POTENTIAL LINKAGES BETWEEN THE QUALITY AND OUTCOMES FRAMEWORK (QOF) AND THE NHS HEALTH CHECK

Author: CHARLOTTE SIMPSON, SPECIALTY REGISTAR PUBLIC HEALTH (ST3), CHESHIRE EAST COUNCIL/MERSEY DEANERY

SUMMARY

Commissioners of NHS Health Checks should be aware of the potential for work carried out within an NHS Health Check to overlap with work which affects the achievement of Quality and Outcome Framework (QOF) points. This may occur in a number of ways:

1) Work within the NHS Health Check may help practices to achieve QOF points under indicators which explicitly refer to clinical activities carried out with respect to the NHS Health Checks eligible population.
2) Identifying those with previously undiagnosed disease (e.g. hypertension) may help practices to increase QOF payments by increasing the number of people on disease registers, thereby increasing the prevalence weighting of QOF payments. This is not the case for indicators within the Organisational or Patient Experience Domains.
3) Conversely, identifying people with previously undiagnosed disease may increase workload and hinder practices in achieving QOF points which are based on achievement of clinical care activities and targets amongst a threshold percentage of patients on the register. This may occur if difficulties in achieving these targets amongst these particular patients are encountered with the resultant overall effect upon the rate being an increase in the denominator but no increase in the numerator.
4) Activities contained within the NHS Health Check could impact upon the achievement of QOF indicators retrospectively (and for a limited period of time) if patients are subsequently diagnosed with a disease (either as part of the NHS Health Check or coincidentally) and placed on a register. Once again though, for some indicators, the net effect will depend on whether or not clinical targets amongst this group of patients are met.

BACKGROUND

The Quality and Outcomes Framework is a group of indicators that has formed part of the General Medical Services (GMS) contract since 2004 (NICE, 2012). General practices score points based on their achievements with respect to care delivery which in turn leads to financial reward, weighted by practice size and disease prevalence.

The NHS Health Checks Programme was launched in 2009 and is aimed at assessing the risk of stroke, heart disease, diabetes and kidney disease amongst people aged 40-74 and providing them with advice to reduce their risk (Department of Health, 2009). From April 2013, the programme will be commissioned by local authorities.

'Putting Prevention First', best practice guidance with respect to the NHS Health Check, outlined how certain QOF indicators overlapped with activities contained within the NHS Health Check and how commissioners may have wished to take this fact into account when agreeing payment with providers (Department of Health, 2009). In particular, commissioners were alerted to the potential for double payment of providers for work undertaken.

However, the proposed QOF for 2013/2014 is likely to differ significantly from the QOF of 2009/2010 and is in fact the subject of a Department of Health consultation which was due to end on the 26th February 2013 (NHS Employers, 2012). The proposed changes include:

- Implementation of NICE recommendations
- Discontinuation of the Organisational Domain
- Increasing thresholds for indicators
- Establishment of a Public Health domain
- Decrease in the time period for most indicators from 15 months to 12 months

Furthermore, significant changes to the NHS Health Checks Programme will be introduced from 2013/2014 with the introduction of an alcohol risk assessment and activities with respect to raising dementia awareness and signposting to memory clinics for those aged 65-74 (NHS Health Checks, 2012). As a result, there is need to consider how NHS Health Checks and the QOF are likely to overlap in 2013/2014.

AIM

The aim of this document is to outline how the NHS Health Checks Programme for 2013/2014 potentially overlaps with the proposed Quality and Outcomes Framework for 2013/2014.

CORE NHS HEALTH CHECK

No changes to the core NHS Health Check are expected for 2013/2014. Some activities within the NHS Health Check contribute directly to the achievement of QOF indicators (by targeting patients who are not excluded from the check and carrying out activities described within the QOF) as outlined in the table below:

	Points	Payment stages
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4	50-90%
MH003 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4	50-90%
MH004. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 12 months	5	45-80%
MH005. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	5	45-80%
SMOK001 The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 24 months	11	50-90%
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50-90%
SMOK004 The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40-90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes contain a record of an offer of support and treatment within the preceding 12 months	25	56-96%
NM61.The percentage of patients aged 40 years and over with a blood pressure measurement recorded in the preceding 5 years*	15	40-90%
Information 5. The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy*	2	
RA003. The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months	7	40-90%
OB001. The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 12 months	8	

* Not affected by prevalence weighting

Although people with certain conditions (e.g. hypertension) are excluded from the programme, some people with established hypertension, chronic kidney disease and diabetes will be purposefully found as a result of the activities of the programme. Consequently, the recorded disease prevalence of a practice will be altered and this could potentially increase the weighting of payments in relation to a number of QOF indicators. Conversely, as highlighted above, it could also make the achievement of QOF points with respect to certain indicators more difficult.

Whilst it is recognized that some people with established heart disease are identified as a result of activities of the programme, the aim of the NHS Health Check is not to screen people for heart disease and so the impact of this upon QOF indicators is not considered here.

Measurements taken and advice provided within the NHS Health Check may also potentially affect the achievement of some QOF indicators retrospectively. This is true for indicators that refer specifically to the monitoring and management of established disease. For example, an eligible person may have their blood pressure measured within the NHS Health Check and then may be identified as having a condition within the check (e.g. diabetes) or may later go on to be identified as having a condition outside of the check (e.g. stroke). In either scenario, for a limited period of time (usually up to one year), the activities within the NHS Health Check for that person could potentially affect the achievement of QOF points for their practice although the impact is likely to be minimal. Relevant indicators are summarized in the table below.

	Points	Payments stages	Explicit case finding of disease within NHS Health Check (and so will affect underlying prevalence)	Activities could retrospectively contribute to QOF directly if disease is subsequently diagnosed	Activities could retrospectively contribute to QOF indirectly if disease is subsequently diagnosed but dependent on reaching clinical thresholds
CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 or less	17	53-93%	No	No	Yes
CHD003. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/L or less	17	45-85%	No	No	Yes
CVD-PP001. In patients with a new diagnosis of hypertension aged 30-74 years, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an agreed risk assessment tool) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins (unless there is a contraindication)	8	40-90%	Yes	No	Yes
CVD-PP002: The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet alcohol consumption and healthy diet	5	40-75%	Yes	Yes	No
STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90	5	40-75%	No	No	Yes
STIA004. The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months	2	50-90%	No	Yes	No
STIA005. The percentage of patients with a stroke shown to be non- haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less	5	40-65%	No	No	Yes
BP1. The practice can produce a register of patients with established hypertension	6		Yes	Yes	No
HYP003. percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less	45	40-80%	Yes	No	Yes

	Points	Payments stages	Explicit case finding of disease within NHS Health Check (and so will affect underlying prevalence)	Activities could retrospectively contribute to QOF directly if disease is subsequently diagnosed	Activities could retrospectively contribute to QOF indirectly if disease is subsequently diagnosed but dependent on reaching clinical thresholds
HYP002. The percentage of patients with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less	10	44-84%	Yes	Yes	No
HYP004. The percentage of patients with hypertension aged 16 to 74 years in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 12 months	3	40-90%	Yes	Yes	No
HYP005. The percentage of patients with hypertension aged 16 to 74 years who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months	3	40-90%	Yes	Yes	No
DM32. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus which specifies the type of diabetes where a diagnosis has been confirmed	6		Yes	Yes	No
DM007. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months	17	35-75%	Yes	No	Yes
DM008. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43-83%	Yes	No	Yes
DM009. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%	Yes	No	Yes
DM011. The percentage of patients with diabetes who have a record of retinal screening in the preceding 12 months	5	50-90%	Yes	No	No
DM012. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50-90%	Yes	No	No

	Points	Payments stages	Explicit case finding of disease within NHS Health Check (and so will affect underlying prevalence)	Activities could retrospectively contribute to QOF directly if disease is subsequently diagnosed	Activities could retrospectively contribute to QOF indirectly if disease is subsequently diagnosed but dependent on reaching clinical thresholds
DM002. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less	8	53-93%	Yes	No	Yes
DM003. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less	10	38-78%	Yes	No	Yes
DM005. The percentage of patients with diabetes who have a record of a urine albumin:creatinine ratio test in the preceding 12 months	3	50-90%	Yes	No	No
DM006. The percentage of patients with diabetes with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	57-97%	Yes	No	No
DM004. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 12 months is 5mmol/l or less	6	40-75%	Yes	No	Yes
DM010. The percentage of patients with diabetes who have had influenza immunization in the preceding 1 September to 31 March.	3	55-95%	Yes	No	No
DM014. The percentage of patients newly diagnosed with diabetes in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months of entry on to the diabetes register	11	40-90%	Yes	No	No
DM013. The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the preceding 12 months	3	40-90	Yes	No	No
DM015. The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 12 months	4	40-90%	Yes	No	No
DM016 The percentage of male patients with diabetes who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months	6	40-90%	Yes	No	No

	Points	Payments stages	Explicit case finding of disease within NHS Health Check (and so will affect underlying prevalence)	Activities could retrospectively contribute to QOF directly if disease is subsequently diagnosed	Activities could retrospectively contribute to QOF indirectly if disease is subsequently diagnosed but dependent on reaching clinical thresholds
CKD1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: stage 3 to 5 CKD)	6		Yes	Yes	No
CKD002. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 12 months, is 140/85 or less	11	41-81%	Yes	No	Yes
CKD003. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB)	9	45-80%	Yes	No	No
CKD004. The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the preceding 12 months	6	45-80%	Yes	No	No
AF1. The practice can produce a register of patients with atrial fibrillation	5		Yes	Yes	No
AF002. The percentage of patients with atrial fibrillation in whom the stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1)	10	40-90%	Yes	No	No
AF003. In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy	6	57-97%	Yes	No	No
A004. In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy	6	40-70%	Yes	No	No
PAD002. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 or less	2	40-90%	No	No	Yes

	Points	Payments stages	Explicit case finding of disease within NHS Health Check (and so will affect underlying prevalence)	Activities could retrospectively contribute to QOF directly if disease is subsequently diagnosed	Activities could retrospectively contribute to QOF indirectly if disease is subsequently diagnosed but dependent on reaching clinical thresholds
PAD003. The percentage of patients with peripheral arterial disease in whom the last measured cholesterol (measured in the preceding 12 months) is 5.0 mmol/l or less	3	40-90%	No	No	Yes

ALCOHOL PATHWAY

The addition of the alcohol pathway into NHS Health Checks creates the possibility of further overlap with the QOF amongst those with mental health issues as outlined in the table below:

	Points	Payment Stages
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%

It should also be noted that it is proposed that the existing Alcohol Directed Enhanced Service, which promotes case finding and provision of brief advice where needed amongst patients registering with a practice is extended for the coming year within the GMS contract. Clearly there is the potential for overlap with NHS Health Checks where these are delivered to new entrants to the practice.

DEMENTIA PATHWAY

Whilst the dementia component of the NHS Health Check will not directly contribute to achievement of any QOF indicators, the indicators in the table overleaf could be affected by changes to practice-level disease prevalence. However, this does assume that additional people will be diagnosed with dementia as a result of the check and it is important to point out that explicit case finding is not the aim of this pathway.

	Points	Payment Stages
DEM1. The practice can produce a register of patients diagnosed with dementia	5	
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 12 months	15	35-70%
DEM003. The percentage of patients with a new diagnosis of dementia recorded between the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register	6	45-80%

Furthermore, within the new GMS contract it is also proposed that a new Directed Enhanced Service be introduced with respect to case finding for patients with dementia. Potential for overlap exists here with respect to patients under the age of 75 with learning disabilities and long-term neurological conditions.

LIMITATIONS

- The above is based on the local delivery model in Cheshire East proposed for the national components of the programme (e.g. use of the General Practice Physical Activity Questionnaire (GPPAQ) and encouragement of atrial fibrillation case finding via a pulse check). It should not be assumed that delivery models elsewhere are exactly the same.
- Where other local additions to the clinical pathway exist, as is the case in Cheshire East, there is likely to be even more overlap with the QOF not considered here.
- The above assumes that proposed changes to the GMS contract, currently the subject of consultation, will be implemented as described.
- Where indicators relate to disease registers, whilst some aspects of management can reasonably be expected to be dealt with within an NHS Health Check, some aspects will still have be managed outside of the Health Check (e.g. within a consultation with their GP), meaning that the opportunities to streamline this process may be limited and there are potential implications for GP workload. Clearly, for practices to make full use of the potential for overlap, there is a need for them to effectively coordinate this. Furthermore, where practices are already reaching upper thresholds for indicators, there may be little financial incentive to identify further people with disease who will require active management. However, if proposed changes to the GMS contract are implemented, some upper thresholds may be increased.
- As highlighted above, NHS Health Checks also have the potential to adversely impact achievement of some QOF points.

For the reasons above, some caution is advised in using these potential links to negotiate payment structures with providers.

REFERENCES

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