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 18th April 2005 to 30th 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.