Personal comment

Does the QOF system of payments help improve diabetes care? A general practitioner’s view

David Unwin

As a general practitioner for 30 years I was interested to read the article in this issue of Practical Diabetes (page 108) by Mark Greener about the Quality and Outcomes Framework (QOF) system of payments to improve the care of people with diabetes (and other conditions) in primary care.

A ‘tick-box’ exercise?

I agree that: ‘There is a worry that QOF is sometimes a “tick-box” exercise. There is a lot of measurement of processes, but far less emphasis on treatment targets.’ However, from my point of view there is even less emphasis on the wishes of patients themselves. It feels as if doctors are mechanically just ‘doing things to patients’ rather than involving them in the process of decision-making.

For example, we are told: ‘The QOF sets a total cholesterol target of 5mmol/L. Many guidelines and specialists believe that the threshold for total cholesterol should be 4mmol/L.’ I feel we should explain the risks and benefits to the patients themselves, and then ask if they want statins or not. We should be paid to explain the pros and cons of any approach to our patients, rather than coralling them into treatments to ‘achieve targets’ which are then linked to our pay. No wonder some patients worry! In the case of statins, it might inform a patient’s decision-making to know that – taking 100 diabetic patients without occlusive arterial disease – treatment with statins for five years may be expected to prevent four and a half vascular events such as stroke and heart attack.1

Too much measuring of things

Simon O’Neill, Director of Health Intelligence at Diabetes UK, is quoted as saying: ‘If doctors don’t measure something they won’t change practice.’ How very depressing. In my opinion there is far too much ‘measuring of things’ going on already. However, I am very interested in how we bring about positive change, and suspect it’s better to exercise or even coming off medication (there is a great new verb for this – to deprescribe). We often measure things, accidentally frightening our patients: the number of times I see someone terrified about their blood pressure result, the fear itself putting their blood pressure up (white coat hypertension), the clue being a bounding pulse of over 100. Recently I attended two elderly patients who had collapsed because of overzealous blood pressure control in one day. The art of medicine is not always about measuring things and prescribing drugs according to guidelines.

The untapped resource – and golden opportunities

Debbie Hicks, Nurse Consultant who heads a nurse-led intermediate care service for Enfield Community Services, Barnet, Enfield & Haringey Mental Health Trust, made some good points in the article. These include: ‘...patients don’t feel ill; the complications can take many years, and sometimes decades, to emerge and sometimes treatments are uncomfortable to administer or cause side effects. So, many people feel they can get away with doing nothing. We need to see why each individual doesn’t engage. Self-care is the biggest untapped resource in the management of diabetes.’ I completely agree with Debbie Hicks about self-care being untapped, but I find there are some golden opportunities to develop this.

For the last two years, before starting any new medication for someone with type 2 diabetes I have discussed the pros and cons of drugs and taken the opportunity to introduce the alternative of diet and weight loss. Without exception the patients have chosen to try and lose weight! When asked, patients tell me they find the idea of life-long medication depressing. Of course, this approach involves more regular review for re-weighing but it makes the patient more aware of self-care, as Debbie Hicks puts it, and there are drug savings. Our practice runs an after work, evening weight-loss clinic just for those with diabetes; it’s a pity QOF payments don’t help pay for this (the average weight loss over a year for those who attend the clinic is >8kg).

The QOF system pros and cons in general practice

I have found the QOF system has unfortunately promoted the doctor’s agenda in a consultation above that of the patient: we are so pressured to take the opportunity to measure blood pressure, arrange blood tests etc, and have less time to just listen to why they have come and how they hope we can help.

On the other hand, the QOF system has stimulated involvement in better IT systems for general practice. We now have up-to-date ‘disease registers’ as they are called. This means we are better able to target resources to specific patient groups. It’s because of the QOF system that I know who the youngest diabetic individuals in the practice are, or the ones with deteriorating renal function.

The QOF system has at least established the idea that it costs money to achieve better care for people with chronic diseases such as diabetes. Perhaps we need to trial different models of care first, before rolling out a single model nationwide. These trials should not be about ‘surrogate’ markers such as cholesterol or blood pressure control, but end-points such as heart disease, and include patient choice and wellbeing.

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Reference