NHS
Wolverhampton
Clinical Commissioning Group

QOF+ Implementation Pack (June 2018)

Background……

- Builds on National Quality Outcomes Framework
- Continued improvement & development of Primary Care (2016)
- Priorities identified with GP Member Practices - focus on prevention (November 2017) Diabetes, Alcohol & Obesity
- Focussed review of effective primary care interventions commissioned via CSU (January 2018)
- Preparatory Scheme Launched (February 2018) 83% sign up*
- Initial draft QOF+ Scheme shared for comment (March 2018)
- Finalised following feedback (May 2018)

Why are we doing this?

Diabetes prevalence in Wolverhampton is higher than other comparable CCGs.

Data indicates a much higher prevalence of diabetes in black and minority ethnic (BME) communities in Wolverhampton when compared with England. BME communities make up 32% of Wolverhampton CCG's population, compared with 15% BME communities in the population of England as a whole.

Therefore, the scheme has been constructed with a combination of preventative and responsive indicators that seek to improve outcomes.

Alcohol mortality in Wolverhampton is worsening and remains above the England average.

The number of emergency alcohol specific admissions to hospital has increased over the past decade from 493 in 2005 to 956 in 2015.

A lifestyle audit commissioned by Public Health Wolverhampton in 2016 identified that alcohol increased with age, was higher in people who earned more and higher in those from a white ethnic background.

The number of males being admitted to hospital for alcohol specific conditions in emergencies is more than double the number in females. This same age range of men account for most of alcohol service users whilst men aged 45 – 69 years account for the highest rate of alcohol related deaths.

Obesity is a significant issue for Wolverhampton.

In the region of 59% of males are either overweight or obese, compared to 52% females in Wolverhampton.

Based on a lifestyle survey conducted by Public Health Wolverhampton respondents who had a black ethnic background had the highest proportion of individuals with excess weight (63%). Only half of Wolverhampton 49.9% of the population were estimated to be physically active, significantly lower compared to England 57% and the West Midlands 55%.

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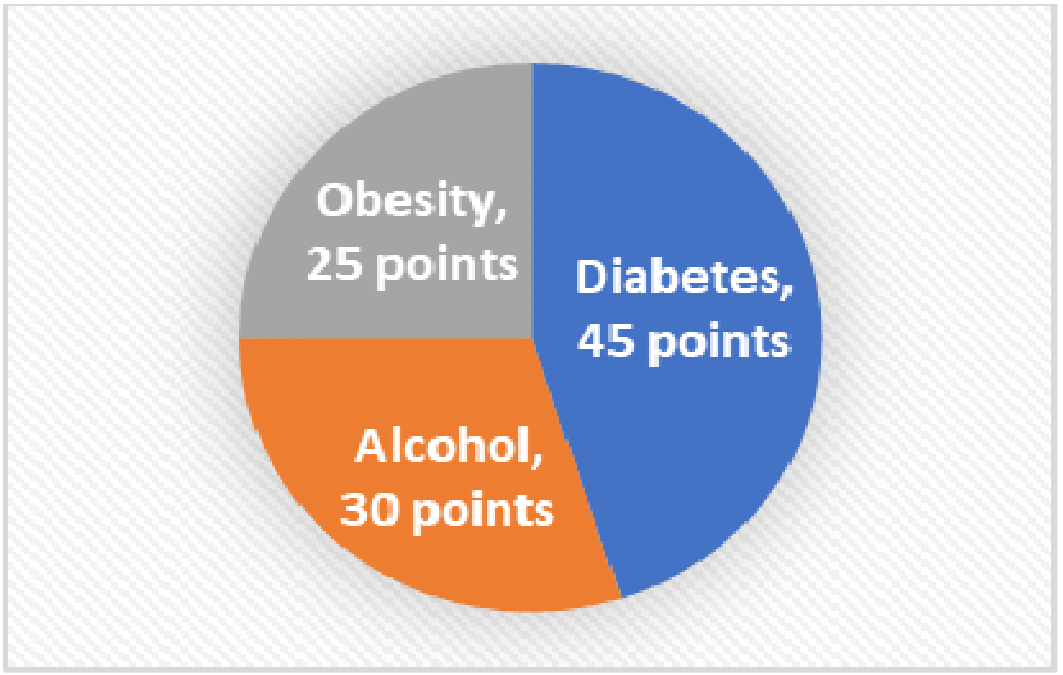
What does the scheme comprise of…….

19 Indicators broken down as follows:-
1-11 Diabetes (primary prevention & secondary prevention)
12-15 Alcohol
16-19 Obesity

National Quality and Outcomes Framework (QOF)

QOF+ Scheme 2018/19
£1.2m

Diabetes	Alcohol	Obesity
45%	30%	25%



IM&T Facilitators will support practices with creating and running QOF+ searches and any general queries associated with the practice's clinical system. Please use the following read codes:-

Diabetes	EMIS/Other	System One
Qdiabetes Risk	38Gj	Xaa0e
Fasting Plasma Glucose	44g1	44g1.
Care Plan Agreed	8CS0	XaKSn
Urine albumin creatinine ratio	46TC	XE2n3
Diabetes Care Plan Declined	81H2	XaXv9
Diabetes – outcome of referral to structured education		
Diabetes structured education declined	9OLM	XaNTH
Did not attend diabetes structured education	9NiA	XaNTa
Attended * diabetes structured education	9OLB	XaKHØ
Diabetes structured education completed	9OLF	XaX5D

Alcohol	EMIS/Other	System One
Audit C Completed	9K17	XaMwb
Alcohol misuse enhanced service completed (parent code)	9K1	XaKAJ
Patient advised about alcohol	8CAM	XaFvp
Declined	81H2	Xa1L0
Obesity	EMIS/TPP Automatically read code patient's BMI	
Advice given about weight	8Cd7	XaX5F
Weight management advice declined	81AU	XaX5G

QOF+ Indicators

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 QDiabetes 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 & outcome recorded.	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 18 or over 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 care processes annually	QOFP06	The percentage of patients 18 or over, with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months.	60	3
	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 18 or over 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 18 or over 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 18 or over 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 18 or over 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 16 or over who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool in the preceding 12 months.	40	9
	QOFP14	The percentage of patients 16 or over 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 16 or over 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 16 or over who whom a BMI is recorded in the preceding 12 months.	50	3
	QOFP17	The percentage of patients 16 or over, with diabetes, for whom a BMI is recorded in the preceding 12 months.	85	8
	QOFP18	The percentage of patients 16 or over, 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 16 or over with BMI >=30 kg/m^2 who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	6

NOTE: Preceding 12 months = April 2017 onwards

What are the expected outcomes……..

- Preventing ill health and achieving better health outcomes for patients
- Reduced emergency admissions & reduced mortality due to early intervention
- Preventative advice & support resulting in lifestyle changes
- Cost savings are anticipated in time
- Re-investment in other priorities including Primary Care

	Diabetes	Alcohol	Obesity
Outcome	Better glycaemic control at 12 months, assuming 10% the population with diabetes could lead to a 5% reduction in A&E Attendances and 6% reduction in hospital admissions & day cases reducing costs by £7,000 per year.	Assuming 20% of the population reduced their alcohol consumption would lead to a 14% reduction in alcohol related health conditions & a reduction in 10% of A&E attendances resulting in costs being reduced by £250,000 per year for secondary care.	Obesity identification, brief advice leading to weight loss leading to reduced demand on general practitioners. Assuming 10% of obese adults was estimated cost savings to primary & secondary care were £37,000 per year.
Saving	For every £1 spent on the intervention there would be a saving of £0.33.	For every £1 spent on the intervention there will be a saving of £2.83	For every £1 spent on the intervention there will be a saving of £0.96

Frequently Asked Questions

- Live document in place to answer questions/ queries raised by practices
- FAQ document will continue to be maintained as further questions & queries arise during the implementation phase
- Send new queries to sarah.southall@nhs.net
- FAQ covers indicators, clinical system queries & a range of generic questions
- Link provided in covering email
- All QOF+ information is available on the CCGs Intranet

Diabetes - points to note

- High risk patients will be identified using the Qdiabetes Risk Tool (pre diabetic) embedded within practice clinical system(s)
- High risk patients should be offered Intensive Lifestyle Intervention
- Currently National Diabetes Prevention Programme provides Intensive Lifestyle Intervention (backlog/limited capacity)
- NHS England are currently reviewing the CCGs proposals for NDPP
- Referrals will need to be held until feedback has been received from NHS England (mid July).
- Further instructions about where to refer to will be provided as soon as further information is available
- Longer term, the CCG is exploring the feasibility of practice groups being commissioned to provide Intensive Lifestyle Interventions, further details to follow.
- Also, a specific extensive template is being finalised for diabetes and will be shared with you shortly. This template will include an extensive list of read codes but for the purposes of QOF+ the codes provided in the table on slide 6 are to be used as a minimum.

What are the implementation timescales…

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 & IM&T Facilitators.	• 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

Approval & Launch June 2018

Implementation within Practices July 2018→

Monitoring & Support from CCG July 2018→

Sign up

- Practice confirm their intention (or not) to participate in delivery of the scheme to their Group Manager (by 13 July 2018)
- Issue Contract Variation Order to practices who have signed up for QOF+ 2018/19 (by August 2018)
- Withdrawal from the scheme should be in writing to the Contracting & Primary Care Team(s)
- Payment will only be made for indicators that have been achieved when reconciliation takes place at the end of the financial year.

When & how will I be paid…….

Level of payment made to practices will be dependent on the number of QOF+ points they accrue;

- Total of 100 available points
- Payment will be based on achievement of indicators
- Minimum threshold must be achieved to warrant payment for each indicator
- Practices complete activity coding by March 2019
- CCG confirms level of award April 2019
- Direct payment to practices May/June 2019
- Please refer to page 45 of the scheme for an example of how payment is calculated

CCG Monitoring Arrangements

- Ensure issues raised with CCG are logged/reviewed/remedied (monthly)
- Forums where monitoring will take place include General Practice as Commissioners, Milestone Review Board & Group Leads
- Progress & Issues may also be shared at Members Meetings
- Review practice progress against scheme (quarterly)
- Ensure practice reminders have been given to practice(s) in December 2018 so that their clinical systems are up to date in anticipation of final searches being carried out
- Final searches carried out & shared with practices & monitoring forums confirming performance/££

If you have any queries please contact your Group Manager:-

Primary Care Homes 1 & 2 – Liz Green lizgreen1@nhs.net

Medical Chambers – Lucy Sherlock lucy.sherlock2@nhs.net

Vertical Integration – Laura Harper laura.harper3@nhs.net