# Changes to Quality and Outcomes Framework for 2008

## Points to be released

NHS Employers and the General Practitioners Committee have agreed that the following indicators will be removed from the QOF.

| Indicators | Points |
|---|---|
| Holistic care | 20 |
| Information 3<br>The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day | 1 |
| Information 7<br>Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO | 1.5 |
| Education 4<br>All new staff receive induction training | 3 |
| Management 4<br>The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care | 1 |
| Management 6<br>Person specifications and job descriptions are produced for all advertised vacancies | 2 |
| Management 8<br>The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation, etc.) | 1 |
| Medicine 7<br>Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend | 4 |
| COPD 9 (remaining points)* | 5 |
| PE5<br>The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:<br>1. Summarises the findings of the survey<br>2. Summarises the findings of the previous year's survey<br>3. Reports on the activities undertaken in the past year to address patient experience issues | 20 |
| **TOTAL** | **58.5** |

*COPD 9 has been reduced by 5 points and the details of the indicator have been changed as per below.

## New patient experience indicators

Two new indicators are required to support the reward of 48 hour appointments and advance booking. These indicators will replace PE 5 and be funded by the 58.5 points released from the removed indicators. The exact wording of the indicators is yet to be agreed, but they will measure the following aspects of patient satisfaction:

PE7 The percentage of patients who, using an approved survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (In Wales this will be within 24 hours).

Points: 23.5
Thresholds: 70-90%

PE8 The percentage of patients who, using an approved survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.

Points: 35
Thresholds: 60-90%

The approved survey that will be used will be a national survey and discussions are still on-going in relation to this.

It is anticipated that these indicators will function in the same manner as other QOF indicators in the non-clinical domain that measure percentage of achievement for patients. Once concluded, these details will be set out in the directions amending the Statement of Financial Entitlements.

PE1, 2 and 6 will remain. PE 2 will continue to reward practices for carrying out an approved local patient survey, which covers a wider range of questions than the national survey. Achievement of PE6 will continue to reward practices for producing an action plan as set out in the indicator. Achievement of PE6 will continue to be dependent on achievement of PE2.

## Further changes to QOF indicators based on the evidence review

From February until October 2007 the QOF Expert Panel reviewed all existing QOF indicators and accepted and reviewed submissions for possible new indicators. This is in line with the QOF review process that both the GPC and NHSE are committed to. This is to ensure that the QOF stays in line with new clinical evidence and the evolving nature and work of general practice.

A number of other changes that have been made in light of the expert panel review and negotiations are detailed below:

**Stroke and TIA**

STROKE 11 becomes STROKE 13 – change highlighted in bold.

| STROKE 13. The percentage of new patients with a stroke **or TIA** who have been referred for further investigation. |
|---|

Guidance clarifies referral should be within **one month** of diagnosis of presumptive stroke or TIA rather than 12 months that the previous guidance stated.

**Diabetes**

Changes to references and the extension of the rationale 13.1 re: microalbuminuria which if present in urine has been identified as an independent risk factor for cardiovascular complications. Its presence is therefore a pointer to the need for more rigorous management of all cardiovascular risk factors.

**COPD**

COPD 9 becomes COPD12 – changes highlighted in bold

| COPD 12. The percentage of all patients with COPD **diagnosed after 1st April 2008** in whom **the** diagnosis has been confirmed by **post bronchodilator** spirometry |
|---|

This has been reduced from 10 to 5 points. The guidance has been altered in light of the new wording.

**Palliative Care**

PC1 becomes PC3 – change highlight in bold.

| PC3: The practice has a complete register available of all patients in need of palliative care/support **irrespective of age**. |
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The guidance has been updated accordingly.

**Mental Health**

Guidance has been updated and expanded in relation to the mental health annual review and what it may include.

**Asthma**

Slight additions to the guidance on 6.1 in relation to asthma reviews

**Depression**

Guidance has been updated including specifically DEP 1 which cannot be carried out via a postal questionnaire.

**Chronic Kidney Disease**

CKD4 becomes CKD5 – changes highlighted in bold

| CKD5: The percentage of patients on the CKD register with hypertension **and proteinuria** who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded) |
|---|

The guidance has also been updated to provide a rationale and details for including proteinuria.

### Atrial Fibrillation

AF2 becomes AF4 – changes highlighted in bold

| AF4: The percentage of patients with atrial fibrillation diagnosed after 1 April **2008** with ECG or specialist confirmed diagnosis. |
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The guidance has been updated and the ECG or specialist confirmed diagnosis must be within **3 months** of the patient being added to the register not the 12 months as written in the previous guidance.

### Smoking

Smoking 1 becomes smoking 3 – changes highlighted in bold
Smoking 2 becomes smoking 4 – changes highlighted in bold

| Smoking 3: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, **CKD**, asthma, **schizophrenia, bipolar affective disorder or other psychoses** whose notes record smoking status in the previous 15 months. |
|---|
| Smoking 4: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, **CKD**, asthma, **schizophrenia, bipolar affective disorder or other psychoses** who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months. |

The guidance has also been updated.

“Never smoked status” to be checked and recorded annually until the patient is aged 25 years or over. Ex-smokers are to be asked about smoking status on an annual basis until they have been a non-smoker for 3 years.

This will be applied to both the smoking domain and the relevant indicator within the organisational domain (Records 22). These will be renamed to reflect this change.

### Guidance

Some updating of references in the guidance in relation to: CHD, Hypertension, Epilepsy, Thyroid, Cancer, Dementia, Obesity and Learning Disabilities and the organisational indicators.

### Thresholds

The thresholds remain unchanged.

## Changes to the financial and accounting arrangements underpinning the QOF

### National Prevalence Day

This would move to the 31st March from 31/03/09 onwards in order that prevalence should be calculated on the same basis as disease registers for indicator denominators.

**Calculating year-end payments**

The deadline for year end achievement payments would be extended to the end of the first quarter of the financial year following the year in question. This is because it has become clear that PCTs need longer than one month to carry out appropriate pre-payment verification checks. To compensate for any effect on cash-flow for contractors, aspiration payments made during 2008/09 would increase from 60 to 70% of achievement in 2007/08.

**Calculating QOF payments for mid year practice splits**

There is currently no procedure in the SFE for adjusting the payment for prevalence until the end of the financial year if a contract ends mid-year. The negotiating parties have agreed that the best solution would be to allow the PCT the flexibility to cash up at the date the original contract ceased. The procedure to be followed would be in line with that set out in *Delivering Investment in General Practice*, Chapter 3, Section F, paragraph 3.64. The achievement payment made at the end of the original contract would be adjusted for prevalence on the basis of the previous year's prevalence, or if there was no previous year figure then the payment would not be adjusted by prevalence.