Quality And Outcomes Framework Guidance for the GMS Contract Wales 2018/19

June 2018

Strategic background

Delivery of more care in the community and closer to home through primary care clusters has been a key strategic aim for Welsh Government and was central to our Plan for Primary Care Services for Wales.

The Quality and Outcomes Framework (QOF) has been around since the GMS Contract was introduced in April 2004. QOF is widely recognised as having introduced improvement in the quality of data recording in general practice and the routine call and recall of patients for the management of chronic conditions.

The Health, Social Care and Sport Committee held an inquiry into Primary Care Clusters and published a report in October 2017. Oral evidence was presented to the committee by many organisations including GPC Wales, RCGP Wales, Local Medical Committees and Health Boards.

The committee report is available at:
http://senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=15126

A key theme of discussion throughout the inquiry into Primary Care Clusters was how to enable clusters to be agile and unconstrained in developing innovative solutions to meet local care needs. The Cabinet Secretary in response to the committee report confirmed he would continue to encourage clusters to evolve and mature and gave his commitment to clusters as the right approach to planning accessible and sustainable local care.

Welsh Government in June will publish its Long Term Plan for Health and Social Care this will set out how we aim to transform the way we plan and deliver health care, through 'new models of seamless local health and social care'. These models will build on a foundation of regionally co-ordinated innovation, which supports local Clusters of primary and community care providers and Regional Partnership Boards which bring together local authorities and health boards.

The transformational model, which has emerged from the national primary care pacesetter programme, is now the strategy for achieving accessible and sustainable care. Its focus is on informed citizens who are supported to self care, on the effective use of the wealth of services, clinical and non-clinical, in the community, and the prudent use of the multi professional team, such as pharmacists, therapists, dentists, audiologists, optometrists, social workers and others; working alongside GPs.

The demonstrating quality work stream is a key element of contract reform and the workstream is being co chaired by Welsh Government and RCGP. There are several strands of work underway which will help shape and inform thinking on quality measurement and improvement within the contract. The impact of QOF relaxation in 2016/17 and 2017/18 was a key discussion with in the work stream. The effectiveness of QOF indicators within both the clinical domain and cluster network domain, has in the past two years been restricted by "QOF relaxation" in January of both years. There was agreement that the 2018/19 QOF would need to take account

of the experience of the past two years, where QOF relaxation has been agreed for the last 3 months of the financial year.

The outcome from the workstream was a recommendation to the contract oversight group (COG):

- To recommend to COG there should be minimal change to QOF for 2018/19, other than simplification of the cluster domain.
- To recommend to COG that the 2018/19 QOF should be structured to avoid the need for QOF relaxation.

The recommendation was agreed by COG and formed part of the 2018/19 GMS contract negotiations.

Payment Arrangements

QOF is one element of the GMS Contract and runs as an annual basis from the 1 April to the 31 March. Payments are made to practices in accordance with the arrangements set out in the Statement of Financial Entitlement Directions that apply at the time.

In summary for 2018/19, for the clinical domain active indicators and cluster domain indicator practices are paid on actual achievement at 31 March 2019, for the clinical domain inactive indicators practices are paid based on the achievement points used for payment in the 2017/18 financial year.

Summary of QOF 2018/19

Area		Points
Clinical Domain:	**Active**	**53**
	Inactive	**314**
Cluster Domain		**200**
Total		**567**

Clinical Domain Active QOF

Indicator	Points	Achievement thresholds
Atrial fibrillation (AF) **AF001** The contractor establishes and maintains a register of patients with atrial fibrillation	2	
Secondary prevention of coronary heart disease (CHD) **CHD001** The contractor establishes and maintains a register of patients with coronary heart disease	2	
Heart failure (HF) **HF001** The contractor establishes and maintains a register of patients with heart failure	2	
Hypertension (HYP) **HYP001** The contractor establishes and maintains a register of patients with established hypertension	2	
Stroke and transient ischaemic attack (STIA) **STIA001** The contractor establishes and maintains a register of patients with stroke or TIA	2	
Diabetes mellitus (DM) **DM001** The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	2	
Asthma (AST) **AST001** The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	2	
Chronic obstructive pulmonary disease (COPD) **COPD001** The contractor establishes and maintains a register of patients with COPD	2	
Dementia (DEM) **DEM001** The contractor establishes and maintains a register of patients diagnosed with dementia	2	
Mental health (MH) **MH001** The contractor establishes and maintains a register of	2	

patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy		
Cancer (CAN) **CAN001** The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	2	
Epilepsy (EP) **EP001** The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	
Learning disability (LD) **LD001** The contractor establishes and maintains a register of patients with learning disabilities	2	
Osteoporosis: secondary prevention of fragility fractures **OST001** The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012	2	
Rheumatoid arthritis (RA) **RA001** The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	
Palliative care (PC) **PC001** The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	
Obesity (OB) **OB001** The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months	2	
Infuenza (FLU) **FLU001W** The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March	5	55- 75%
FLU002W The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or	15	45- 65%

Stroke who have had influenza immunisation in the preceding 1 August to 31 March		
Total Clinical Domain Active QOF	**53**	

Clinical Domain Inactive QOF

Indicator	Points
Atrial fibrillation (AF) **AF006** The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12
AF007 In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	12
Hypertension (HYP) **HYP006** The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	25
Diabetes mellitus (DM) **DM002** The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8
DM003 The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less	10
DM007 The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17
DM012 The percentage of patients with diabetes , on the register , with a record of a foot examination and risk classification; 1) low risk (normal sensation, palpable pulse) , 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 15 months	4
DM014 The percentage of patients newly diagnoses 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 on to the diabetes register	11
Asthma (AST) **AST003** The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20

AST004 The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6
Chronic obstructive pulmonary disease (COPD) **COPD002** The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	5
COPD003 The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9
COPD005 The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months	5
Dementia (DEM) **DEM002** The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	28
Mental health (MH) **MH002** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6
MH007 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	4
MH009 The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1
MH010 The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2
MH011W The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI and alcohol consumption in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months	12
Epilepsy (EP) **EP003W** The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic	2

drugs who have a record of being given information and advice about pregnancy or conception, or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years	
Rheumatoid arthritis (RA) **RA002** The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months	10
Cancer (CAN) **CAN003W** The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.	6
Palliative care (PC) **PC002W** The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	6
Smoking (SMOK) **SMOK002** The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months	25
SMOK004 The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months	12
SMOK005 The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months	25
Cervical screening (CS) CS001 The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates	2
CS002 The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11

Medicines management (MED) **MED006W** The contractor meets the LHB prescribing advisor at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	8
MED007W A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%	10
Total Clinical Domain Inactive QOF	**314**

Cluster Network Domain

Indicator	Points
CND013W – The contractor actively engages in the work of the cluster network through cluster meetings. The cluster network will meet on 5 occasions during the year; the timing of meetings should be agreed around the planning of the health board and to avoid the period of winter pressure.	**200**
Total Cluster Network Domain QOF	**200**

Clinical Domain

The detailed rationale and requirements for achievement for all clinical indicators, active and inactive within QOF for 2018/19 remain the same as in 2017/18. This information is not replicated here but can be accessed in the 2017/18 guidance document and is available online

http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=91788

Cluster Network Domain: 2018/19

The Cluster Network Domain for 2018/19 consists of one high level indicator. The policy intent behind rationalisation of the cluster domain is to act as an enabler to clusters, giving them more control over their work and to enable them to shape their own programme to deliver local priorities.

Indicator	Points
CND013W – The contractor actively engages in the work of the cluster network through cluster meetings. The cluster network will meet on 5 occasions during the year; the timing of meetings should be agreed around the planning of the health board and to avoid the period of winter pressure.	**200**
Total Cluster Network Domain QOF	**200**

Representation and attendance at cluster meetings

It is a requirement of CND013W that the contractor attends five cluster network meetings during the year, with representation by a GP. The attendance at these meetings may prove difficult for single handed and small practices (2 or 3 partners). The LHB will work with cluster representatives to enable single handed and small practices to engage fully either through having a Practice Manager attending or enabling “buddying” of a small practice with a larger practice and thus reducing the need for attendance at each meeting.

Arrangements for “buddying” **must** be agreed with the health board in advance. Health boards will need to consider the sustainability of local services when considering practice requests and give an explanation to the practice if the request is not agreed. Where a “buddying” arrangement has been agreed the practice must actively engage in the full work of the cluster through e-mail participation/directly feeding in comments etc to the “buddy practice”.

In addition, for all practices, it may not be practicable in **exceptional** circumstances to attend a cluster meeting. In these circumstances, and with the prior agreement of the LHB, the practice may be represented at these meetings by another senior practice employed clinician/administrator.

The changes made for 2018/19 with the removal of defined prescriptive QOF indicators are in line with the principles of the recommendations contained in Health and Social Care Committee inquiry into Primary Care Clusters report and the ongoing contract reform work being taken forward by the demonstrating quality workstream.

There are no specific indicators for previously defined activities such as updating practice development plans, completion of the sustainability assessment framework matrix or Clinical Governance Self Assessment Toolkit, however these are activities which are of benefit to practices and health boards. Practices when agreeing their cluster work programme for the year will need to consider these activities and the benefit to their practice and whether to include in the cluster plan.

Data for both the clinical active and inactive indicators is available via the primary care portal, peer review of practice activity will help strengthen local clinical governance assurance within clusters.