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Our Ref: GPC/LB/uf

31 January 2013

Dear Richard

Interim response to the QOF sections of the GP contract proposals

The proposed changes to the Quality and Outcomes Framework (QOF) from April 2013 are likely to have serious implications for patients and for GP practices. As the clinical changes are complex and will need to be planned for well before April, we have decided to submit an early response to this aspect of your consultation. We intend to submit a full response to the proposals in due course informed by the views of GPs gathered through our roadshows and GP survey.

We are deeply disappointed that the issues discussed in the QOF subgroup meetings last year have not been reflected in the QOF proposals, even on points where there appeared to be agreement between GPC and NHS Employers. The views expressed in this response reiterate the points made previously, and we sincerely hope that as part of this consultation you will work with us to ensure the current proposals are refined for the sake of both patients and practices.

As requested, we will be submitting detailed comments on the draft QOF guidance to NHS Employers. However, we are surprised that detailed guidance has been developed before the consultation period has ended.

We outline below our detailed response to the QOF sections of the contract proposals. Please note that we have used the new indicator numbering and wording as sent to us by NHS Employers for consistency throughout.

Implementation of all NICE recommendations for changes to QOF

During the 2012 negotiations, there were a number of recommendations that were agreed between the negotiating parties in the QOF subgroup, including re-wording of the diabetes and erectile dysfunction indicators (DM015 and DM016), and the amendment of CVD-PP001 to include an 'offer' of a statin. However, these changes have not been included in the current proposals, despite the clinical experts from NICE and NHS Employers agreeing with the GPC's position. We would request their inclusion in the final contract, and also again suggest that the annual revaluation of cardiovascular risk in the rheumatoid arthritis domain is too frequent. It would be better repeated on a triennial basis.

Indicators rejected due to services not universally available

DM014, COPD006 and HF003 were rejected by the GPC during negotiations on the grounds that they are unworkable. The services required are not universally available across the UK, effectively making the associated points impossible for practices in certain areas to achieve.

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The GPC does not believe that relying on exception reporting where the programmes are unavailable is enough to make these new indicators acceptable because:

- with the increased public scrutiny of practices' annual QOF achievement, and the way the media, PCTs and politicians have handled exception reporting in the past, the GPC does not want to see practices forced to justify exception reporting rates inflated as a result of these changes
- where the services are not available, this would eliminate the indicator denominator.

We believe that at the very least where services are not conveniently available to patients, a code to recognise this should be included and counted toward the QOF target. This would also enable CCGs to evaluate where important gaps to patient services exist and encourage rectification. The points should be awarded as though there were a service available. Otherwise, we accept these indicators with a guarantee of service availability.

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
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The GPC rejects the inclusion of DM014 due to lack of universal availability of structured education programmes. If such availability could be ensured, the GPC would accept the inclusion of this indicator.

COPD006: The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 12 months.	5
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The GPC rejects the inclusion of COPD006 due to lack of universal availability of pulmonary rehabilitation programmes. If such availability could be ensured, the GPC would accept the inclusion of this indicator.

HF003: The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise based rehabilitation programme within the preceding 15 months.	5
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The GPC rejects the inclusion of HF003 due to lack of universal availability of exercise based rehabilitation programmes. If such availability could be ensured, the GPC would accept the inclusion of this indicator.

Indicators rejected due to workload implications

The GPC rejects the inclusion of HYP003, HYP004, HYP005 and BP001 because we believe that the workload implications would be so profound that they could skew health care toward certain sections of the patient population at the expense of other patients. This could result in other patients finding it more difficult to make an appointment.

In the QOF subgroup discussions, the GPC rejected the retirement of BP5 [now HYP002] to be replaced with HYP003, because it is the single biggest workload change for practices. The appointments lost in trying to deliver this work would outweigh marginal benefits, adversely affecting patient access. Using QOF to hit such targets for a whole population risks increasing the number of patients suffering from the adverse effects of polypharmacy, including potentially dangerous hypotension. The GPC does not believe that relying on exception reporting would provide enough safeguards to avoid these risks, which could be significant, particularly as the government is intent on raising upper thresholds to high and ever-rising levels, as outlined in their proposals for changes to GP contracts.

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
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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.	45
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The GPC remains opposed to the inclusion of HYP003 and we are concerned that although the NICE recommendations suggested that HYP003 should replace BP5, it has now been decided to include both indicators. Our preference would be to retain HYP002 as it is, with 55 points.

Offering more or longer appointments for some patients to achieve QOF targets will also be necessary for HYP004 and HYP005, again reducing access for other patients. GPs already encourage their patients to take more exercise when it is clinically appropriate, but many patients with hypertension will not like having to complete an exercise questionnaire every year, especially when it is unlikely that the results will change significantly from one year to the next. The perception of this as a tick-box exercise a practice is required to do to secure resources, would undermine the doctor-patient relationship. Practices will have to spend time and resources filling in such questionnaires, to the detriment of other services. In light of the prevalence of hypertension in the population, this proposal would result in nearly nine million questionnaires administered annually across the UK. This would clearly have significant knock-on effects for the rest of the service arguably with very little discernible benefit.

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.	3
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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.	3
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The GPC rejects the inclusion of HYP004 and HYP005 due to the workload implications of having to use the GPPAQ to assess physical activity.

In the QOF subgroup discussions, the GPC agreed that BP001 would replace Records 11 and 17. However, we did not agree to the change in age range from 45 to 40 years. The DH has suggested that this is a 'tiny' change. However, we believe this would result in a large increase in workload for GP practices, while delivering no clear clinical benefits. We are not convinced that encouraging large numbers of healthy young people, who would not otherwise make an appointment to see their GP, to come to the practice, should be prioritised at the expense of offering enough appointments to those who are ill. Chasing these targets would impact on appointment availability for those who genuinely need to see their GP or practice nurse. It would mean significant extra work with no new resource to provide additional capacity to deal with it.

BP001: The percentage of patients aged 40 and over who have a record of blood pressure in the preceding 5 years	15
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The GPC agrees to the inclusion of BP001, subject to the age range being changed back to 45 years.

Indicator rejected due to extra training being required

The GPC opposes the inclusion of DM013 due to the use of 'suitably competent professional' in the wording of the indicator. This would require diabetic dietary advice to be given by GPs or diabetic nurses who have done extra training. This could add significant extra costs for practices and require longer consultations. We would argue that GPs and practice nurses are already capable of doing routine chronic disease management without having to do extra training. We question the value of an increasing number of days away from the practice spent doing training for areas in which they already have the necessary skills. It is the responsibility of the practice to ensure that all members of staff have the necessary skills and training to be able to provide the care they offer. We do not believe the NHS Commissioning Board should become involved in the micromanagement of practice training requirements, which is what acceptance of this indicator would lead to. It could also mean an increase in unnecessary referrals to other professionals outside the practice, which is at variance with current CCG pressure to reduce such referrals. The reference to 'suitably competent professional' should be removed or clearly defined in the QOF guidance. GPs and practice nurses should not 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
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Concerns over indicators using repetitive and inappropriate questioning

DM015 and DM016 refer to diabetic patients with a record of erectile dysfunction (ED). Although GPC agrees that asking diabetics about ED may be appropriate in certain circumstances, there are concerns about having to do this on an annual basis. To repeatedly remind a man he has ED every year, when all treatment options have been discounted, seems unnecessarily insensitive.

The time frame for these indicators should be extended and linked to newly diagnosed patients. The QOF guidance on 'a record of being asked' should include a leaflet, and patients with existing complaints of ED who had already considered all treatment options should be excluded. Unfortunately, it appears that these points will not be included in the new guidance, despite having had agreement in principle by NICE and NHS Employers that these were valid points and would be explained in the guidance. GPC agrees to the inclusion of DM015 and DM016, subject to the QOF guidance being amended in this way.

DM015: The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months.	4
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DM016: The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months.	6
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Many men with ED will question why the DH is so keen to promote this indicator when large numbers are not entitled to receive NHS prescriptions for their treatment. GPC believes equality in access to treatment should be the first priority.

Other new indicators, replacements and amendments

CAN002: The percentage of patients with cancer diagnosed within the preceding 15 months who have a review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis.	6
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The GPC agrees to this indicator [CAN002] being amended from 6 to 3 months [to replace Cancer 3], subject to amendment of the wording in the QOF guidance to clearly explain the reason for this change, the previous 6 month time-frame being evidence based. We are pleased that phone reviews have been included in the draft QOF guidance.

COPD005: The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months.	5
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The GPC agrees to the inclusion of this indicator [COPD005].

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 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 $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins.	10
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The GPC agrees that CVD-PP001 should replace PP1, subject to amendment of the indicator wording to allow an 'offer' of a statin. This change had been agreed by NICE [and NHS Employers] in the QOF subgroup, but has not been included in the draft QOF guidance. We would therefore ask that the wording of CVD-PP001 is amended accordingly.

CVD-PP002: The percentage of people diagnosed with hypertension (diagnosed after on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5
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In the QOF subgroup, this indicator [CVD-PP002] was not discussed or agreed as we rejected HYP004 and HYP005. The GPC would like to retain the wording 'increasing physical activity' in this indicator.

DEP001: The percentage of patients with a new diagnosis of depression in the preceding 1st April to 31st March, in the target population, who have had a bio-psychosocial assessment by the point of diagnosis.	21
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The GPC agrees that DEP001 should replace DEP1 and DEP6, subject to the definition of 'point of diagnosis' in the QOF guidance.

DEP002: The percentage of patients with a new diagnosis of depression in the preceding 1 April to 31 March, in the target population, who have been reviewed within 10-35 days after the date of diagnosis.	10
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The GPC agrees that DEP002 should replace DEP7, subject to the guidance for DEP001 being explicit that the date of diagnosis is the date of the face-to-face consultation to address the depression, not the date of recording from an outside consultation.

DM005: The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months.	3
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The GPC agrees that DM005 should replace DM13.

RA001: The contractor establishes and maintains a register of all patients aged 16 years and over with rheumatoid arthritis.	1
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The GPC agrees to the inclusion of this indicator [RA001]. However, in the QOF subgroup discussions, NICE agreed to add 'plasma viscosity' to the QOF guidance so that it is clear that this refers to RA only. We would ask that this is included.

RA002: The percentage of patients with rheumatoid arthritis, on the register, who have had a face to face annual review in the preceding 12 months.	5
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The GPC agrees to the inclusion of this indicator [RA002].

RA003: The percentage of patients with rheumatoid arthritis, on the register, aged 30 or over and under the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months.	7
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The GPC agrees to the inclusion of this indicator [RA003], subject to universal availability of the CVD risk assessment tool and compatibility with IT systems. However, we believe that an annual reassessment adds little to this indicator, and suggest a longer review period of 3-5 years.

RA004: The percentage of patients aged 50 or over and under the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months.	5
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The GPC agrees to the inclusion of this indicator [RA004], subject to universal availability of the risk assessment tool.

STIA005: The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less.	5
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The GPC agrees that STIA005 should replace Stroke 8.

Amendments

We also agree to amendments in wording to DM006 and MH002:

DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with ACE-I inhibitors (or ARBs2 antagonists).	3
MH002: The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses on the register who have a comprehensive care plan documented in the records (in the preceding 12 months) agreed between individuals, their family and/or carers as appropriate.	6

Retirements

The GPC agrees that CHD10, DM2, DM10 and DM22 should be retired.

However, we reject the retirement of some process indicators such as CKD2, EPILEPSY 6 and BP4, as the work will still need to be done, but without any resource to do it. In particular, removing EPILEPSY 6 leaving only the often clinically unachievable EPILEPSY 8 means many practices may stop doing epilepsy reviews at all for the most complex of their patients. GPC does not believe this is in the best interests of patients with epilepsy.

CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months.	4
EPILEPSY 6: The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months.	3
BP4: The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding nine months.	8

Public health domain

We agree to the proposal to set up a new public health domain within QOF. We would expect that the negotiations for this domain to remain within the QOF subgroup, as currently set up between BMA, NHS Employers and NICE, with the inclusion of Public Health England as from April 2013.

Quality and productivity indicators

Although on the whole we agree with retaining the quality and productivity (QP) indicators for another year and to streamline the wording of these indicators, we are very disappointed that our discussions in the QOF subgroup and plenary were not taken into account with respect risk profiling potentially replacing sections of the QP domain (QP004, QP005, QP006). This was set out in our joint proposal paper on 22 October 2012:

'All practices are expected to undertake patient risk profiling in order to improve their care and reduce unscheduled hospital admissions. In the event practices are already participating in a risk profiling scheme or are shortly due to participate in one that is in the process of being finalised and implemented (i.e. outside of QOF) then practices will not be expected to undertake these indicators. Instead, they will continue with the current quality and productivity emergency admission indicators.'

Raising upper thresholds for existing indicators

The GPC rejects the proposal for a blanket increase in thresholds, as this would disadvantage practices financially, could put patient care at risk and will reduce patient choice. We also reject the suggestion that practitioners stop treating patients once the practice has reached a particular threshold level. We do not believe there is any evidence to support this and that it could have serious implications on patient care.

For a practice to meet an upper threshold above 90%, they would need to aim higher than the upper thresholds to ensure that they reach the threshold by year end. This could lead to reduced patient autonomy and impact disproportionately on access for non-QOF consultations.

Our analysis shows that if practice achievement stays at current levels, unless there is additional investment in the contract, the average practice will lose about £3,700 from their QOF income in 2013-2014, rising to £11,300 in 2014-2015.

The GPC therefore rejects the increase in thresholds as proposed. However, as we suggested in the negotiations, we are willing to increase by 5% the upper thresholds of nine indicators where we believe the impact to practices would be minimal and the gain to patients the greatest:

		2012-13 Thresholds	2013-14 thresholds
CHD6	CHD002	40-75%	40-85%
CHD8	CHD003	45-70%	45-75%
HF3	HF004	45-80%	45-85%
HF4	HF005	40-65%	40-70%
DM15	DM006	45-80%	45-85%
DM18	DM010	45-85%	45-90%
COPD8	COPD07	45-85%	45-90%
Stroke6	STIA003	40-75%	40-80%
Stroke10	STIA006	45-85%	45-90%

Remove the overlap of QOF years

We believe that the implication of reducing the time-periods from 15 to 12 months or from 27 to 24 months is considerable. If reviews have to be done within the year, flexibility for GPs will be reduced, compressing appointment opportunities and QOF workload into a shorter timeframe.

It is possible that a small number of patients may indeed have missed a review because of this current rule (although ONLY if the GP practice had no other recall than QOF software - like medication reviews for instance), but practices need some flexibility to accommodate their patients' needs. In practice GPs would have to schedule all QOF reviews between April and mid-February to take account of the need for flexibility for patients and human nature. Appointments scheduled later, which are missed and run over to the next year, would otherwise lead to that year's funding being lost.

The proposed change would have significant workload and access implications for practices and patients, as well as leading to some lost funding for practices and reduced patient satisfaction due to the reduced flexibility of the system for patients. The GPC therefore rejects the reduction of time-periods in indicators from 15 to 12 months and from 27 to 24 months.

I hope that the early submission of this response will give you time to consider all of these points and make the necessary amendments to your proposals.

We are of course happy to discuss this further with you at any time.

Yours sincerely



DR LAURENCE BUCKMAN
Chairman of the General Practitioners Committee