Drivers and Incentives in Primary Care

Blood Pressure Optimisation and Lipid Management

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1333_Update-on-Quality-Outcomes-Framework-changes-for-2022-23_310322.pdf

Key hypertension indicators in QOF 22/23

- **BP002.** The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years (Value: 15 QOF points; Thresholds: 50-90%)
- **HYP001.** The contractor establishes and maintains a register of patients with established hypertension (Value: 6 QOF points)
- **HYP003**. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less (Value: 14 QOF points; Thresholds 40-77%)
- **HYP007**. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (Value: 5 QOF points; Thresholds: 40-80%)

Other QOF indicators exist for control of BP in patients with co-morbidities such as CHD, diabetes, stroke and TIA.

Key lipid incentives in QOF 22/23

There are limited lipid incentives in QOF relating to use of statins in people with diabetes:

- **DM022.** The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)
- **DM023.** The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin

Primary Care Network (PCN) Directed Enhanced Service (DES)

The aim of the Network Contract DES is to support PCNs to deliver the ambition for improved standards of care across the country, setting realistic expectations for delivery that benefit patients. By 2023/24, the Network Contract DES commits an investment of £2.4 billion into primary care across the country, or £1.47 million per typical PCN. This includes funding for around 26,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers.

https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-ii-annex-a-pcn-plans-for-21-22-and-22-23.pdf

Key hypertension indicators in PCN DES 22/23

- Improve diagnosis of patients with hypertension, in line with NICE guideline NG136, by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up.

- Undertake activity to improve coverage of blood pressure checks, by:
  - i. Increasing opportunistic blood pressure testing where patients do not have a recently recorded reading
  - ii. Undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups
  - iii. Working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the NHS community pharmacy hypertension case finding service

Key lipid management indicators in PCN DES 22/23

- Identify patients at high risk of Familial Hypercholesterolaemia (as defined in NICE guideline CG71, section 1.1), and make referrals to secondary care for further assessment where clinically indicated. This should include systematic searches of primary care records to identify those aged 30+ with Chol > 9mmol/L or with Chol > 7.5mmol/L aged less than 30.
- Offer statin treatment to patients with a QRISK2&3 score >= 10%, where clinically appropriate, and in line with NICE guideline CG181.

Investment and Impact Fund (IIF)

The Investment and Impact Fund (IIF) is an incentive scheme focussed on supporting PCNs to deliver high quality care to their population, and the delivery of the priority objectives articulated in the NHS Long Term Plan and in Investment and Evolution; a five-year GP contract framework. For CVD prevention, the indicators align with the PCN DES.

https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-iii-annex-b-investment-and-impact-fund-21-22-22-23.pdf

Key hypertension indicators in IIF 22/23

- **CVD-01:** Percentage of patients aged 18 or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension (Value: £16m / 71 points; Thresholds: 25% (LT), 50% (UT))
- **CVD-02:** Percentage of registered patients on the QOF Hypertension Register (Value: 7.9m /35 points; thresholds: Increase 0.6pp (LT), Increase 1.2pp (UT))

Key lipid management indicators in IIF 22/23

- **CVD-03**: Percentage of patients aged between 25 and 84 years of age inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins. (Value: £7m / 31points; Thresholds 48% (LT), 58% (UT))
- **CVD-04:** Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia (Value: £4.1m / 18 points; Thresholds 20% (LT), 48% (UT))

AHSN Network programmes- *AHSNs provide practical implementation support for primary care teams*

Lipid Management and FH	Blood Pressure Optimisation
Implementation of the NICE endorsed lipid and FH pathway enables a holistic approach by all stakeholders to use the most up to date evidence in optimising lipids for patients. The Lipid programme emphasises a whole pathway approach that is not limited to the introduction of novel therapies.	Implementation of the UCLPartners Proactive Care Framework for hypertension, a free, Royal College of General Practitioners recommended support package. Practical resources for primary care teams to identify, prioritise and optimise care of patients with long term health conditions (inc. lipid management). The programme focuses support to reduce health inequalities and has a secondary focus on case finding.