Audit of the new GMS contract Quality and Outcomes Framework: raising standards in CHD

This paper looks at what the Quality and Outcomes Framework in the new General Medical Services contract for general practitioners has achieved in the West of Scotland.

Abstract

This paper briefly reviews an analysis carried out in the West of Scotland of the Quality and Outcomes Framework data gathered for coronary heart disease under the new General Medical Services contract for general practitioners. It shows encouraging progress in achieving clinical outcome predictors.

Key words: new GMS contract, Quality and Outcomes Framework, primary care, coronary heart disease.

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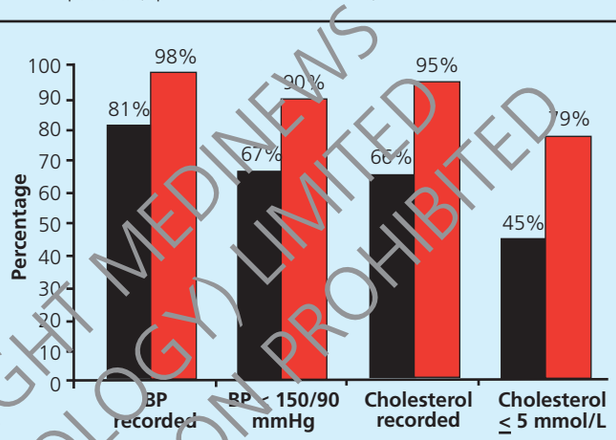
Figure 1. Blood pressure (BP) and cholesterol monitoring among 19,884 coronary heart disease patients (April 2004 and March 2006)



Introduction

The new General Medical Services (GMS) contract for general practitioners (GPs) includes a Quality and Outcomes Framework (QOF) that rewards practices on the basis of quality care.[1] Practices are required to submit regular data to allow payment according to clinical performance. In order to investigate the effect of the contract on secondary prevention for coronary heart disease (CHD), contract monitoring data for CHD from Ayrshire and Arran were analysed. This has shown early progress in achieving clinical outcome predictors.

Participants, methods and results

In Ayrshire and Arran where coronary heart disease (CHD) mortality is high,[2] a collaborative, proactive approach has been taken to promote secondary prevention. It was proposed that the contract monitoring data for CHD should be analysed in order to assess the effect of the contract on CHD secondary prevention.

> ***'The Quality and Outcomes Framework is pushing up standards in the identified clinical priority areas'***

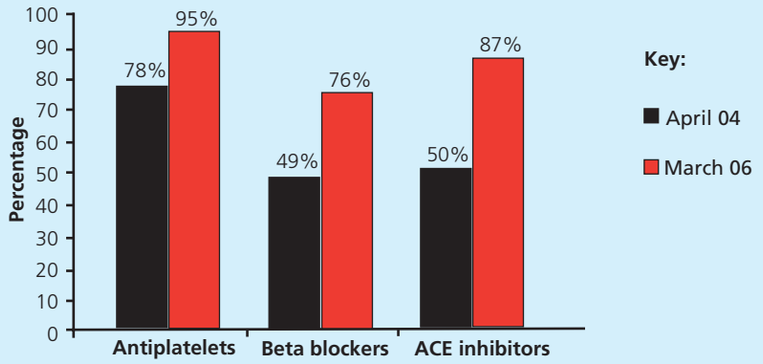
Practice data from Information Services Division (ISD) Scotland via the Quality Management Analysis System (QMAS) – the national database collecting QOF data – were analysed for March 2006. Fifty-eight out of sixty practices returned data relating to a total of 19,884 patients with CHD, with a combined population of 367,028 representing 97% of the Ayrshire and Arran total population. The two remaining practices did not participate for technical or contractual reasons.

In this sample (19,884), the prevalence of patients with CHD is 5.42 per 100 patients in comparison with the QMAS Scottish prevalence of 4.5.

Comparison of April 2004 (the first month of the new contract) with March 2006 (the most recently available data) shows progress in achieving the specified clinical outcome indicators. The results are presented for the whole CHD population, with individual patients excluded where agreed exception criteria have been met.

The proportion of CHD patients having blood pressure recorded in the previous 15 months rose from 81% to

Figure 2. Antiplatelet, beta blocker and angiotensin-converting enzyme (ACE) inhibitor therapy among 19,884 coronary heart disease patients (April 2004 and March 2006)



Key messages

- Primary care has a major role in provision of quality chronic disease management
- High-quality care is more likely to be achieved through the use of incentives
- Monitoring data from the new GMS contract Quality and Outcomes Framework for coronary heart disease gives early indication of improvement in care

98% and cholesterol recordings rose from 66% to 95% (figure 1). The proportions achieving the target blood pressure level of 150/90 mmHg rose from 67% to 90% of the CHD population (figure 1). For cholesterol, the proportion of the population achieving the target of 5mmol/L rose from 45% to 79% (figure 1).

In addition, the proportions of CHD patients receiving drugs known to improve secondary prevention increased. The proportion being prescribed antiplatelet therapy (aspirin, clopidogrel or warfarin) rose from 78% to 95%. For beta-blocker therapy, the proportion of patients receiving prescriptions rose from 49% to 76%. For the subgroup of CHD patients who had had a myocardial infarction (since 1 April 2003), the proportion being prescribed angiotensin-converting enzyme (ACE) inhibitors increased from 50% to 87% (figure 2).

Comment

Routine monitoring data made available to facilitate payments within the new GMS contract are an extremely valuable source of clinical effectiveness data. Analysis gives early indication that the Quality and Outcomes Famework is pushing up standards in the identified clinical priority areas.

This new source of data is particularly useful in that it is now available across the UK and is collected with standardised inclusion and exclusion criteria. It should therefore provide a powerful audit tool in clinical priority areas.

The high prevalence of CHD in Ayrshire is in line with long recognised high mortality for CHD in the West of Scotland.[2]

The accuracy of data has yet to be assessed but guidance on proposed systems to do this has been widely circulated. Both the payment system and quality review proposals incentivise accurate coding and data collection.

Allowance is made for certain patients who fail to achieve prescribing targets, and practice payment is still earned. For example, practice payment is still achieved if a patient intolerant of any statin fails to achieve a cholesterol level < 5 mmol/L. The number of exclusions is small: 2,045 (10%) of patients were recognised for practice payment despite not reaching cholesterol targets and 5,314 (27%) for beta-blocker prescription. Exclusions (which may be for very good reason) nevertheless ultimately represent a failure of therapy. The authors of the GMS contract know that 100% concordance is impossible, given the side-effect profiles and known contraindications of the relevant drugs, so worthy attempts are remunerated.

The improved outcomes in blood pressure and cholesterol control, for example, suggest that not only is more monitoring taking place, but interventions implemented appear to be appropriate.

The early progress is encouraging as practices focus on improving agreed clinical indicators. If this improvement can be maintained, the implications for improving outcomes of chronic disease management are immense.

A national strategy of paying practices by results is likely to show rapid, real benefits in CHD events and stroke.

Conflict of interest

AB has received research grants, lecture fees and consulting honoraria from pharmaceutical companies which manufacture drugs for cardiovascular disease. RE and JM: none declared.

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Quality, evidence-based medicine and pay for performance: the primary care experience

The report from McCarlie and colleagues in this issue (pages 117–19) on the success of Scottish general practice in achieving cardiovascular disease (CVD) targets for clinical indicators within the Quality and Outcomes Framework (QOF) mirrors similar progress across England and Wales. Despite abundant evidence of the benefits of proven interventions for the secondary prevention of CVD, few data were available before the QOF system was implemented on the prevalence of treatment for CVD outside *ad hoc* studies such as EUROASPIRE and HEALTHWISE. Few would now deny that the QOF has proved a successful innovation in ensuring the systematic delivery of evidence-based care.

McCarlie *et al.* report on high levels of treatment with antihypertensive agents, aspirin, beta blockers and lipid-lowering agents. The attainment levels for coronary heart disease (CHD) represent some of the highest of the clinical domains along with hypertension, diabetes and hypothyroidism. In total, across the UK, 1,661 practices achieved the maximum 550 points in the year to April 2006 across the 11 clinical domains. This represents a three-fold increase from the 564 practices in the previous year. In the background, Primary Care Trusts (PCTs) have not fared as well, with the healthcare commission finding that of all the NHS Trusts in England examined in the commission's recent annual "health check", PCTs performed least well.

'Can the next hurdle, payment by results, bring improvements in either quality or outcomes for patients?'

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Evidence of high levels of prescription of pharmacotherapy and control of cardiovascular risk factors does not reflect the overall patient journey for people with heart disease. Patient experience is important and this is also quantified within QOF. More practices carried out satisfaction surveys and met the target for consultation length to boost the average patient experience score to 97 (97%) of the maximum 100 points available. This compares with an average for 2004/05 of 93 points (93%). Holistic care, defined as the proportion of points across the 10 domains, has also increased from 88.1 in 2004/05 to 95.5 (out of a maximum of 100 points) in 2005/06.

Interpreting the data

So attainment levels for cardiovascular clinical domains have been reassuringly high and patient experience, or satisfaction, has not suffered – is it all good news? Prevalence rates for disease registers have shown considerable variation, with hypertension registers ranging from 0% to to 50.1% among practices, and there are four-fold variations in prevalence rates for CHD and heart failure. Clearly, issues around accurate Read coding and local variations resulting from deprivation, ethnic and demographic differences are important when interpreting the crude data within QOF. Heart failure prevalance rates have caused some confusion for the unwary, with a separation of patient subgroups with a CHD aetiology from others with an

ischaemic aetiology, co-existent valvular disease or asymptomatic left ventricular systolic dysfunction. As with clinical medicine, targets and data are no substitute for knowledge and comprehension.

Change is one of the few constants within the UK health service and congratulations must go to general practitioners and their primary care teams which include practice nurses, health care assistants, numerous administrative staff and managers. With the introduction of substantial new targets for chronic kidney disease and atrial fibrillation, there is little imminent likelihood of respite. Future indicators may include other major disease areas, such as osteoporosis and the primary prevention of cardiovascular disease. Although the National Service Framework for CHD and the Quality and Outcomes Framework have been successfully absorbed and proven effective, there is considerable apprehension about whether the next hurdle – payment by results – can bring improvements in either quality or outcomes for patients.

Conflict of interest

None declared.

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