

## **FOCUS ON**

### **THE QUALITY AND OUTCOMES FRAMEWORK 2006**

#### **WHAT HAS CHANGED**

This guidance gives an overview of what changes have been made to the Quality and Outcomes Framework (QOF), what has come out, what has gone in and the reason why this was done. For a full list of all the indicators in the new QOF and the guidance related to them please refer to the BMA website '*The Quality and Outcomes Framework 2006*' <http://www.bma.org.uk/>

#### **Background**

The Quality and Outcomes Framework has always been a key component of the new GMS contract. It has rewarded the delivery of high-quality general practice over the last few years by supporting the provision of an excellent service to both patients and the NHS.

It has also been critical in ensuring adequate remuneration of GPs for the service they provide. From its inception, it was always intended that it would be reviewed in light of new clinical evidence and the evolving nature and work of general practice.

The QOF review process started in February 2005 with the appointment of the University of Birmingham in conjunction with the Royal College of General Practitioners and the Society of Academic Primary Care to form the expert panel. An open call for evidence was then held from 18<sup>th</sup> April 2005 to 30<sup>th</sup> May 2005. In total 514 submissions were received. The expert panel reviewed all the submissions and provided recommendations for both modifications of existing indicators and potential new indicators to the negotiating parties, NHS Employers and the General Practitioner Committee. The negotiating parties spent the following months considering the expert group reports and negotiating the evidence-based changes. During this period of the negotiations, the expert panel were available, and clarified questions of evidence for all parties. The Quality and Outcomes Framework was also reviewed in relation to practice achievement, which included analysing the results of QMAS for threshold trends.

#### **The Agreement on Points**

The QOF negotiations took place within the context of the review of the entire new GMS contract. In light of the new funding available for the new contract, it was agreed that 138 points would be removed from the QOF to be replaced with new indicators and clinical domains. A further 28 points were redistributed amongst the current indicators.

A full list of those indicator points removed, redistributed and added is attached at Appendix 1.

A full list of text changes to existing indicators is presented at Appendix 2.

#### **Indicator Points Removed**

- **Holistic points and Quality Practice Payments**

Eighty holistic and all the quality practice points were removed as part of the deal to reduce the current QOF by 138 points and to allow the inclusion of new clinical areas. Twenty holistic points remain to encourage practices to engage across the board in both the old and new clinical indicators.

- **Asthma 7**

The removal of this indicator, for the flu vaccination of patients with asthma, was because there was no longer supporting evidence to prove that it is of benefit.

- **Mental Health 3, 4 and 5**

These indicators relate to the monitoring of patients on lithium therapy. It was recognised by the experts and negotiating teams that these indicators covered a very small percentage of patients. It was felt that Mental Health 3 could be made redundant as Mental Health 4 and 5 provided sufficient monitoring. Equally, because of the small number involved, the points for MH4 and 5 were reduced.

- **Disease Registers**

Nine of the disease registers were reduced in points. This was because, in most cases, it was recognised that the largest piece of work had already been achieved with the setting up of the registers. Although work was needed to maintain the registers, this was generally less demanding than setting it up. Where maintaining the register will still require significant work, as is the case with cancer, the reduction in points was minimal.

- **Organisational points**

Records 1, 2, 4, 5, 6, 7, 12 and 14 were removed because it was recognised that all these indicators should be met by practices maintaining a level of clinical care that was professionally competent.

Information for patients 1, 2, 6 and 8 were removed as they were deemed to cover information that would necessarily be presented to patients already and there were issues with Records 8 with regard to telephone systems which made this quality indicator redundant.

Management 2 and 10 were reduced in points. Management 2 should be followed by all practices as a matter of course and Management 10 represents best employment practice. The points remaining in these indicators acknowledge the workload involved in completing them.

Medicines 1 was removed as this is standard practice and it was felt it should not remain in the QOF.

### **Indicator points redistributed**

Twenty eight points taken out of the QOF were redistributed amongst existing indicators. This corresponded to indicators where it was felt that the extra work required to achieve them was not adequately reflected in the money available through them.

- **Clinical indicators**

Analysing the QOF results for all practices using QMAS data, it was possible to see which indicators practices were having the most difficulty achieving. In order to encourage a higher percentage achievement the following indicators were each given an extra point: CHD8, BP5, DM6, DM12, COPD 6, COPD 7.

- **Organisation indicators**

It was recognised that summarising records was an extremely demanding task for practices to keep up to date with. In light of this a further summarising indicator, with a 70% target has been introduced to

further incentivise practices who have reached the 60% indicator but find the 80% target too demanding.

Significant event reviews are important educational tools and the points for them have been increased and the explanatory text has also been altered. This is to encourage reflective working within practices. "Near-misses" can also be included within this review.

Eight points have been added to the Patient Experience indicators. The patient experience survey and follow-up actions are an important mechanism for improving practice in relation to patient-specific feedback. To do the job well requires time and money, this is reflected in the higher point value put into these indicators.

### **Smoking indicators reconfiguration**

All the smoking and smoking cessation indicators in the CHD, Stroke, Hypertension, Diabetes, COPD and Asthma clinical domains were removed from the disease indicator sets and placed within two specific smoking indicators. Their point value was also carried over into the new smoking indicators (ie: 68 points were removed from the clinical indicator sets and distributed 33 and 35 points in the new smoking indicators).

### **New indicators**

The process of deciding on the new areas of work to be introduced to the QOF involved appraising the submitted evidence and then prioritising their clinical importance in primary care. There were 138 points available for new indicators. There was very strong evidence supporting the inclusion of indicators in the following clinical disease areas:

Atrial Fibrillation  
Chronic Kidney Disease  
Dementia  
Depression  
Mental Health  
Palliative Care

The evidence will be published on the RCGP/University of Birmingham website.

Furthermore, new indicators were introduced for the setting up of an Obesity register and Learning Disability register. The obesity register can aid the formulation of public health policy and the learning disability register can enable further work on defining the service and development needs of patients with a learning disability.

One point was also awarded to recording the ethnic origin of patients when they register at the practice. This brings such recording into line with the rest of the NHS. Patients can decline to record this information and practices can choose not to take part in this or any other indicator.

Many other sets of evidence were submitted for other diseases, some of them of considerable importance. None of these were ignored but only a number could be incorporated and resourced through the QOF. Within this context it should be remembered that QOF accounts for only a small proportion of general practice. The decision not to include a clinical area in QOF should not be interpreted as diminishing either the importance of the condition or the expectation that patients should receive appropriate care from their general practice.

## **Thresholds**

Analysis of the overall QOF results showed very high achievement rates across all four nations. In light of this, and the determination that the QOF should be a tool that encourages the improvement of standards in general practice, all the lowest thresholds were raised to 40% and in most instances the higher threshold was raised to 90%. Where there was clear evidence that setting a 40% and 90% threshold would be likely to discourage work in specific indicators, or was clearly unachievable, thresholds were altered within a more reasonable range for those indicators (for example CHD6, 8,10 and 11) or left as they were (for example BP5).

## **Exception reporting**

There have been no changes to the rules around exception reporting.

**QOF POINTS  
REMOVAL, REDISTRIBUTION, ASSIGNMENT**

| <b>Indicator set</b>            | <b>Points removed</b> | <b>Points remaining or<br/>Indicator gone</b> |
|---------------------------------|-----------------------|---|
| Holistic points                 | 80                    | 20  |
| Quality Practice Payments       | 30                    | gone  |
| Asthma 7 (flu vaccs)            | 12                    | gone  |
| Mental Health 3                 | 3                     | gone  |
| Mental Health 4                 | 2                     | 1   |
| Mental Health 5                 | 3                     | 2   |
| <b><u>Disease registers</u></b> |                       |   |
| CHD                             | 2                     | 4   |
| Stroke & TIA                    | 2                     | 2   |
| Hypertension                    | 3                     | 6   |
| COPD                            | 2                     | 3   |
| Epilepsy                        | 1                     | 1   |
| Hypothyroidism                  | 1                     | 1   |
| Cancer                          | 1                     | 5   |
| Mental Health                   | 3                     | 4   |
| Asthma                          | 3                     | 4   |
| <b><u>Organisational</u></b>    |                       |   |
| Records 1                       | 1                     | gone  |
| Records 2                       | 1                     | gone  |
| Records 4                       | 1                     | gone  |
| Records 5                       | 1                     | gone  |
| Records 6                       | 1                     | gone  |
| Records 7                       | 1                     | gone  |
| Records 12                      | 2                     | gone  |
| Records 14                      | 3                     | gone  |
| Info for patients 1             | .5                    | gone  |
| Info for patients 2             | .5                    | gone  |
| Info for patients 6             | .5                    | gone  |
| Info for patients 8             | 1                     | gone  |
| Management 2                    | .5                    | 1   |
| Management 10                   | 2                     | 2   |
| Medicines 1                     | 2                     | gone  |

**TOTAL POINTS TAKEN: 166**

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| <p><b>28 for redistribution amongst existing indicators</b><br/> <b>138 for new indicators</b></p> |
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**WHERE THEY HAVE GONE**

| <b>Redistributed indicators</b> | <b>Points added</b> | <b>Indicator new total</b> |
|---------------------------------|---------------------|----------------------------|
| CHD08                           | 1                   | 17                         |
| BP05                            | 1                   | 57                         |
| DM06                            | 1                   | 17                         |
| DM12                            | 1                   | 18                         |
| COPD6                           | 1                   | 7                          |
| COPD7                           | 1                   | 7                          |
| Records 20 (70% summarising)    | 12                  | 12                         |
| Education 2                     | 2                   | 6                          |
| PE1                             | 3                   | 33                         |
| PE2                             | 5                   | 25                         |
| <b>TOTAL</b>                    | <b>28</b>           |                            |

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**NEW INDICATORS**

|                     |            |
|---------------------|------------|
| Dementia            | 20         |
| Depression          | 33         |
| CKD                 | 27         |
| Atrial Fibrillation | 30         |
| Obesity             | 8          |
| Palliative Care     | 6          |
| Mental Health       | 9          |
| Learning Disability | 4          |
| Records 21          | 1          |
| <b>TOTAL</b>        | <b>138</b> |

**THE QUALITY AND OUTCOMES FRAMEWORK 2006**

**CHANGES TO THE TEXT OF EXISTING INDICATORS**

Textual changes are highlighted in bold.

The indicator numbers have been changed to distinguish the changed indicator from the previous one when analysing data from QOF.

**STROKE**

|                          |   |
|--------------------------|---|
| <b>Previous STROKE 2</b> | The percentage of new patients with presumptive stroke (presenting after 1 April 2003) who have been referred for confirmation of the diagnosis by CT or MRI scan |
| <b>New STROKE 11</b>     | The percentage of new patients with a stroke <b>who have been referred for further investigation.</b>   |

|                          |   |
|--------------------------|---|
| <b>Previous STROKE 9</b> | The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless contraindication or side-effects are recorded).   |
| <b>New STROKE 12</b>     | The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that <b>an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination),</b> or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded). |

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**DIABETES MELLITUS**

|                     |  |
|---------------------|--|
| <b>Previous DM1</b> | The practice can produce a register of all patients with diabetes mellitus.  |
| <b>New DM19</b>     | The practice can produce a register of <b>all patients aged 17 years and over</b> with diabetes mellitus, <b>which specifies whether the patient has Type 1 or Type 2 diabetes</b> |

|                     |   |
|---------------------|---|
| <b>Previous DM6</b> | The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months.                |
| <b>New DM20</b>     | The percentage of patients with diabetes in whom the last HbA1C is <b>7.5</b> or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. |

|                     |   |
|---------------------|---|
| <b>Previous DM8</b> | The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months.  |
| <b>New DM21</b>     | The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months.<br><b>CHANGE OF NUMBER BECAUSE CHANGE OF READ CODE IN THAT</b> |

|                      |   |
|----------------------|---|
|                      | <b>NOW PRACTICES NEED TO DEMONSTRATE PATIENTS HAVE RECEIVED SCREENING</b>   |
| <b>Previous DM14</b> | The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months.   |
| <b>New DM22</b>      | The percentage of patients with diabetes who have a record of <b>estimated glomerular filtration rate (eGFR) or</b> serum creatinine testing in the previous 15 months. |

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**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)**

|                                 |  |
|---------------------------------|--|
| <b>Previous COPD2<br/>COPD3</b> | The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003<br>The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing. |
| <b>New COPD9</b>                | The percentage of <b>all patients</b> with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing.  |

|                       |   |
|-----------------------|---|
| <b>Previous COPD6</b> | The percentage of patients with COPD with a record of FeV1 in the previous 27 months        |
| <b>New COPD10</b>     | The percentage of patients with COPD with a record of FeV1 in the previous <b>15 months</b> |

|                       |   |
|-----------------------|---|
| <b>Previous COPD7</b> | The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months.        |
| <b>New COPD11</b>     | The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the <b>previous 15 months</b> . |

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**EPILEPSY**

|                            |   |
|----------------------------|---|
| <b>Previous EPILEPSY 1</b> | The practice can produce a register of patients receiving drug treatment for epilepsy.                        |
| <b>New EPILEPSY 5</b>      | The practice can produce a register of <b>patients aged 18 and over</b> receiving drug treatment for epilepsy |

|                            |  |
|----------------------------|--|
| <b>Previous EPILEPSY 2</b> | The percentage of patients age 16 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months.        |
| <b>New EPILEPSY 6</b>      | The percentage of patients <b>age 18 and over</b> on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months. |

|                                |  |
|--------------------------------|--|
| <b>Previous<br/>EPILEPSY 3</b> | The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months.   |
| <b>New<br/>EPILEPSY 7</b>      | <b>The percentage of patients age 18 and over on drug treatment</b> for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months |

|                                |  |
|--------------------------------|--|
| <b>Previous<br/>EPILEPSY 4</b> | The percentage of patients age 16 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the last 15 months.            |
| <b>New<br/>EPILEPSY 8</b>      | The percentage of patients <b>age 18 and over</b> on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months. |

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**CANCER**

|                              |   |
|------------------------------|---|
| <b>Previous<br/>CANCER 2</b> | The percentage of patients with cancer diagnosed from 1 April 2003 with a review by the practice recorded within six months of confirmed diagnosis. This should include an assessment of support needs, if any, and a review of co-ordination arrangements with secondary care. |
| <b>New<br/>CANCER 3</b>      | The percentage of patients with cancer, <b>diagnosed within the last 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis.</b>  |

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**MENTAL HEALTH**

**MH1**

|                         |   |
|-------------------------|---|
| <b>Previous<br/>MH1</b> | The practice can produce a register of people with severe long-term mental health problems who require and have agreed to regular follow-up |
| <b>New<br/>MH8</b>      | The practice can produce a register of people <b>with schizophrenia, bipolar disorder and other psychoses.</b>                              |

**MH2**

|                         |  |
|-------------------------|--|
| <b>Previous<br/>MH2</b> | The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care.  |
| <b>New<br/>MH9</b>      | The percentage of patients with <b>schizophrenia, bipolar affective disorder and other psychoses</b> with a review recorded in the preceding 15 months. <b>In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status.</b> |

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**ASTHMA**

|                              |  |
|------------------------------|--|
| <b>Previous<br/>ASTHMA 2</b> | The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2003 where the diagnosis has been confirmed by spirometry or peak flow measurement. |
| <b>New<br/>ASTHMA 8</b>      | The percentage of patients aged eight and over diagnosed as having asthma from 1 April <b>2006 with measures of variability or reversibility.</b>                          |

**RECORDS AND INFORMATION ABOUT PATIENTS**

|   |   |
|---|---|
| <b>Previous<br/>Records 10<br/>Records 16</b> | The smoking status of patients aged from 15 to 75 is recorded for at least 55% of patients.<br>The smoking status of patients aged 15 to 75 is recorded for at least 75% of patients.                                     |
| <b>New<br/>Records 22</b>                     | <b>The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once. (payment stages 40-90%)</b> |

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**EDUCATION**

|                                 |   |
|---------------------------------|---|
| <b>Previous<br/>Education 2</b> | The practice has undertaken a minimum of six significant event reviews in the past 3 years.           |
| <b>New<br/>Education 10</b>     | The practice has undertaken a <b>minimum of three significant event reviews within the last year.</b> |

**EDUCATION 7**

|                                |   |
|--------------------------------|---|
| <b>Previous<br/>Education7</b> | The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred): <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• Two new cancer diagnoses</li> <li>• Two deaths where terminal care has taken place at home</li> <li>• One patient complaint</li> <li>• One suicide</li> <li>• One section under the Mental Health Act</li> </ul>   |
| <b>New<br/>Education7</b>      | The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include: <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• <b>New cancer diagnoses</b></li> <li>• <b>Deaths where terminal care has taken place at home</b></li> <li>• <b>Any suicides</b></li> <li>• <b>Admissions under the Mental Health Act</b></li> <li>• <b>Child protection cases</b></li> <li>• <b>Medication errors</b></li> <li>• <b>A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss).</b></li> </ul> |

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## MEDICINES MANAGEMENT

|   |   |
|---|---|
| <b>Previous Medicines 5 Medicines 9</b> | A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%<br>A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80% |
| <b>New Medicines 11 Medicines 12</b>    | <b>Text remains unchanged in indicators but definition of medication review changes in guidance.</b>  |

## PATIENTS EXPERIENCE

|   |  |
|---|--|
| <b>Previous PE3 Patient Surveys (2)</b> | The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate.  |
| <b>New PE5 Patient Surveys (2)</b>      | The practice will have undertaken a patient survey each year and having reflected on the results, <b>will produce an action plan that:</b><br><ol style="list-style-type: none"> <li><b>1. Summarises the findings of the survey</b></li> <li><b>2. Summarises the findings of the previous year's survey</b></li> <li><b>3. Reports on the activities undertaken in the past year to address patient experience issues</b></li> </ol> |

|   |   |
|---|---|
| <b>Previous PE4 Patient Surveys (3)</b> | The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted.   |
| <b>New PE6 Patient Surveys (3)</b>      | The practice will have undertaken a patient survey each year and, <b>having reflected on the results, will produce an action plan that:</b><br><ol style="list-style-type: none"> <li><b>1. Set priorities for the next 2 years</b></li> <li><b>2. Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative)</b></li> <li><b>3. Describes the plans for achieving the priorities, including indicating the lead person in the practice</b></li> <li><b>4. Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group</b></li> </ol> |

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## SMOKING INDICATORS RECONFIGURATION

CHD 3, CHD 4, Stroke 3, Stroke 4, BP 2, BP 3, DM 3, DM 4, COPD 4, COPD 5, Asthma 4, Asthma 5 have been removed, with their points and reconfigured into:

|                              |   |
|------------------------------|---|
| <b>SMOKING 1 (33 points)</b> | The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis |
|------------------------------|---|

|                                  |   |
|----------------------------------|---|
| <b>SMOKING 2<br/>(35 points)</b> | The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma 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 |
|----------------------------------|---|

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**CERVICAL SCREENING**

|                                      |  |
|--------------------------------------|--|
| <b>Previous CS2<br/>Previous CS3</b> | The practice has a system to ensure adequate/abnormal smears are followed up.<br>The practice has a policy on how to identify and follow up cervical smear defaulters. Patients may opt for exclusion from the cervical cytology recall register by completing a written statement which is filed in the patient record (exception reporting). |
| <b>Previous CS4</b>                  | Women who have opted for exclusion from the cervical cytology recall register must be offered the opportunity to change their decision at least every 5 years.   |
| <b>New CS7</b>                       | <b>The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates.</b>   |