GP contract survival guide

QOF clinical changes

Introduction

The 2013-2014 GP contract imposition includes clinical changes to the Quality and Outcomes Framework (QOF), many of which were not agreed by the General Practitioners Committee (GPC) negotiators during discussions with NHS Employers in 2012.

The GPC is concerned that some of the new unagreed indicators will:

- Increase practice workload with no additional resourcing
- Skew patient care away from those who need it most by focusing on narrowly defined and sometimes relatively healthy patient groups
- Reduce general access for patients by encouraging GPs to use disproportionate time and resources on certain indicators
- Reduce the amount of consultation time available for a patient-led, holistic agenda by focusing too heavily on politically driven box ticking
- Irritate patients who are becoming increasingly fed up by being asked the same and sometime inappropriate questions year after year
- Put patients at risk if not mitigated by the actions of GPs and practice nurses by careful appropriately increased use of exception reporting

The GPC emphasised these points with the Government during negotiations and during the imposition "consultation period". We are disappointed, though not surprised, that the Government failed to take our concerns on board showing little regard for patient access or practices' constantly escalating workload.

Since the introduction of the new contract, QOF achievement has often been suggested by NHS management as an indicator of practice competence. There has been an assumption that practices will strive to fulfil QOF requirements wherever possible and that failure to achieve full points is a sign of poor quality.

The GPC believes that with the imposition of QOF clinical changes practices should take a more cautious and balanced approach to QOF. QOF remains voluntary.

Given the likely implications of some of the changes to practice workload, resourcing and patient access, practices need to take a considered approach to each new indicator and decide whether the new work makes sense for their practice and patients.

As practices start to take this approach, some will see a reduction in their QOF achievement. Far from indicating a struggling practice, a reduction in QOF achievement may be the result of business rationale and wholly appropriate clinical decisions. Practices need to consider all costs associated with the new work against the resources available.

It will also be necessary to look at the likely benefits for and costs to the practice population. As practice circumstances differ, this is a decision that can only be made on a practice-by-practice basis, though this guidance should help you make an informed decision.

In the guidance we highlight the most important clinical changes to QOF for 2013-2014. The official QOF guidance will also be necessary reading for practices.

Remember

QOF is voluntary

Carefully consider each new indicator to decide whether the work makes sense for your practice and patients – look at the costs versus the associated resources and the impact on your workload and wider patient access

Less than maximum QOF scores may come to indicate sound decision making at practice level

Read this guidance to help you understand the changes

Changes to diabetes indicators

New indicator DM014 requires referral of patients newly diagnosed with diabetes to a structured education programme.

DM014	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	**11 points**

Availability of this service is patchy - only 60% across the country in 2011. As a result, the Department of Health has conceded that practices are allowed to provide the structured education in-house provided they meet the required standards.

It could end up being the case that where services are not available locally, practices will be expected to create and provide their own programme, despite the extra workload this will entail.

Practices need to consider the cost of developing and providing this service – potentially up to half an hour of nurse time for each of 20 to 30 newly diagnosed diabetic patients, plus in some cases additional training costs.

11 QOF points are worth £1726 to an average practice (one with a population of 6.911 patients).

Alternatively, new exception reporting codes will be introduced for practices to use where secondary services are not available. The GPC wanted practices to be able to use exception reporting as a valid alternative to in-house provision of structured education for DM014 where services are not available locally and still receive the full QOF payment but this was not agreed by the Department of Health despite being agreed elsewhere in the UK.

Advice to practices for DM014

Where local structured education services are not available consider whether to provide the service in-house or exception report patients

Look at the cost of developing and providing in-house structured education versus the associated 11 point QOF value of this indicator

The Government is also imposing the introduction of DM013, which expects patients with diabetes to be given a dietary review annually by a ‘suitably competent professional’, despite our concerns that this implies that GPs and practice nurses require mandatory extra training.

DM013	The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months.	**3 points**

'Suitably competent' will be defined as 'a healthcare professional with specific expertise and competencies in nutrition', which may include a 'registered dietician who delivers nutritional advice on an individual basis or as part of a structured

educational programme', or a 'practice nurse who has reached level 1 in the Diabetes UK competency framework for dieticians'.

The GPC believes this is too prescriptive and constitutes micro-management. It should be implicit that both GPs and practice nurses are already capable of doing routine chronic disease management without having to do any extra training.

Whether it is cost effective to fulfil this indicator will therefore depend on whether the practice needs to invest in further training for a practice nurse and the amount of additional time any healthcare professional needs to spend performing a dietary review.

If no 'suitably competent' healthcare professional is deemed to be available within the practice, this indicator is likely to lead to an increase in referrals to professionals outside the practice, which is at variance with current Clinical Comissioning Group (CCG) pressure to reduce such referrals. Dieticians are already in scarce supply.

DM013 is worth 3 QOF points or £470.76 to the average practice.

Advice to practices for DM013

Before committing to this indicator, consider the additional workload involved for staff. Do your staff already have the necessary qualifications or will additional training be required?

DM015 and **DM016** are new indicators which measure the number of diabetic patients with a record of erectile dysfunction (ED). The GPC agreed to the inclusion of these, although we were concerned about the need to question patients annually and suggested this should be linked to newly diagnosed patients only.

In response to our concerns, the Government has agreed to ask NICE to review the indicator wording for 2014-2015 to consider how to ensure that men whose symptoms may change between annual reviews are offered care while avoiding repetitive questions where all treatment options have already been fully explored.

Where the GP or practice nurse already knows the man's past medical history, including previous discussions about erectile dysfunction, it may be appropriate to exception report this indicator rather than asking further insensitive or inappropriate questions. Patients should only be asked about ED as often as clinically appropriate and not simply as a requirement to fulfil QOF.

DM005, which measures percentage of patients with diabetes with a record of an albumin:creatinine ratio test, replaces DM13.

Changes to hypertension indicators

There are several major new hypertension indicators, despite the very serious concerns of GPC about associated implications for practice workload and patient safety. HYP003, a new indicator, is being introduced alongside the existing HYP002 target (which previously had an associated 55 points).

HYP002	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.	**10 points**
HYP003	The percentage of patients aged 79 and under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90mmHg or less.	**50 points**

The decision to allocate 60 points to these two indicators does nothing to reduce the associated workload for practices but will heavily penalise practices that fail to reach these targets.

Clinically, the GPC believes that the new HYP003 could adversely affect patient access for marginal clinical benefit. Despite the associated 60 point value, practices should consider the impact of these indicators on patient care, patient access and practice workload.

It is likely that the need to use exception reporting will increase. Practices should do this whenever appropriate and in particular to meet clinical needs including safety concerns you may have about over-treatment in the elderly. A clear record should be made in the patient's record about the reason for exception reporting.

In addition to the increased workload which will result from providing HYP002 and HYP003, the Government has imposed two new indicators which require an annual physical activity assessment for hypertensive patients as well as a brief intervention in those patients who are deemed 'less than active' (HYP004 and HYP005). Upper thresholds for these two indicators will be 80% in 2013-2014 rising to 90% in 2014-2015.

HYP004	The percentage of patients with hypertension aged 16 or over and under the age of 75 in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 12 months.	**5 points**
HYP005	The percentage of patients with hypertension aged 16 or over and under the age of 75 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.	**6 points**

These indicators were opposed by the GPC owing to the workload implications of using GPPAQ to assess physical activity and because we believed that many patients would soon become irritated by yet more repeated questioning when the answer is already known.

We were also concerned that offering more or longer appointments for some patients to achieve QOF targets will be necessary, again reducing access for other patients. NICE estimates that it takes 30 seconds to complete the questionnaire and then 1-2 minutes for the nurse or GP to transfer this to the system during the consultation.

Nevertheless, a practice with 900 hypertensive patients will need to spend around 37 hours of clinical time doing this work. An average practice will be paid £770 for HYP004 and £940 for HYP005.

Advice for practices for HYP002 and HYP003

Consider the likely impact of these indicators on patient access and practice workload

Use exception reporting as appropriate so patient safety is not compromised.

Advice for practices for HYP004 and HYP005

Consider the likely impact of this work on the rest of your service before deciding to engage in this work. Look at the cost of this work versus the associated funding for your practice.

New clinical area for rheumatoid arthritis

A new clinical area for rheumatoid arthritis (RA) comprising of four new indicators (RA001, RA002, RA003 and RA004) has been introduced for 2013-2014. The GPC agreed to the introduction of this new area and to the concept of referring such patients to specific services if these were universally available. Nevertheless, in the context of the wider contract imposition, practices may struggle to complete this new work.

RA001 is aimed at setting up and maintaining a register of patients with rheumatoid arthritis. The GPC asked that plasma viscosity as an alternative test to erythrocyte sedimentation rate to determine accuracy of diagnosis, was added to the QOF guidance, which the Government has agreed to.

RA002 measures the percentage of RA patients who have had an annual review.

RA003 measures percentage of RA patients aged 30-85 who have had a CVD risk assessment. The GPC had concerns about the availability of the CVD risk assessment tool and its compatibility with IT systems. Following the consultation, the Government has advised that it anticipates that the QRISK2 tool will be used, which is freely available on the web and is embedded into a number of GP clinical systems. If it is not embedded in the system used by the practice they will need to enter QRisk2 (38DP) manually as calculated via an online engine.

The GPC also felt that an annual reassessment was unnecessary and suggested a longer review period. The Government advised that NICE had recommended annual risk assessment for RA003 on the basis that this is highly cost-effective and can be carried out at the same time as the annual review rewarded in RA002. The GPC believe that this is a meaningless box-ticking exercise, but if this can be embedded in a template, it should not cause practices a significant increase in workload.
RA004 measures the percentage of RA patients aged 50-91 with an assessment of fracture risk using a risk assessment tool. The fracture risk can be calculated by using wither FRAX or QFracture, both of which are available to practices free of use, This is likely to be new work for many practices but the GPC believes it is a reasonable thing to do for patients with RA.

Advice for practices for RA003 and RA004

Practices should use the QRISK2 CVD risk assessment tool.

Other indicators being introduced

BP001	The percentage of patients aged 40 and over who have a record of blood pressure in the preceding 5 years.	**15 points**

BP001, which replaces Records 11 and 17, will result in increased practice workload and, the GPC believes, will deliver little clear clinical benefit.

Instead large numbers of healthy young people, who would not otherwise make an appointment to see their GP, will be encouraged to attend at the expense of patient access for those who wish to consult.

NICE has stated that BP001 can be done 'opportunistically' in "all adults presenting at the practice as part of standard care". They pay little regard to the fact that the 35-40 year old age group is possibly the lowest attending of all which, with the thresholds so high, will lead to , wasteful chasing of these patients for miniscule clinical benefit.

Again though, practices will need to come to their own conclusions about whether the resources available make this work worthwhile taking into account the likely impact on care for other patients.

Advice for practices for BP001

Consider extra workload and impact on care for other patients

CVD-PP001, which measures the percentage of newly diagnosed hypertensive patients with a high CVD risk score currently treated with statins, has replaced the PP1 indicator.

CVD-PP001	In those patients with a new diagnosis of hypertension aged 30 or over and under the age of 75, recorded between the preceding 1	**10 points**

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 assessment tool agreed with the NHS CB) of >20% in the preceding 12 months: the percentage who are currently treated with statins.

The GPC asked to change the wording of this indicator to allow an 'offer' of a statin, which NICE had provisionally agreed to, but following consultation the Government decided to retain the original wording of the indicator 'because it is the treatment that improves health and not the offer of treatment' and has advised that patients may be excepted from the indicator if they do not wish to have treatment.

Advice for practices for CVD-PP001

Do not hesitate to use exception reporting as appropriate where treatment with statins is not appropriate, making a clear record of this in the patient's notes.

CAN002 measures the percentage of cancer patients who have had a review within three months (this was previously CANCER 3 and the review time frame was previously six months).

The Government has agreed to make it clear in the QOF guidance that while a face-to-face review is preferable in most cases, making contact with a patient over the telephone will also meet the requirements for this indicator.

COPD005 is a new indicator which measures the percentage of patients with COPD and MRC Dyspnoea grade >3 (walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace) with a record of oxygen saturation value within the last year. There will be cost implications for practices without sufficient supply of oxygen saturation monitors.

DEP001 and **DEP002**, which measure patients with new diagnosis of depression who have had a bio-psychosocial assessment (BPA) completed by the point of diagnosis (so making it essential that practices have robust systems in place to make sure the diagnosis is recorded and the code for the assessment done are added at the same time) and such patients who have been reviewed within 10-35 days of the diagnosis, replace DEP1/6 and DEP7. The QOF guidance makes it clear what should be included in BPAs.

STIA005, which measures percentage of patients with non-haemorrhagic stroke or history of TIA with <5mmol/l cholesterol, replaces Stroke 8.