blood pressure

The government has recognised the urgency of tackling the growing problem of obesity and has commissioned numerous papers aimed at addressing the issue via a population wide approach.[10,11] Primary care is also ideally placed to assist with such work and the government is highly likely to support the inclusion of some measures aimed at tackling obesity in the revised QOF. The real question is, which ones?

Traditionally, obesity has been measured in the form of BMI (the only aspect of obesity targeted in the present QOF, with a maximum of 3 QOF points payable for measurement of BMI in patients with diabetes). Recent studies have shown, however, that abdominal obesity is a much better predictor of heart attack than weight or BMI.[7]

A huge raft of patients at high risk of obesity-related complications are not, at present, targeted within the QOF, which concentrates largely on secondary prevention. If real inroads are to be made in cardiovascular morbidity and mortality, the QOF would need to target all patients with obesity, particularly those with metabolic syndrome (table 2). Such patients are five times more likely than those without metabolic syndrome to develop diabetes.[13] They are also twice as likely to die from, and three times as likely to suffer from, CVD.[14]

Of course, measurement of abdominal circumference and diagnosis of abdominal obesity are relatively easy, even in a large section of the primary care population – but such work will be unproductive if it is not linked with strategies for addressing the problem. There is significant anxiety among general practitioners that targets for tackling obesity will discriminate against those caring for socio-economically deprived populations. Such groups are statistically more likely to be obese and less likely to respond to lifestyle measures aimed at weight reduction. They are also more likely to have other risk factors which magnify their risk of CVD.[10]

However, it is possible to reward the work involved in offering health promotion advice, regardless of whether it

translates into changes in behaviour – such a system already exists for smoking recording and cessation advice in the current QOF. A comparable system for identifying and targeting the abdominally obese should offer equitable incentives for all GPs.

Conclusion

CVD is already well represented within the current QOF – the only national mechanism to offer financial reward for achieving high standards of clinical care in primary care. Large numbers of submissions, both within and outwith CVD, have been submitted for possible inclusion in the first revision of the QOF, due for implementation in April 2006.

Some of the submissions relating to CVD – such as obesity – can expect strong government support. Others – such as PAD – have an evidence base just as strong at existing domains, and should logically have been included in the first version of the QOF. Still others – such as tightening current standards for achievement of maximum points, to bring QOF targets into line with national and international guidelines – would drive up standards of care in CVD overall.

The crystal ball remains cloudy, but discussions within the corridors of power are likely to be robust. Whatever the outcomes, we must hope that both healthcare professionals and patients will gain.

Conflict of interest

SJ has received honoraria for serving on advisory boards and for lecturing for AstraZeneca, Sanofi Aventis and Bristol-Myers Squibb.

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Sarah Jarvis
General Practitioner
Richford Gate Medical Practice, Richford Gate Primary Care Centre, Richford Street, London, W6 7HY.
(email: sarah.jarvis@gp-E85016.nhs.uk)

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