QOF+ Framework
2018/19

Version 2.3 (Final Draft)

Contents

1 Background

1.1 Leadup to this work

Supporting the continued improvement and development of Primary Care is a key ambition for Wolverhampton CCG, reflected in the plans set out in our Primary Care Strategy. We have assumed fully delegated responsibility for commissioning primary care from April 2017 and undertaken significant work to support emerging clinical groupings to meet the needs of their patients, in line with the priorities set out in the *GP Forward View*.

Interventions for 2018/19 include:

- Retrospective GP peer review of referral behaviours, to manage demand for acute services;
- Risk stratification, to direct review of patients at highest risk of unplanned admission to hospital;
- Early diagnosis and enhanced review/care planning for people with COPD and asthma;
- Improving uptake of bowel cancer screening.

The 'QOF+' scheme builds on the benefits of the national Quality and Outcomes Framework (QOF) scheme. The purpose of the national QOF scheme is to reward and incentivise GP practices in England for the quality of care they provide to their patients and to help standardise improvements in the delivery of primary care.

QOF awards practices funding for:

- Managing some of the most common chronic diseases (such as asthma or diabetes);
- Managing public health concerns (such as smoking or obesity);
- Implementing preventative measures. (such as regular blood pressure checks).

Our QOF+ scheme has been developed in response to engagement with our member practices. Group discussions at a session with our Members in November 2017 identified a range of potential scheme ideas, with a broad focus on prevention. These were assessed for feasibility, potential impact and alignment with wider local priorities. They were subsequently refined by our Primary Care team into three main priority areas for further exploration:

- Diabetes
- Excessive alcohol consumption
- Obesity

We undertook a focused review of effective primary care interventions relating to these three priority areas in January and February 2018. This included scoping work, a review of the evidence and a return on investment exercise, to quantify potential impacts. The findings of this review have informed the components of the QOF+ scheme, detailed in the sections below.
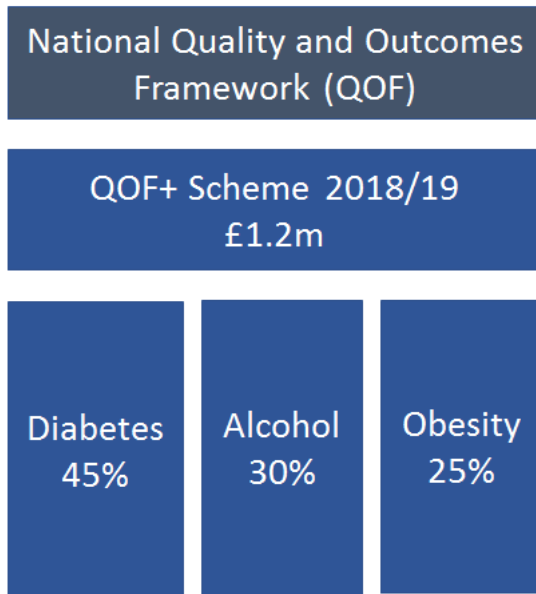
Figure 1 – Highlighting Wolverhampton CCG interventions in Primary Care for 2018/19

In February 2018, a preparatory scheme was launched with a focus on improving data quality for:

- Patients classified as 'pre-diabetic' (i.e. aged 18+ with HbA1c 42-47 mmol/mol or FPG 5.5-6.9 mmol/L);
- Patients with a body mass index (BMI) of 40+ kg/m^2;
- Patients with gestational diabetes;
- Patients with prognostic indicators of a respiratory condition.

This document sets out:

- National and local context for the priorities of the QOF+ scheme, including population need;
- The underlying evidence base and a description of proposed interventions;
- Intended outcomes and 'QOF+ indicators' to be measured;
- Payment mechanisms for the QOF + scheme.

1.2 National context

Diabetes

- **Public Health England (2015) estimates there are 3.8m people aged 16 years and over in England with diabetes (of which 940,000 are undiagnosed).** This is equivalent to 8.6% of the population in this age group.
- Based on population projections, **by 2035, diabetes prevalence is expected to increase to 4.9m (9.7%).**
- Prevalence is higher in men than in women (9.6% vs 7.6%), higher in people from South Asian and black ethnic groups compared with people from white, mixed or other ethnic groups (15.2% vs 8.0%) and increases with age.
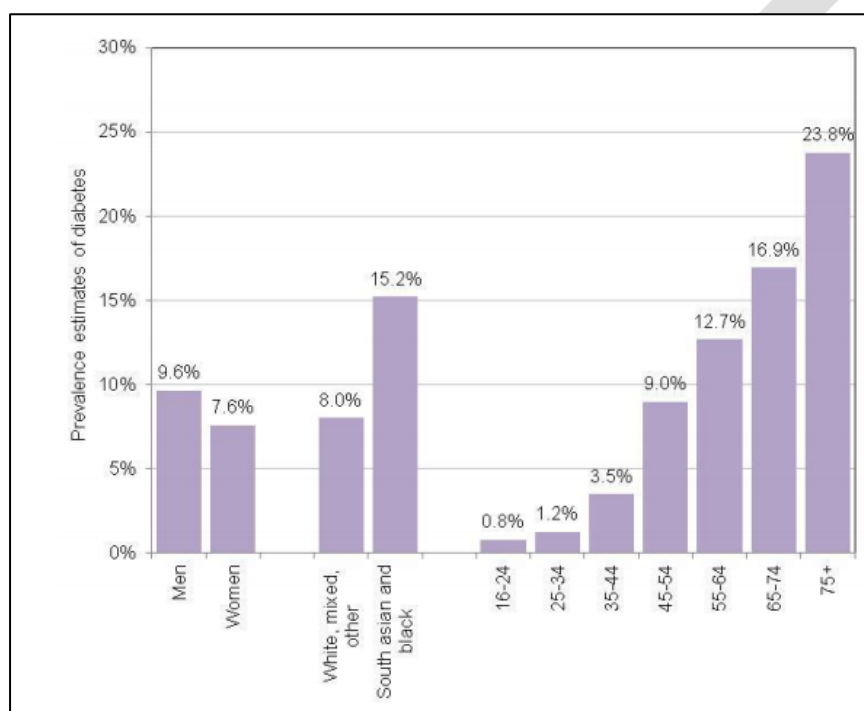
Figure 2 – Summary of expected diabetes prevalence for England in 2015 by age group, sex and ethnicity (Taken from Diabetes Prevalence Model, PHE 2015)

- **Obesity is the most potent risk factor for Type 2 Diabetes Mellitus (T2DM)**, accounting for ~80-85% of the overall risk.
- **Diabetes UK (2016) estimate people with diabetes in England and Wales are 34.4% more likely to die earlier than their peers** – in T2DM, the average reduced life expectancy for an individual diagnosed in their 50s is ~6 years.
- **It is estimated that £10bn is spent by the NHS on diabetes annually** – people with diabetes are twice as likely to be admitted to hospital and 45.1m prescriptions items were dispensed in primary care across England in 2013/14 (net ingredient cost of over £803m).
- In England and Wales, the National Diabetes Audit 2016-17 indicated **only 40.8% of all people with T2DM are achieving the treatment targets** recommended by NICE to reduce the risk of complications, **whilst only 47.6% of people with T2DM receive the recommended eight annual care processes.**

Alcohol

- **Public Health England (2016) reports 10.8m adults in England are drinking at levels that pose some risk to their health**, whilst 1.6m may have some level of alcohol dependence. Alcohol dependence is more common in men (6%) than in women (2%).
- **The cost of alcohol to society is estimated as £21bn per year**, made up of £11bn in alcohol-related crime, £7bn in lost productivity and £3.5bn in the cost to the NHS. In 2013/14, there were 333,014 admissions to hospital where the main reason was alcohol-related.
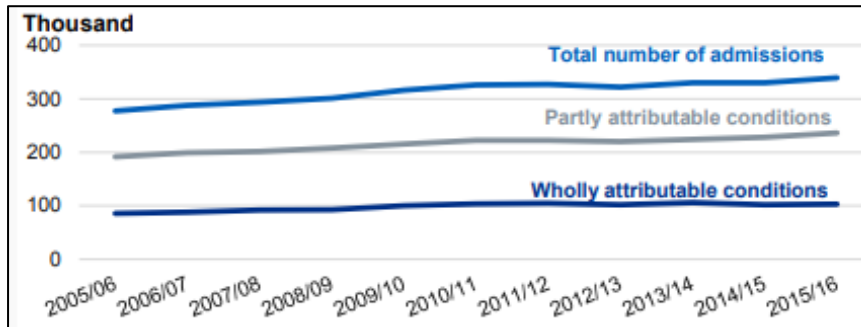
Figure 3 – Alcohol attributable deaths in England by condition (from Statistics on Alcohol, NHS Digital 2017)

- **Excessive alcohol consumption is a major cause of preventable premature death.** It accounts for 1.4% of all deaths registered in England and Wales in 2012. An analysis of 67 risk factors and risk factor clusters for death and disability found that **alcohol is the third leading risk factor for death and disability,** after smoking and obesity.
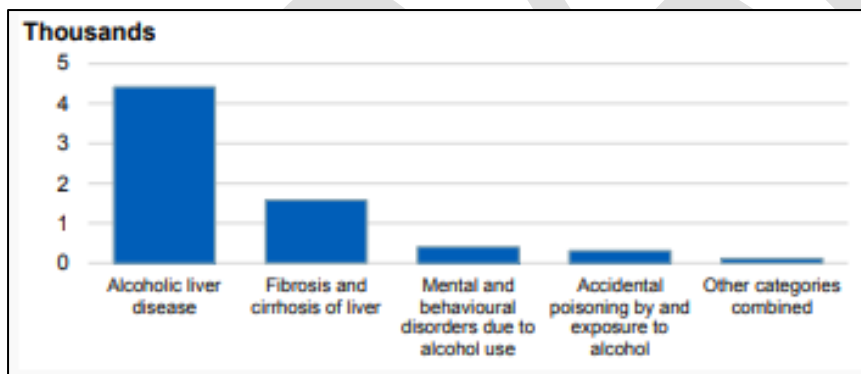
Figure 4 – Alcohol attributable deaths in England by condition (from Statistics on Alcohol, NHS Digital 2017)

- **Guidance from the Chief Medical Officer (2016) warns that drinking any amount of alcohol carries a health risk, including increasing risk of a range of cancers (such as mouth, bowel, stomach and breast).**
- **Alcohol misuse is associated with mental health problems.** There is a strong association between alcohol misuse and suicide.
- **The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.**

Obesity

- **Public Health England (2017) reports nearly two-thirds (63%) of adults in England were classed as being overweight (BMI of over 25 kg/m^2) or obese (BMI over 30 kg/m^2) in 2015.** Prevalence of obesity is similar between men and women.

- **Prevalence of obesity in England has risen sharply, from 14.9% to 26.9% between 1993 and 2015**. Highest obesity levels are found in the 55-64 age group.
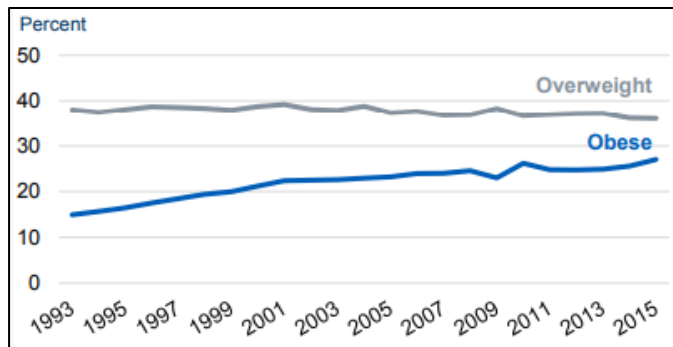
Figure 5 – Prevalence of obesity over time in England (from Statistics on Obesity, Physical Activity and Diet, NHS Digital 2017)

- **The cost of obesity to society is estimated at £27bn.** It is estimated the NHS spent £6.1bn on overweight and obesity-related ill health in 2014-15 – this is projected to reach £9.7bn by 2050.

- **Obesity is responsible for more than 30,000 deaths per year**, on average reducing lifespan by 9 years. It increases the risk of a range of diseases, including cancers, hypertension and T2DM.

- Figures from the Health Survey for England (2016) show that **only 67% of men and 55% of women aged 16 were classed as 'active'** (doing at least 150 minutes of moderate physical activity per week.) People from Asian, Black and Chinese ethnic groups were more likely to be inactive than those from White and Mixed Asian groups.
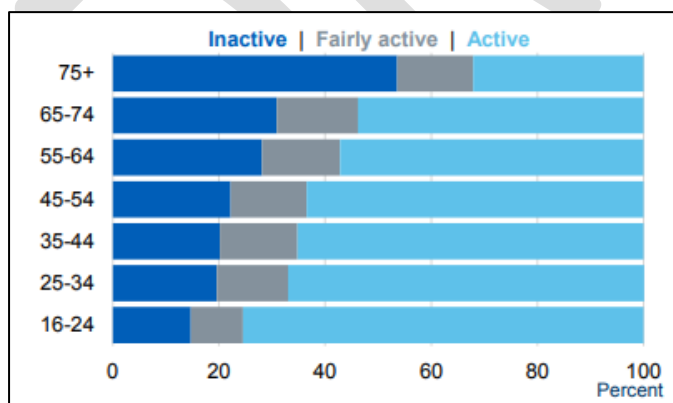

Figure 6 – Activity levels by age in England (from Statistics on Obesity, Physical Activity and Diet, NHS Digital 2017)

- **Only 26% of adults ate the recommended 5 portions of fruit and vegetables a day in 2015.** More than a quarter (27.1%) of adults and one fifth of children eat food from out-of-home food outlets at least once a week.

1.3 Local context and population needs

Diabetes

Analysis undertaken as part of the RightCare programme identified:

- **Wolverhampton has a reported diabetes prevalence of 8.17% of the adult population,** equating to 17,424 registered diabetic patients (2015/16).
- **Reported prevalence is higher than other comparable CCGS (apart from Walsall), and in addition, estimated prevalence is higher than all comparable CCGs.**
- **Wolverhampton has an estimated prevalence of 9.40%, equating to ~20,000 people with diabetes.**
- Data indicates a much higher prevalence of diabetes in Black and Minority Ethnic (BME) communities in Wolverhampton when compared to England. BME communities make up approximately 32% of the Wolverhampton CCG population, compared with the average of ~15% BME communities in the population of England as a whole.

The 2016-17 CCG Integrated Assessment Framework (IAF) assessment for diabetes was rated as 'Requires improvement'. Data from the **2016/17 National Diabetes Audit** identified:

- 38.9% of patients with all types of diabetes achieved all treatment targets.
- 2.7% of patients with diabetes diagnosed less than a year attended a structured education course.
- **For the eight recommended care processes for T2DM:**

Care process	Wolverhampton	National
HbA1c	95.2%	95.1%
Blood pressure	96.8%	96.2%
Cholesterol	93.8%	92.7%
Serum Creatinine	94.0%	95.0%
Urine albumin	58.2%	65.2%
Foot surveillance	84.7%	79.4%
BMI	81.0%	83.1%
Smoking	81.4%	85.5%
All eight care processes	44.0%	47.6%

- **For the treatment targets for people with T2DM:**

Care process	Wolverhampton	National
HbA1c <7.5%	65.8%	66.8%
Blood pressure <=140/80 mmHg	73.1%	74.2%
Cholesterol <5 mmol/L	75.1%	76%
All three treatment targets	40.2%	40.8%

Alcohol

The most recent Joint Strategic Needs Assessment (JSNA) for Wolverhampton identified:

- **Alcohol related mortality is worsening over time** and remains above the England average (17.4 DSR per 100,000[1] in Wolverhampton vs 11.6 per 100,000 in England for 2012/14).
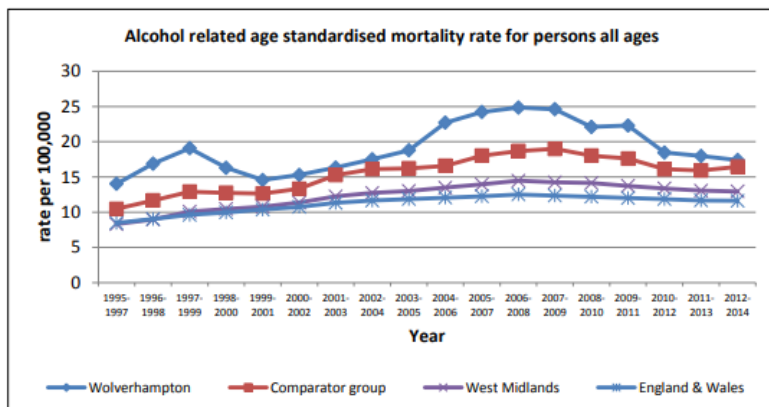
Figure 7 – Alcohol-related age-standardised mortality rate by age in Wolverhampton, 1995-2014 (from Causes of Early Death, JSNA Overview Report 2016)

- **The alcohol related mortality is worst in the most deprived areas of Wolverhampton** – DSR per 100,000 ranges from 4.5 in the least deprived areas, to 24.9 in the most deprived areas.
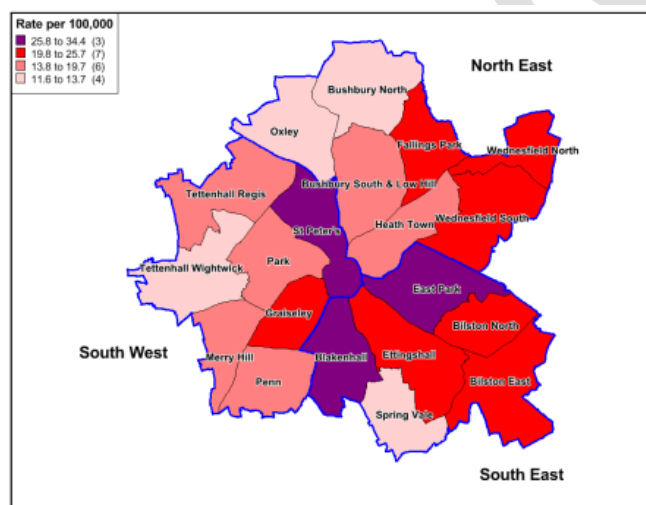
Figure 8 – Alcohol-related mortality by ward in Wolverhampton (from Causes of Early Death, JSNA Overview Report 2016)

Wolverhampton Public Health Team commissioned an adult lifestyle survey in 2016, including the short Audit-C questionnaire to identify the prevalence of alcohol misuse. **The use of alcohol increased with age, was higher in people who earned more (i.e. less deprived) and was higher in those from a white ethnic background.**

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[1] The DSR for an area is the number of deaths, usually expressed per 100,000, that would occur in that area if it had the same age structure as the standard population and the local age-specific rates of the area applied. Directly standardised mortality rate is calculated by dividing the number of deaths by the actual local population in a particular age group, multiplied by the standard population for that particular age group and summing across the relevant age groups. The rate is usually expressed per 100,000.
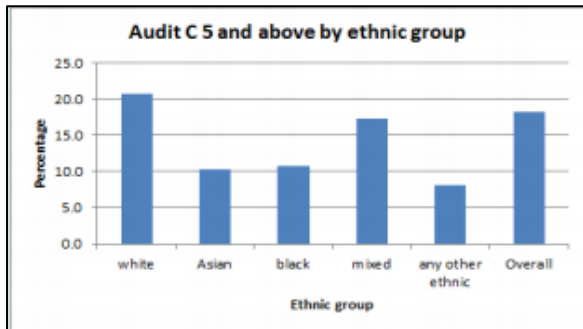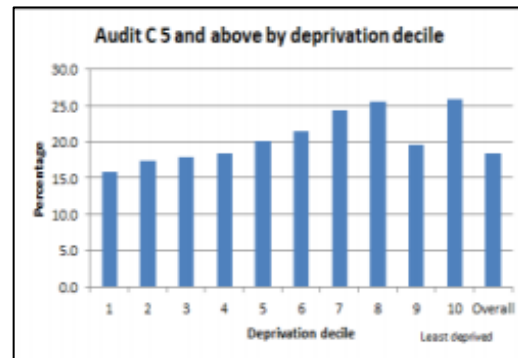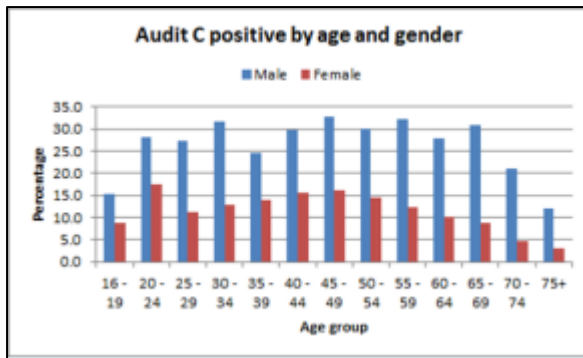
Figures 9-11 – AUDIT-C positive individuals by age, gender, deprivation and ethnicity in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

The number of emergency alcohol-specific admissions to hospital in Wolverhampton has increased over the past decade, from a low of 493 in the year prior to September 200,5 to a peak of 956 in the year prior to February 2015.

- The number of males being admitted into hospital for alcohol specific conditions in emergencies is more than double the number of females.
- Men age 35 to 54 years account for the highest rate of alcohol admissions – this same age range of men account for most of alcohol service users, whilst men aged 45 to 69 years account for the highest rate of alcohol-related deaths.
- Over three quarters of emergency alcohol specific hospital admissions are of individuals with a White ethnicity (77.9%).
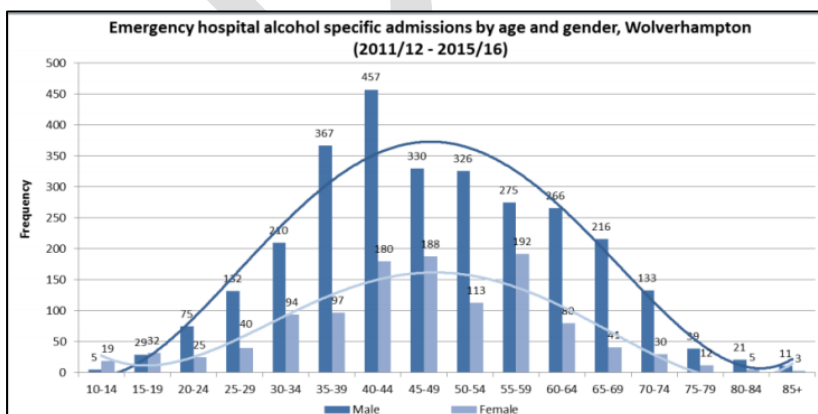
Figure 12 – Emergency alcohol-specific admissions to hospital by age and gender in Wolverhampton, 2011-16 (from Live, Work and Stay Well, JSNA Overview Report 2016)

Obesity

The most recent JSNA identified obesity as a significant issue for Wolverhampton:

- Almost two-thirds (59.6%) of males are either overweight or obese, compared to 52.1% females in Wolverhampton.
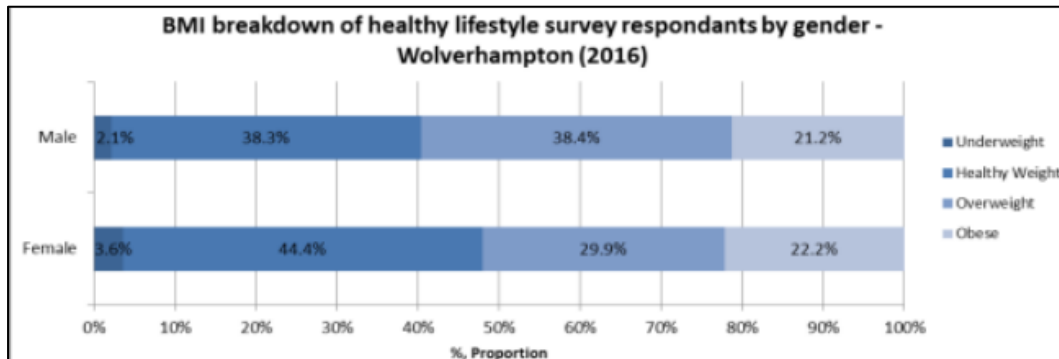
Figure 13 – BMI by gender in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **Respondents who had a Black ethnic background had the highest proportion of individuals with excess weight** (63.6%). Individuals with an ethnic background other than those stated had the second highest proportion of individuals with excess weight (56.9%).
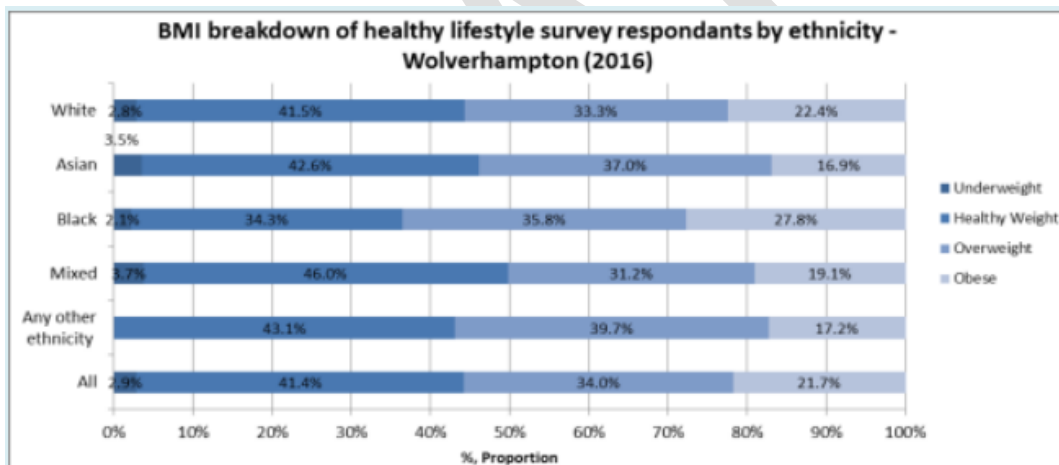
Figure 14 – BMI by ethnicity in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **The proportions of individuals with excess weight are higher in the wards in the East of Wolverhampton,** compared to the wards in the West of the city.
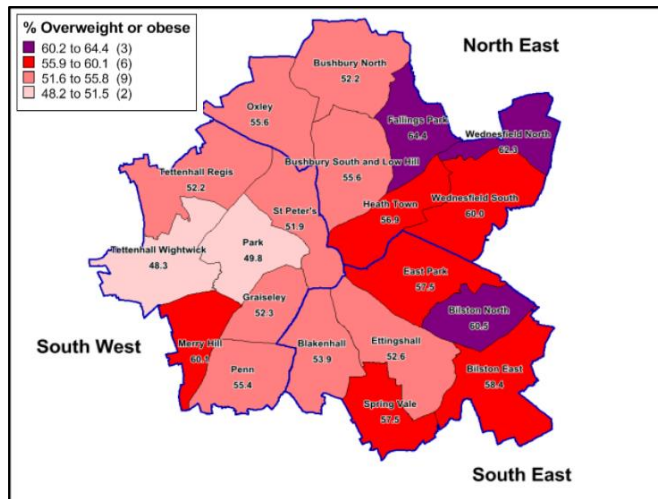
Figure 15 – % Overweight or obese by ward in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **Only half of the Wolverhampton (49.9%) population were estimated to physically active,** which is significantly lower compared to England (57.0%) and the West Midlands (55.1%). The proportion of physically active adults has fallen slightly since 2012.
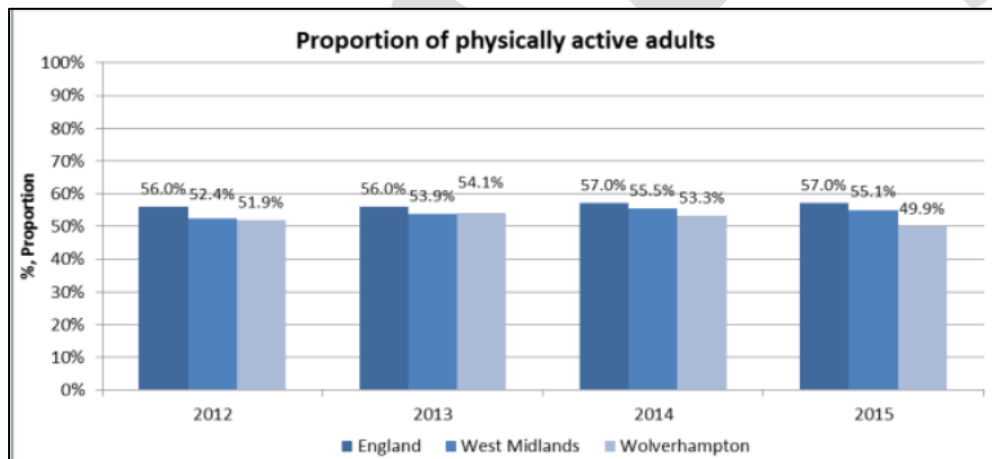
Figure 16 –Proportion of physically active adults in Wolverhampton, 2012-15 (from Live, Work and Stay Well, JSNA Overview Report 2016)

1.3 Evidence base for proposed interventions

Diabetes

Screening for T2DM

What is the intervention?

NICE recommends that a two-stage approach be taken in primary care for identifying people at high risk of developing T2DM (NICE PH38, 2012) or being in a pre-diabetic state (impaired fasting glycaemia or IFG):

1. Conduct a risk assessment, using either a computer-assisted tool or a self-assessment questionnaire;
2. With people identified as high risk, conduct either a glycated haemoglobin blood test (HbA1c) or fasting plasma glucose blood test (FPG).

Populations or risk factors considered to be particularly worth targeting for a risk assessment include:

- All eligible adults aged 40 and above, except pregnant women
- People aged 25–39 of South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups, except pregnant women
- Adults with conditions that increase the risk of T2DM[2]
- NICE also recommend that people with a family history of T2DM take part in risk assessment tests. (NICE PH38, 2012)

A systematic review underpinning NICE PH38 (ScHARR Public Health Collaborating Centre, 2011a) considered evidence on the effectiveness of different risk assessment tools. The tools they considered with moderate to strong evidence of effectiveness included the **Leicester Risk Assessment Score (LRA)**, a 7-item questionnaire, designed to be used to identify either Impaired Glucose Regulation (IGR) or undiagnosed T2DM in a multi-ethnic population (Gray et al, 2010). It has been developed into the **Leicester Practice Database Score,** which can be used to interrogate electronic patient records, which is particularly useful where people have glucose or HbA1c data already collected. (Gray et al, 2012)

NICE recommends that individuals with a **fasting plasma glucose of 5.5–6.9 mmol/l or an HbA1c level of 42–47 mmol/mol [6.0–6.4%]** should be treated as high risk of developing T2DM and considered to be suffering from prediabetes.

Which staff should deliver the intervention?

The NICE cost-effectiveness modelling review (ScHaRR, 2011b) created a model that involved **admin staff** to administer the risk assessment and **HCAs or nurses** to conduct the blood tests.

What are the outcomes or benefits?

This strategy has been found effective and cost-effective for correctly identifying people at risk of diabetes. The outcomes for the identification are often discussed in conjunction with a preventative lifestyle intervention, as it is considered the first step in ensuring the success of that intervention in reducing rates of T2DM.

Prevention of T2DM
What is the intervention?

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2 These include: cardiovascular disease, hypertension, obesity, stroke, polycystic ovary syndrome, a history of gestational diabetes and mental health problems. NICE also advises people with learning disabilities and those attending accident and emergency, emergency medical admissions units, vascular and renal surgery units and ophthalmology departments may be at high risk.(NICE PH38 2012)

Based on the outcomes of the risk assessment tests, different interventions are recommended by NICE, which correlate with different risk of diabetes (PH38, 2012).

Table 1 - Preventative interventions for different risk levels for T2DM

Risk level	Intervention	Follow-up/recall
Low **(Low or intermediate risk score)**	Brief advice (5 minutes)	Every 5 years
Moderate **(High risk score, with HbA1c <42mmol/L or FPG <5.5 mmol/L)**	Brief intervention	Every 3 years
High **(High risk score, with HbA1c 42-48 mmol/mol or FPG 5.5-6.9 mmol/L)**	Referral to intensive lifestyle intervention	Annually
Diabetic	Management processes	As appropriate

Adapted from: NHS Right Care Casebook (2015)

What is meant by 'brief advice'?

For people at low risk (with a low or intermediate risk score), primary care staff are advised by NICE (PH38, 2012) to inform the individual that they are currently at low risk, but that it may increase in the future.

They are advised to offer them brief advice of 5-15 minutes long, discussing the patient's risk factors, as well as lifestyle choices that may keep their risk low. (NHS Right Care Casebook, 2015) Encouragement and reassurance should be offered. (PH38, 2012)

Who should deliver 'brief advice'?

The NICE evidence review does not specify who should deliver brief advice. Based on who is delivering the risk assessment tool, **this could be a healthcare assistant or nurse.** Phillips (2013) recommends that nurses with diabetes or CVD expertise are best placed to provide this kind of communication with patients.

Health inequalities and population differences:

NICE advises offering verbal and written information about culturally appropriate local services and facilities that could help them change their lifestyle. Examples could include information or support to: improve their diet (including details of any local markets offering cheap fruit and vegetables); increase their physical activity and reduce the amount of time spent being sedentary (including details about walking or other local physical activity groups and low-cost recreation facilities). The information should be provided in a range of formats and languages. (PH38, 2012)

What is meant by 'brief intervention'?

For people with a moderate risk (a high-risk score, but with a fasting plasma glucose less than 5.5 mmol/l or HbA1c of less than 42 mmol/mol [6.0%]), NICE advises that staff inform the person of their moderate risk, the chance of that risk increasing but also the opportunity to prevent it.

Staff are advised to provide a longer conversation, a 'brief intervention' which aims to improve a person's diet and help them to be more physically active. Staff are advised to identify which of a patient's risk factors can be modified and discuss with them how they can achieve this by changing their lifestyle. Staff should be trained in evidence-based behaviour techniques and only signpost providers that use similar techniques (PH38, 2012). This could involve asking the patient whether they would like to join a structured personalised weight-loss programme, with tailored advice about diet, physical activity and behaviour change. A brief intervention may be delivered in groups or on a one-to-one basis. Diabetes UK provides resources to people directly who wish to reduce their risk of prediabetes, free of charge. This includes goal-setting action plans and food diaries to encourage people to monitor their diet.

How often should risk be reassessed?

The reassessment/ recall period for each of these preventative interventions is shown in Table 1. **NICE recommends that primary care practices keep an up-to-date register of people's level of risk of prediabetes or diabetes and introduce a recall system based on the same two-step strategy mentioned previously**.

Primary care staff are recommended to use clinical judgement on whether people may need more frequent monitoring of their health and risk factors (such as their BMI, relevant illnesses or conditions, ethnicity and age). An annual review is recommended for people who were found to have risk scores and blood test readings indicating prediabetes, to monitor their progress. (PH38, 2017)

Care planning for T2DM

The NHS Right Care Pathway for Diabetes (2017) highlights the importance of involving patients with diabetes in their own care planning, **which should include agreeing set goals and creating an action plan.** They refer to NICE guidance (NICE QS6, 2011) that this should be reviewed annually, but also note that the frequency of care planning should be based on an individual need, which can vary with condition.

There is systematic review evidence (Coulter et al., 2015) that personalisation in care planning leads to small positive outcomes for patients with long term conditions, particularly diabetes. Diabetes UK and Year of Care provide materials to support professionals to engage in collaborative care planning.

Which staff should deliver the intervention?

Collaborative care planning is a whole-system approach that can involve administrators, HCAs, nurses and GPs.

What are the benefits?

The systematic review by Coulter et al. (2015) found that involvement in personalised care led to better HbA1c levels in diabetic patients – there was a mean difference of -0.24% across nine studies, between those receiving personalised care planning and those who received 'usual care'.

Structured education for people with diabetes

What is the intervention?

NICE recommends that patients diagnosed with diabetes are enabled to access evidence based structured education programmes for people with diabetes in line with NICE Guidance (NICE NG17, 2015, updated 2016; NICE NG 28, 2009, updated 2015). NICE recommends that DAFNE is offered to people with Type 1 diabetes within 6-12 months diagnosis and that carbohydrate (CHO) counting training is an essential element of training (NICE NG17, 2016). For patients with T2DM, an immediate referral to structured education is recommended (such as DESMOND or XPERT). Patients who have missed structured education when first diagnosed should be referred at the earliest opportunity (NICE NG28, 2015).

Which staff should deliver the intervention?

These programmes are mainly delivered outside of primary care. DAFNE is delivered by specially trained educators (diabetes specialist nurses and diabetes specialist dietitians) to groups of 6–8 adults over 5 consecutive days. It is provided on an outpatient basis in any setting (secondary care or community). DESMOND and XPERT groups are run by trained health educators in community-based settings. Primary care staff therefore can refer their patients to local groups – XPERT provide classes in Wolverhampton (XPERT Health website).

What are the benefits?

Structured education has been found to improve glycaemic control – HbA1c levels decreased after three years in a follow up of a cluster randomised controlled trial of DESMOND. Khunti et al. (2012) found that compared with baseline at 12 months HbA1c levels decreased by 1.49% in the intervention group receiving DESMOND and a decrease was sustained after three years (Khunti et al., 2012). In a review of different studies of DAFNE it was found to decrease Hba1c levels and improve quality of life, although studies with long follow up found that these benefits may not be long-term (Owen and Woodward, 2012).

Care processes

NICE recommends all people with diabetes aged 12 years and over should receive each of the nine care processes annually and, when diagnosed, attend a structured education programme. (NG28, 2015).

Nine Annual Care Processes for all people with diabetes aged 12 and over	
Responsibility of Diabetes Care providers (included in the NDA 8 Care Processes)	
1. HbA1c (blood test for glucose control)	**5. Urine Albumin/Creatinine Ratio** (urine test for early kidney disease)
2. Blood Pressure (measurement for cardiovascular risk)	**6. Foot Risk Surveillance** (foot examination for foot ulcer risk)
3. Serum Cholesterol (blood test for cardiovascular risk)	**7. Body Mass Index** (measurement for diabetes management)
4. Serum Creatinine (blood test for kidney function)	**8. Smoking History** (question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)	
9. Digital Retinal Screening (photographic eye test for diabetic eye disease)	

Figure 17 – Nine annual care processes for people with diabetes (from National Diabetes Audit, 2016-17: Care Processes and Treatment Targets short report)

Treatment Targets

NICE recommends treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol:

- Target HbA1c reduces the risk of all diabetic complications;
- Target blood pressure reduces the risk of cardiovascular complications and reduces the progression of eye disease and kidney disease;
- Target cholesterol reduces the risk of cardiovascular complications.

In addition, practices should ensure engagement with acute consultants to review complex patients, care planning requirements etc through regular MDTs with acute consultants (Minimum 2 per year).

In addition, the Diabetes Network are currently reviewing educational requirements of primary care workforce to review and training/ educational requirements to upskill workforce, to improve the management of patients within primary care. We will be looking to hold an 'XPERT in a Day' for nominated representatives from practices (ideally practice nurses) to improve the uptake of patient attendance.

Alcohol
Screening for hazardous and harmful drinking
What is the intervention?

NICE recommends that primary care professionals should carry out alcohol screening as "an integral part of their practice" (PH24, 2012). The Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organisation (WHO) has been found to be both effective and cost-effective for identification (O'Donnell et al., 2014; Angus et al., 2014; NICE PH24, 2012). NICE found the evidence for the use of shorter tools including AUDIT-C (3 item) is variable in quality, **but they are recommended for use if time is tight**. (NICE PH24, 2012)

Which staff should deliver the intervention?

Staff that can undertake screening include GPs or nurses. Purshouse et al. (2012) highlights the cost-effectiveness of practice nurses delivering screening during patient registration appointments.

Who should be screened?

Purshouse et al. (2012) found that **universal screening was cost-effective,** whilst the AUDIT handbook emphasises the importance of a whole-population approach (WHO, 2001).

NICE guidance acknowledges that universal screening may not be feasible or practicable (NICE PH24, 2012). Where this is the case, primary care professionals are recommended to focus on groups at an increased risk of harm from alcohol and those with alcohol-related conditions. This includes people:

- With relevant physical conditions (such as hypertension and gastrointestinal or liver disorders);
- With relevant mental health problems (such as anxiety, depression or other mood disorders);
- Who have been assaulted;
- Who are at risk of self-harm;
- Who regularly experience accidents or minor traumas;
- Who regularly attend GUM clinics or repeatedly seek emergency contraception.

NICE guidance highlights key opportunities for screening:

- New patient registrations;
- Screening for other conditions;
- Other chronic disease management appointments;
- Carrying out medicine reviews.

Health inequalities and population differences:

NICE indicates that discussions about alcohol with patients should be sensitive to people's culture and faith and tailored to their needs. Clinicians should use professional judgement as to whether to revise the AUDIT scores downwards when screening:

- Women, including those who are, or are planning to become, pregnant;
- Younger people (under the age of 18);
- People aged 65 and over;
- People from some black and minority ethnic groups.

What outcomes/benefits might be expected?

The outcome of screening alone is identification of risky alcohol consumption. Purshouse modelled that screening only patients newly registering with a practice would identify up to 40% of all hazardous drinkers; screening all at their next visit, about 80%.

Brief advice

What is the intervention?

'Brief advice' is a structured education session, ideally offered to individuals immediately after completing AUDIT screening, if their score indicates they may be consuming alcohol in a hazardous or harmful way (NICE PH24, 2012). If this is not possible, NICE recommends the appointment to provide this advice take place as soon as possible.

The framework that continues to be the recommended basis of brief advice is FRAMES. (Bien et al., 1993) – 'feedback, responsibility, advice, menu, empathy, self-efficacy'. It is recommended that the session covers:

- The potential harm caused by their level of drinking and reasons for changing the behaviour, including the health and wellbeing benefits;
- The barriers to change;
- Outline practical strategies to help reduce alcohol consumption (to address the 'menu' component of FRAMES);
- Developing a set of goals.

Providers may choose the tool that is most appropriate for them. In the UK this includes a Structured Advice Tool from PHE Alcohol Learning Centre. NICE recommends that where there is an ongoing relationship with the patient or client, the **primary care professional should routinely monitor their progress** in reducing their alcohol consumption to a low-risk level. **Where required, offer an additional session of structured brief advice or, if there has been no response, offer an extended brief intervention** (which could include motivational interviewing or motivational-enhancement therapy).

Which staff should provide brief advice?

Platt et al. (2016) found a small effect that indicated **brief advice provided by nurses had the most effect** in reducing the quantity of alcohol consumed, but not the frequency.

What outcomes/benefits might be expected?

Screening tools are recommended to be used in conjunction with brief advice or brief interventions, when screening identifies that an individual is drinking in a hazardous or harmful way. Most of the evidence base considers the screening and brief advice or intervention together and found it to be **both effective and cost-effective in reducing alcohol consumption among hazardous or harmful drinkers**. (Platt et al., 2016; O'Donnell, 2014; Angus et al., 2014, Purshouse et al., 2013; NICE PH24, 2012). De-Xing (2017) found a consistent international evidence base for the effectiveness of screening and brief intervention.

NICE recommends that if an AUDIT score suggests that a person may be dependent on alcohol, they are referred onto a specialist alcohol team for further diagnostic tests and provision of specialist support (NICE PH24, 2012).

A summary of recommendations for intervention for different levels of alcohol use is provided in Table 2.

Table 2 - Intervention or referral pathways for different kinds of drinkers

Type of drinker	Notes	Intervention
Hazardous or harmful drinker	Full AUDIT score of 8 or more.	Brief advice delivered in primary care
Resistant harmful drinkers	Have not responded to brief advice	Referral to extended brief intervention
Dependent drinker	Further diagnostic tests required to confirm dependency	Referral to specialist alcohol services

Obesity

Measurement opportunities

What's the intervention?

NICE recommend that primary care staff use clinical judgement when deciding when to measure a person's height and weight to calculate BMI. (NICE CG189, 2014)

Opportunities for measurement highlighted by the guidance include:

- Registration with a general practice;
- Consultation for related conditions (such as type 2 diabetes and cardiovascular disease);
- Other routine health checks. (NICE CG43, 2006/2015)

Weight is acknowledged to be a sensitive subject, but a recent RCT found that patients are not as offended by a doctor discussing their weight as might be expected. Aveyard (2016) found that 81% (n=1530) patients felt that a GP brief intervention about their weight was appropriate and helpful. Only four patients out of 2728 felt the discussion was inappropriate or unhelpful.

The RCGP have designed brief guidance for health professional on raising the topic of weight. (RCGP 2013). NICE acknowledges that people may not be ready to change when suggestions are made about lifestyle changes – they recommend providing information and communicating with the patient that they can return another time. (NICE CG189, 2006/2015).

Brief advice
What's the intervention?

Obesity identification and brief advice has been highlighted by Public Health England as one of five key effective interventions to facilitate patients to better self-care and reduce demand on general practices[3].The intervention consists of giving brief advice and a booklet of self-help weight-management strategies to people who are obese. **There is evidence for the effectiveness of brief interventions in primary care in reducing weight outcomes.** Free online training resources are available from the RCGP and the World Obesity Federation (see references).

As part of a Brief Intervention for Weight Loss (BWeL) study, (Aveyard, 2016) GPs advised people who were obese about losing weight. They raised the topic of conversation at the end of a consultation about something else. The conversation was very brief (at 30 seconds long) and patients were either randomised to receive recommendations on weight loss and provided with written materials or referred to an NHS-funded 12 week commercially-run weight management programme, organised outside of primary care.

What are the benefits?

Although there was more weight loss among the BweL group that were randomised to receive the weight management group at 12 months, **weight loss was still recorded among those who only received advice.** The mean weight change was 1·04 kg in the advice only group, giving an adjusted difference of 1·43 kg (95% CI 0·89–1·97). 2·43 kg in the advice plus support group. The number needed to treat to achieve a 5% weight loss (about 5 kg) at 12 months was 8·8, which is very effective for a preventive intervention.

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[3] Public Health England (2017) Five key interventions to facilitate patients to better self-care, improve their health and wellbeing and reduce demand on general practice if implemented systematically across primary care. Available at: https://www.swahsn.com/wp-content/uploads/2017/11/PHE-Report-2017-Five-Key-Interventions.pdf

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
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	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Locally defined outcomes

- A total of 100 'QOF+ points' are distributed between the three priority areas to incentivise continuous improvement.
- Points are distributed to reflect the number of indicators and anticipated workload associated with each priority area:

Figure 18 – Distribution of QOF+ points between priority areas 2018/19

- Where present, thresholds reflect the intention that this is a developmental piece of work. These are relatively low in Year 1 (without a sliding scale for achievement), with the intention of improving the baseline position and reducing unwarranted variation between practices. In subsequent years, these thresholds will be subject to change as improvements are realised.
- See 3.6 'Payment' and 3.7 'Implementation' for further details.

QOF+ Indicators 2018/19

Diabetes – primary prevention

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton at medium or high risk of developing T2DM	QOFP01	The contractor establishes and maintains a register of those at overall moderate risk and overall high risk of developing diabetes.	-	9
	QOFP02	The percentage of patients aged 18 or over that are new to list in the preceding 12 months, who have had screening carried out using the Leicester Risk Assessment Score.	50	4
Reduce the risk of people at medium or high risk of developing T2DM	QOFP03	The percentage of patients deemed at 'moderate' overall risk of developing diabetes, for whom 'brief intervention' has been offered in the preceding 12 months.	35	6
	QOFP04	The percentage of patients deemed to have 'pre-diabetes' (high overall risk), who have a record of being referred to an intensive lifestyle intervention in the preceding 12 months.	35	4

Diabetes – secondary prevention

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Increase the proportion of people with diabetes who receive care planning annually	QOFP05	The percentage of patients with diabetes, on the register, for whom a care plan has been completed in the preceding 12 months.	40	3
Increase the proportion of people with receive each of the NICE recommended	QOFP06	The percentage of patients, with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months.	60	3

care processes annually				
	QOFP07	The percentage of patients with diabetes, on the register with a record of a foot examination and risk classification within the preceding 12 months. (DM012 Stretch Goal)	80	3
	QOFP08	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 onto the diabetes register. (DM014 Stretch Goal).	80	3
Increase the proportion of people with diabetes who receive all eight NICE-recommended care processes annually	QOFP09	The percentage of patients with diabetes, on the register, in whom all eight care processes are complete in the preceding 12 months.	50	4
Increase the proportion of people with diabetes who achieve NICE-recommended treatment targets	QOFP10	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less. (DM003 Stretch Goal)	80	3
	QOFP11	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. (DM004 Stretch Goal)	80	3

Alcohol

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are consuming alcohol at hazardous or harmful levels	QOFP12	The contractor establishes and maintains a register of patients with hazardous, harmful or dependent levels of alcohol consumption.	-	3
	QOFP13	The percentage of patients aged 16 or over who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool.	40	9
	QOFP14	The percentage of patients with any or any combination of the following conditions: hypertension, anxiety/depression or other mood disorders, gastrointestinal disorders or liver disorders, who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool in the preceding 12 months.	50	9
Reduce alcohol consumption amongst people who are consuming at hazardous or harmful levels	QOFP15	The percentage of patients identified as having hazardous or harmful levels of alcohol consumption, who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	9

Obesity

| Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are obese	QOFP16	The percentage of newly registered patients aged 16 or over who whom a BMI is recorded in the preceding 12 months.	50	3
	QOFP17	The percentage of patients, with diabetes, for whom a BMI is recorded in the preceding 12 months.	85	8
	QOFP18	The percentage of patients, with any or any combination of the following conditions: atrial fibrillation, coronary heart disease, heart disease, hypertension, peripheral arterial disease, stroke and TIA, for whom a BMI is recorded in the preceding 12 months	50	8
Reduce the weight of people who are classified as obese	QOFP19	The percentage of patients with BMI >=30 kg/m^2 who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	6

3 Scope

3.1 Aims & objectives

See intended outcomes above.

3.2 Service description/care pathway

See section 1.3 'Evidence Review' for rationale and a more detailed description of interventions.

Diabetes – primary prevention

- GP practices will implement the Leicester Practice Database Score to assess the risk of their current practice population.
- They will undertake the Leicester Risk Assessment Score for all new patients registering with the practice.
- They will invite individuals with a 'high' risk score for blood tests (HbA1c or FPG).
- Following results of these blood tests, they will establish a register of patients deemed to be at 'moderate' overall risk or 'high' overall risk of developing Type 2 Diabetes Mellitus.
- Practices will undertake intervention and follow up/recall dependent on patient risk, as per the figure below:
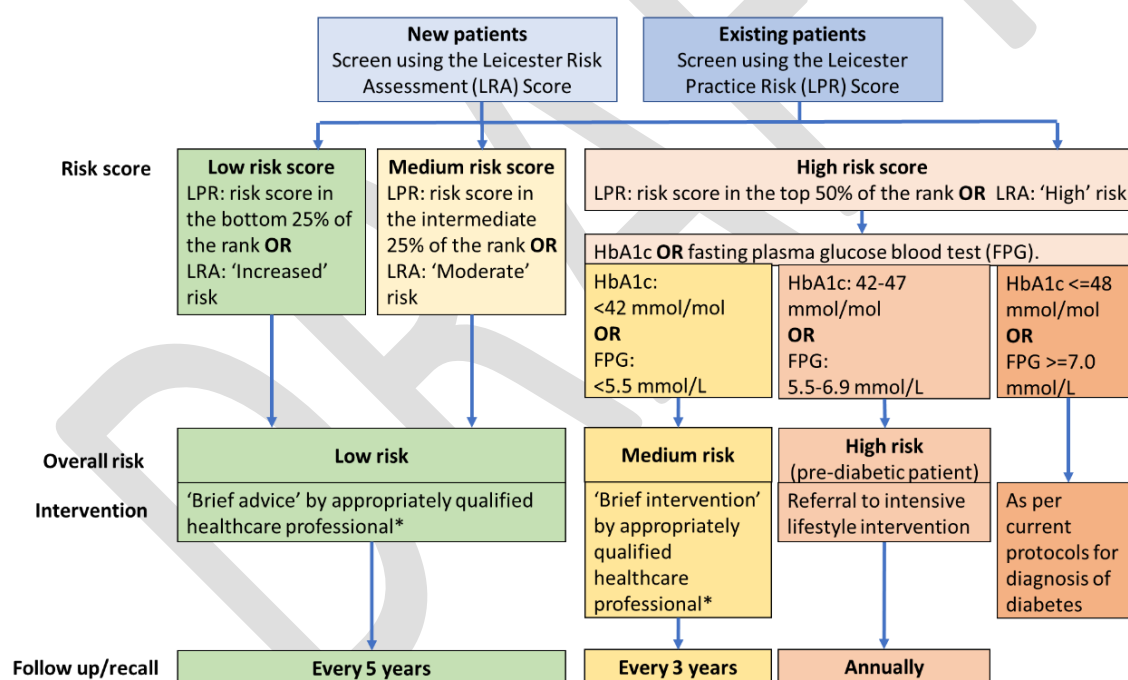
Figure 19 - Interventions and follow up/recall to be carried out by practices, based on patient risk of diabetes.

- Patients suspected to be suffering from diabetes will be managed in line with current practice.

Diabetes – secondary prevention

- GP practices will produce care plans for all patients with a known diagnosis of diabetes, customised to the level of patient need. As a minimum, this should include agreeing set goals and creating an action plan, based on the description in the evidence review above.

- GP practices will review care plans for people with diabetes based on individual need, but at least on an annual basis.
- GP practices will continue to refer patients newly diagnosed with diabetes to an approved structured education programme (such as DAFNE or X-PERT) and use appropriate coding on clinical systems to indicate whether patients have completed/partially completed/not attended the course.
- GP practices will continue current efforts to achieve recommended treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol. They will aim to improve the proportions of individuals who achieve the targets for **blood pressure** and **serum cholesterol**.
- GP practices will continue current efforts to achieve the recommended eight individual care processes for patients with diabetes. They will aim to improve the proportions of individuals with diabetes who receive **each of these** care processes annually.
- They will focus efforts on achieving a higher proportion of individuals with diabetes who receive **all eight** NICE-recommended care processes annually.

Alcohol

- GP practices will undertake screening for 'hazardous' or 'harmful' or 'dependent' levels of alcohol consumption in their practice population aged over 16, using the 'AUDIT-C' tool.
- Patients with a positive AUDIT-C score will have the full AUDIT score carried out.
- Practices will initially focus screening on groups at an increased risk of harm from alcohol and those with alcohol-related conditions (see description in 2.2 'Locally defined outcomes')
- They will establish a register of patients deemed to be consuming alcohol at hazardous, harmful or dependent levels.
- **Practices will undertake intervention dependent on patient risk, as per the figure below:**
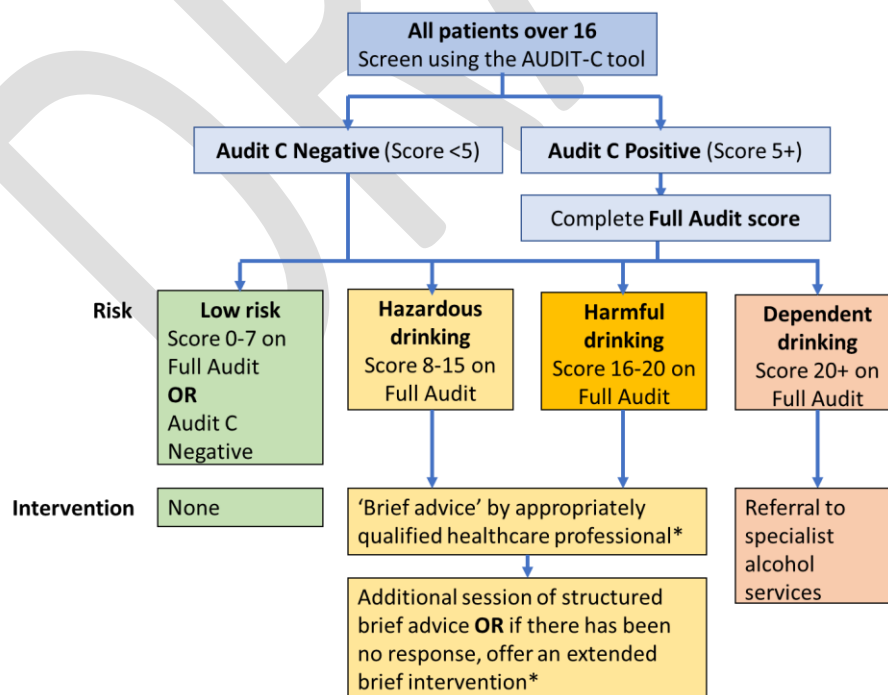
Figure 20 – Interventions to be carried out by practices, based on risk associated with alcohol consumption

- **Patients will have progress routinely monitored,** by an appropriate primary care professional, in reducing their alcohol consumption to a low-risk level.

Obesity

- GP practices will undertake screening for obesity through calculation of Body Mass Index (BMI) in their practice population.
- They will offer calculation of BMI for all new patients registering with the practice.
- They will offer calculation of BMI for patients with obesity-related conditions such as diabetes and cardiovascular disease (see description in 2.2 'Locally defined outcomes').
- **Practices will undertake intervention dependent on patient risk, as per the figure below:**
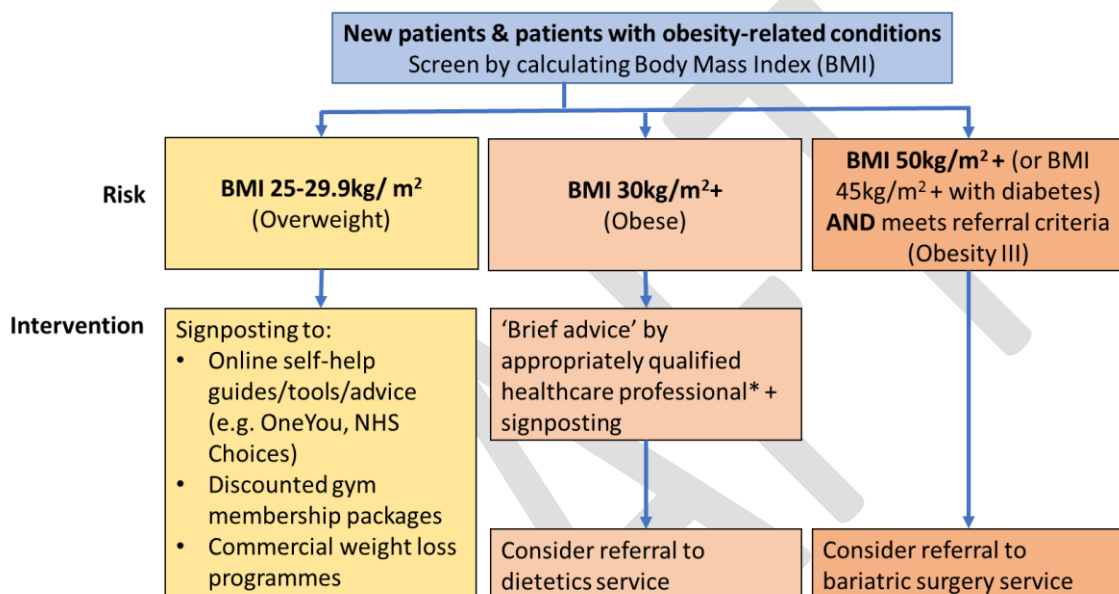
Figure 21 – Intervention to be carried out by practices, based on risk associated with obesity

- **Patients will have progress routinely monitored,** by an appropriate primary care professional, in reducing their weight to a low-risk level.

3.3 Population covered

- **Diabetes:** Any patient aged 18 or over registered with a Wolverhampton GP who is participating in this enhanced service.
- **Alcohol:** Any patient aged 16 or over registered with a Wolverhampton GP who is participating in this enhanced service.
- **Obesity**: Any patient aged 16 or over registered with a Wolverhampton GP who is participating in this enhanced service.

3.4 Any acceptance and exclusion criteria and thresholds

- **Acceptance criteria:** See 'Population covered'.
- **Exclusion criteria:** As in the national QOF scheme, 'exceptions' are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However,

they are excepted from the indicator denominator because they meet at least one of the exception criteria (see Annex D of the Statement of Financial Entitlements for further details) (DHSC, 2017):

- o Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate.
- o Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.
- o Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.
- o Patients who are on maximum tolerated doses of medication, whose levels remain sub-optimal.
- o Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.
- o Where a patient has not tolerated medication.
- o Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.
- o Where the patient has a supervening condition, which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease.
- o Where an investigative service or secondary care service is unavailable.

Mechanisms for exception reporting will be confirmed during implementation.

3.5 Interdependence with other services/providers/programmes
The NHS Health Check programme

- **The NHS Health Check programme for the Wolverhampton area is commissioned by the Local Authority.**
- It provides a systematic mechanism for identifying and managing people with the common risk factors for cardiovascular disease, stroke, T2DM, kidney disease and dementia.
- **It has a focus on providing a structured approach to cardiovascular disease risk management, for those aged 40-74 who are not already on another disease register.**
- It offers personalised advice/treatment, an individually tailored management programme and behaviour change support, to help individuals manage their risk more effectively.
- **The NHS Health check programme aligns with both the national QOF scheme and our QOF+ scheme**, strongly supporting the achievement of several assessment and management indicators.
  - o **Diabetes:** Collection of indicators needed for calculation of Leicester Risk Assessment/Leicester Practice Risk score (including ethnicity, BMI, waist circumference and opportunity to assess for potential hypertension)
  - o **Alcohol:** Completion of AUDIT-C and opportunity to give brief advice.

- o **Obesity:** Measurement of height/weight and calculation of BMI and opportunity to give brief advice.

The National Diabetes Prevention programme

- **The National Diabetes Prevention programme (NDPP) identifies those at the highest risk of developing T2DM and encourages referral to a structured educational programme.**
- The local provider of the programme is **Living Well Taking Control.**
- The core programme takes place over 7 weeks, with ongoing support for 12 months. Topics covered include eating a healthy diet, undertaking regular activity, achieving and maintaining a healthy weight, positive mental health and making healthy choices.
- The aims are to reduce the incidence of T2DM, reduce implications of complications associated with T2DM and reduce health inequalities in access/outcomes for those suffering from T2DM.
- **Referral criteria are** patients aged 18 and over **with** HbA1c 42 47 mmol/mol **OR** FPG 5.5-6.9 mmol/L ('pre-diabetes').
- **Patients currently access the programme in one of two ways:**
  - o Opportunistic referral by GPs, in response to an eligible HbA1c/FPG blood test result;
  - o GP practices searching clinical systems for eligible patients, then sending letters to patients asking them to contact the provider.
- The **QOF+ scheme aligns strongly with the NDPP**, incentivising referral of high risk patients with 'pre-diabetes' into intensive lifestyle interventions.
- **Access to the NDPP is currently supported by time-limited funding** – therefore local negotiations will inform future provision of this or equivalent services.

Local weight management services

- **Adult Weight Management Programmes have been decommissioned by the Local Authority from 31st December 2017.**
- Furthermore, the Healthy Lifestyles Team (providing access to health trainers) will be closing from 31st March 2018.
- **There are therefore no Tier 2 or Tier 3 weight management services for Wolverhampton from this point** – this is subject to ongoing discussion.
- Practices are advised to signpost individuals who are overweight/obese to self-help guides, tools and advice available online, such as through the One You website and NHS choices.
- Discounted gym/swimming membership packages are available from WV Active (owned by Wolverhampton City Council).
- Commercial weight loss programmes will need to be self-funded by individuals.
- **The Royal Wolverhampton NHS Trust dietetics service remains in place.**
  - o Dietitians can work with patients to develop personalised eating plans, incorporating personal preferences and clinical conditions to optimise health and well- being.
  - o Dietitians can also deliver group education and provide a cost-effective solution to optimising health for people with long term conditions e.g. diabetes, renal failure, coeliac disease.
  - o Referral criteria are a BMI of >30kg/m^2 and a willingness to engage with services to make lifestyle changes.

- **The Tier 4 (bariatric surgery) service also remains** – commissioning policy/referral guidelines are unchanged.

Local alcohol services

TBC

3.6 Payment

Payment for participation in the scheme will be made as follows:

- **Level of payment made to practices will be dependent on the number of QOF+ points that they accrue, out of a total of 100 available points.** These are distributed between the QOF+ indicators, as detailed in '2.2 Locally defined outcomes'.
- **Award of points for each indicator will depend on achieving the threshold values.** Practices that achieve the threshold value for an indicator will be awarded the associated points.
- **Clinical facilitators will work with practices in-year, to set up the appropriate searches on clinical systems**, such that they can understand their level of achievement throughout the year and monitor/respond appropriately.
- **Measurement to determine final level of achievement will occur at the end of April 2019**, in line with the National QOF scheme. These end of year searches will be carried out remotely at the CCG, by means of the Graphnet system.
- As part of the reconciliation process, practices will have the opportunity to confirm reported figures that will inform payment.

3.7 Timescale and implementation

Following approval at Governing Body, practices will be given the opportunity to raise any queries and sign up for the scheme. Practices will be supported to implement the scheme effectively, including provision of relevant templates and protocols for clinical systems.

The sequence of events is summarised in the figure below:

Approval of scheme at Governing Body				CCG Graphnet searches to determine level of practice payment
Q1 2018/19	**Q2**	**Q3**	**Q4**	**Q1 2019/20**
• Scheme shared with practices for sign up. • Implementation support from group managers.	• Review of progress against scheme. • Ensure any issues raised with CCG primary care team.	• Review of progress against scheme, • Ensure any issues raised with CCG primary care team.	• Practices ensure clinical systems are up to date in anticipation of final searches being carried out	• CCG confirms level of award • Payment to practices based on performance

Further development of schemes in response to member feedback →

Support through existing governance arrangements →

- 'General practices as providers' Task and Finish Group
- Group Leads Meeting
- Primary Care Milestone Review Board
- Opportunity for discussion at Members meetings
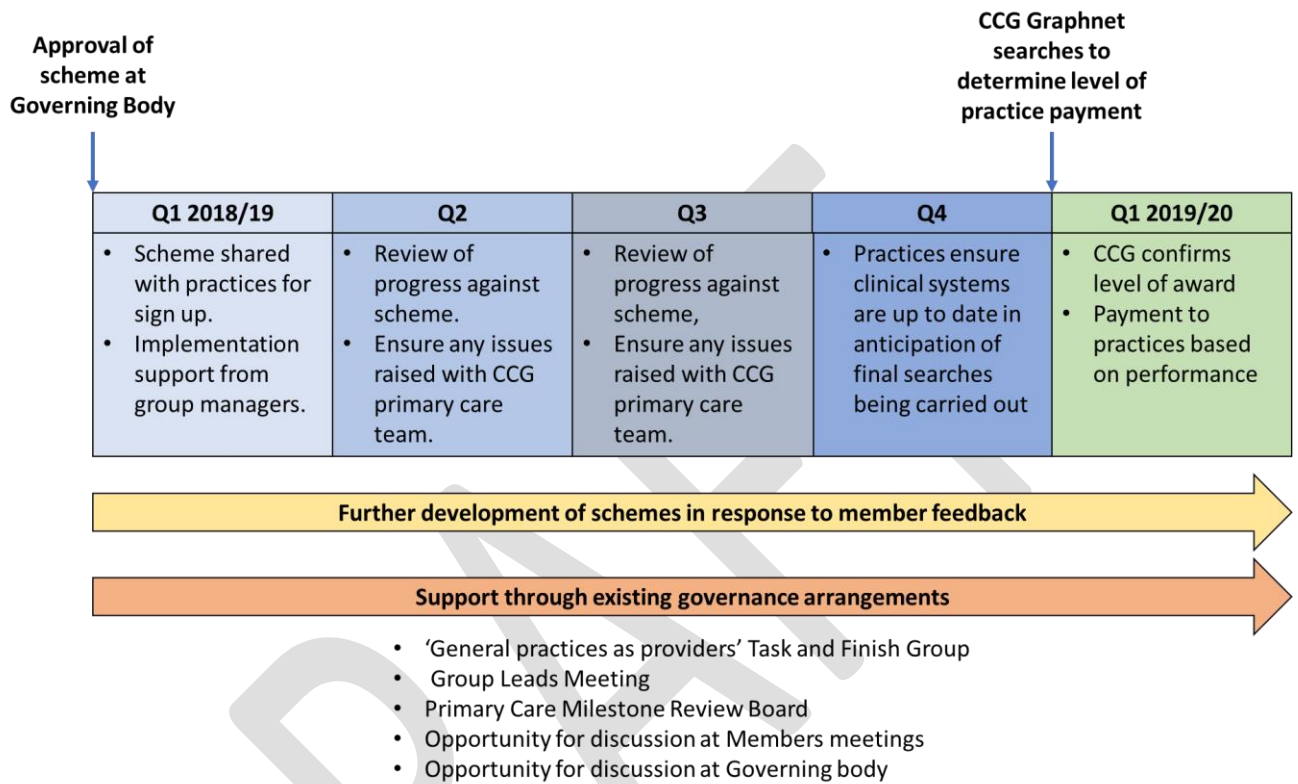- Opportunity for discussion at Governing body

Figure 22 – Timescale of events for QOF+ scheme

4 Applicable service standards

4.1 Applicable national standards (e.g. NICE)
See reference list.

4.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)
See reference list.

4.3 Applicable local standards
N/A

5 Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements
See 3.6 'Payment'.

5.2 Applicable CQUIN goals
N/A

6 Location of provider premises
It is expected that the components of this scheme are likely to be provided at individual Wolverhampton GP member practices.

However, practices may wish to explore the feasibility of providing this service (or parts of it) at scale, through their own local agreement.

7 Individual service user placement
N/A

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Appendix 1 – Diabetes supporting materials

Read/SNOMED codes to be used

To be confirmed during implementation.

Supporting materials

The table below summarises the components of the Leicester Risk Assessment Score and the Leicester Practice Risk Score:

Table 3 Diabetes risk assessment methods, tools and questionnaires in scope

Name of assessment tool	Data collection method	Risk factors considered	Advantages	Disadvantages
Leicester Risk Assessment Score (LRA)	Self-assessment questionnaire.	■ Age ■ Ethnicity ■ Sex ■ Family history of diabetes ■ Treatment or history of hypertension. ■ Waist circumference ■ BMI	Designed for use with multi-ethnic UK population.	Self-assessment questionnaire requires patient presence for assessment
Leicester Practice Risk Score (LPRS)	Online software to enable automated calculation of risk scores using patient medical records.	■ Age ■ Ethnicity ■ Sex ■ Family history of diabetes ■ Treatment or history of hypertension. ■ BMI	Software provides spreadsheet to enable ranking of risk within practice (e.g. top 10%); does not consider waist measurement to enable use of existing information.	Information in patient records may be inaccurate.

The Leicester Risk self-assessment score is available from:

https://riskscore.diabetes.org.uk/start

The Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/risk-score-zip-file/view

Guidance for implementation of the Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/LPRSBackground.doc/view

An example output spreadsheet for the Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/SampleOutput.xls/view

Appendix 2 – Alcohol supporting materials

Read/SNOMED codes to be used

To be confirmed during implementation.

Supporting materials

The AUDIT-C and full AUDIT screening tool is available from:

https://www.alcohollearningcentre.org.uk/Topics/Latest/The-AUDIT-Alcohol-Consumption-Questions-AUDIT-C-An-Effective-Brief-Screening-Test-for-Problem-Drinking-/

Appendix 3 – Obesity supporting materials

Read/SNOMED codes to be used
<mark>**To be confirmed during implementation.**</mark>

Supporting materials

Training on delivering brief advice is available from:

- RCGP *Obesity and Malnutrition e-learning* Available at:
  http://www.rcgp.org.uk/learning/online-learning/ole/obesity-and-malnutrition.aspx

- World Obesity Federation *SCOPE Obesity e-learning* Available online at:
  https://www.worldobesity.org/scope/e-learning/