PULSE Intelligence
Taking care of your business

Maximising your QOF income: Diabetes mellitus

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- Indicators: 10
- Points: 70
- Prevalence (2016-17): 5.3%
- £/patient on the register (est.): £29.20

Indicator 1: Maintain register of patients over 17 years (6 points)

Indicator 2: Blood pressure under 140/80 mmHg in patients w/o frailty (10 points)

Indicator 3: Patients over 40 w/o CHD or frailty on statin (4 points)

Indicator 4: Patients with CHD on statin (2 points)

Indicator 5: Proteinuria or microalbuminuria diagnosis, with ACE-I or ARB prescription after October in 97% of patients (3 points)

Indicator 6: HbA1c is 59 mmol/mol or less in patient w/o frailty (17 points)

Indicator 7: HbA1c is 75 mmol/mol or less in patients with frailty (10 points)

Indicator 8: Foot check: risk/presence of ulcers (4 points)

Indicator 9: Referred for a structured education programme (11 points)

Indicator 10: Influenza vaccination given to 95% of patients (3 points)

Diabetes has been part of the QOF since its inception and its prevalence has increased every year. It is the largest disease area in QOF, accounting for around 15% of both indicators and points. It is also an area with a high rate of exception reporting.

Indicator 1: Maintain patient register (6 points)

There are six points for maintaining the register. Only patients 17 years or older will be included. The description says that the type of diabetes (normally Type 1 or Type 2) should be specified, although in practice this does not seem to be checked. Patients with gestational diabetes do not appear on the register.

Drugs used in diabetes are pretty specific to the condition, so it is relatively easy to search for patients who are being treated but not appearing on the register. Blood results supporting diagnosis are also well defined, so it is useful to check these for any diagnosis that may have been missed.

Most of the rest of the indicators will be met during an annual review. It is important that patients are called and that the person conducting the review is aware of all the measurements and thresholds that must be achieved. Computer templates can help with this.

For blood pressure, cholesterol and HbA1c only the last reading in the year will count so there is good reason to measure each early in the year and have a robust system to re-measure after treatment has been changed.

From April 2019, there are new indicators for each of these measures, which apply only to those without moderate or severe frailty. There are also two new indicators for statin treatment, dependent on frailty and CVD status.

Indicator 2: Blood pressure <140/80 mmHg in patients without moderate or severe frailty (10 points; payment threshold: 38-78%)

There are 10 points for 78% of patients having a reading of 140/80 mmHg or lower. As usual, only the final blood pressure reading of the QOF year counts.

- There are exception reporting codes covering the whole diabetes area where patients either do not wish or are unsuitable for treatment. The code for patients on maximal tolerated antihypertensive treatment is the same as for similar indicators in other disease areas. Patients may also decline to have their blood pressure taken.
- The structure of the indicator effectively makes coding moderate or severe frailty another form of exception reporting. There is an incentive here, and in the later blood glucose indicators, to look at whether frailty should be recorded in patients who are not meeting the target. They should certainly be the first patients to have their frailty assessed.
- Similarly there is an incentive to avoid coding frailty in patients who meet the target.

Indicators 3 and 4: Statin treatment (4 + 2 points; payment thresholds: 50-90%)

Two groups of patients should be prescribed statins. The first, and easiest to capture, is patients with a diagnosis of cardiovascular disease. There are two points if 90% of these patients are prescribed a statin in the final six months of the QOF year.

The second group includes all patients on the diabetes register who do not have CVD or frailty. There are four points for prescribing to 90% of patients in this group.

- Once again frailty is effectively a form of exception reporting for the second indicator.
- There is a further exception to this indicator where patients have a CVD risk score (usually QRISK2 or 3) of less than 10% recorded in the previous three years.
- More conventional exception reporting includes allergies or adverse reactions to statins. Allergies to pravastatin or simvastatin count, but at time of writing allergy to atorvastatin does not – the more general code for statins causing adverse effect should be used.

Indicator 5: Proteinuria or microalbuminuria diagnosis and treatment (3 points; payment threshold: 57-97%)

There is a two-stage indicator carrying three points for recording patients who have a diagnosis of proteinuria or microalbuminuria at any time in the past, and prescribing an ACE inhibitor or an angiotensin II receptor blocker (ARB). As with most prescribing indicators, only prescriptions from October onwards count towards achievement. The maximum threshold is 97%, so there is little room for error.

Exception reports for allergies or when patients are unsuitable or unwilling to take these tablets must be coded separately for ACE inhibitor and ARBs.

Indicators 6 and 7: HbA1c testing (27 points)

These reward achievement of the following target HbA1c levels:

Indicator 6: ≤ 58 mmol/mol in 75% of patients *without* moderate or severe frailty (17 points; payment threshold: 35-75%)

Indicator 7: ≤ 75 mmol/mol in 92% of patients *with* moderate or severe frailty (10 points; payment threshold: 52-92%)

Tips:

- While the higher level for patients with frailty can be seen as a form of partial exception reporting the points distribution and the threshold make these patients your top priority. Over a third of the points are allocated to patients with frailty who will likely account for a much smaller proportion of patients with diabetes. Each patient with frailty is therefore worth considerably more in points and cash terms than a typical diabetes patient. An upper threshold of 92% is also fairly challenging.
- Blood tests can be difficult to organise for housebound patients who are much more likely to have a diagnosis of frailty. Due to the relatively high points value of these patients it is worth trying to do these as early in the year as possible so that community phlebotomy services do not become overwhelmed as QOF deadlines approach.
- In a similar way to the blood pressure indicators above, there is effectively an incentive to review patients with HbA1c between 59 and 75 mmol/mol to see whether a diagnosis of frailty would be appropriate.
- The last blood test in the year is the one that counts for this indicator, so when you reach the target, stop checking.
- Formal exception reporting applies here The diabetes area codes can be used, or a code for the patient having maximal tolerated therapy for diabetes. Lesser used, but valid exception codes include blood test is refused. A further exception is a blood result for fructosamine, which is sometimes used where patients have unusual haemoglobin levels.

Indicator 8: Foot checks (4 points; payment threshold: 50-90%)

While there may be many things recorded in foot checks, it is the assessment of risk for foot complications that allows patients to pass this indicator. Feet should be classified as at low, medium or high risk of ulcers or to have ulcers. Four points are available if 90% of patients have this assessment.

There are exception codes where diabetic foot examination is declined or not indicated. An automatic exception exists where a patient has bilateral foot amputations.

Depending on local services this may be done in secondary care or community services. Reviewing letters for relevant information and making sure foot checks are coded correctly can save time in the practice and increase achievement.

Indicator 9: New patients referred for a structured education programme (11 points; payment threshold: 40-90%)

Newly diagnosed patients should be referred for a diabetes structured education programme within nine months after their diagnosis is made. The clock starts as soon as the diagnosis is recorded.

Most commonly referral will be to a DESMOND course, although XPERT and DAFNE are also accepted, as well as a generic code for referral to structured education. As this only applies to newly diagnosed patients, the 11 points for 90% of patients is fairly generous.

Positive achievement is a little odd due to that nine-month window which can often cross from one QOF year to another. You can code referral at any point during that period and it will count in the QOF year that it happened.

Exception codes must be recorded in the QOF year that the nine-month clock stops. For example, if a patient is diagnosed on 1 July but declines the structured education programme, then the exception code must be entered after 1 April the next year.

Indicator 10: Influenza vaccination (3 points; payment threshold: 55-95%)

The final indicator has three points for giving 95% of the patient with diabetes a 'flu vaccination. The rules here will be the same as the Enhanced Service, with the addition of the diabetes area exception codes.

It is worth taking every opportunity to deliver 'flu vaccinations during the season. This can be in reviews, appointments for blood tests or sometimes when they bring another member of their family into the surgery.

Removed in 2019/20:

Indicators for blood pressure, HbA1c and cholesterol targets have been retired (replaced by the corresponding indicators qualified by frailty status).

For reference:

- *Indicator 1: 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 (DM017)*
- *Indicator 2: The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (DM019). Payment threshold: 38-78%*
- *Indicator 3: The percentage of patients with diabetes aged 40 years and over, with no history of CVD 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 (DM022). Payment threshold: 50-90%*

- *Indicator 4: The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin (DM023). Payment threshold: 50-90%*
- *Indicator 5: The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) (DM006). Payment threshold: 57-97%*
- *Indicator 6: The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (DM020). Payment threshold: 35-75%*
- *Indicator 7: The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 12 months (DM021). Payment threshold: 52-92%*
- *Indicator 8: 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 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 (DM012). Payment threshold: 50-90%*
- *Indicator 9: 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 on to the diabetes register (DM014). Payment threshold: 40-90%*
- *Indicator 10: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March (DM018). Payment threshold: 55-95%*

Guide URL:
http://preview.pulse-intelligence.co.uk/guide/how-to-increase-your-qof-payments-diabetes-mellitus/

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