Consultation on GP contract 2013/14:

Government response
CONSULTATION ON GP CONTRACT 2013/14: GOVERNMENT RESPONSE

INTRODUCTION

1. The Department of Health wrote to the BMA General Practitioners Committee on 6 December 2012 to consult it on proposed changes to primary medical care contractual arrangements from April 2013. The Department also wrote to a number of other key stakeholders (NHS Alliance, National Association of Primary Care, Family Doctor Association, Royal College of Nursing and the NHS Commissioning Board) to consult them on the proposed changes.

2. The proposed changes were intended to maintain current levels of investment in general practice, whilst promoting continuous improvement in the quality of services.

3. The Department of Health received formal responses from the BMA General Practitioners Committee (GPC), National Association of Primary Care (NAPC), Family Doctor Association (FDA), Royal College of Nursing (RCN) and the NHS Commissioning Board (NHS CB). The Royal College of General Practitioners (RCGP) wrote to the Secretary of State about the NICE recommended indicators. In addition, the Department received 68 representations from or on behalf of individual general practices and four from members of the public.

SECURING EQUITABLE FUNDING IN GMS CONTRACTUAL ARRANGEMENTS: 2014/15 AND BEYOND

Proposals

4. The Department’s proposals were intended to reflect the suggested approach developed in negotiations between the GPC and NHS Employers of phasing out the Minimum Practice Income Guarantee (MPIG) over a seven-year period, beginning in 2014/15, along with redistribution of correction factor payments between contractors.

5. The proposals stated that the value of the annual correction factor payments made to any practice, as part of their entitlement as at 31 March 2014, would be reduced by one-seventh in each subsequent year until the payment has been reduced to zero (or less than a de minimis level of £10 per month) at which point it would cease. Correction factor resources released in this way would be reinvested into Global Sum payments so as to benefit all practices, not just those in receipt of correction factor payments.

6. Separate to these provisions, the proposals envisaged that the NHS CB would, from April 2013, begin discussions with PMS contractors to identify and agree the basis for implementing similar actions to achieve
equitable and fair core funding between GMS and PMS contractors on the basis of a standard weighted capitation funding formula.

7. In addition, for 2013/14 the Department proposed to apply any annual uplift in GP contract payments, following advice from DDRB, partly to Global Sum payments and partly to other payments, so as to narrow the funding gap between practices while providing some uplift to all practices.

Summary of responses

8. The GPC suggested that the Department’s proposals did not accurately reflect those developed between NHS Employers and the GPC for reducing variability in practice funding. They also commented that any correction factor monies and PMS funding removed from practices should be ring-fenced and reinvested into GMS global sum payments, that the proposals should be fully modeled prior to implementation and that consideration be given to outliers, excluding from the process those practices that needed higher funding for legitimate reasons.

9. The NAPC were broadly supportive of the proposed approach with a number of caveats. These were around the process and definitions used in the exercise, and the difficulties in identifying resources that cover value added PMS activities, ie for key performance indicators and extra services that are over and above core services.

10. The NAPC were also clear that they wished to see PMS contractors treated equitably, which they defined as fairly and impartially, and that any changes to PMS contracts should take place over the same seven year period proposed for GMS contracts. Their greatest concern was the suggestion that the extra funding for the value added elements of PMS contracts might be devolved to CCGs.

11. The RCN were concerned over the lack of transparency between GMS and PMS practices’ core funding distribution at present. They were also concerned that any re-balancing in core income could disproportionately affect some practices and suggested a more nuanced approach that considered the impact at practice level.

12. The RCN also suggested the main advantages of the current PMS contract is its flexibility, allowing specific local needs to be taken into account. They also had a number of detailed comments on the factors that should be taken into account when calculating GP practice funding, including age profile, deprivation and patient turnover.

13. The NHS CB was supportive of the proposals and confirmed it will begin discussions with PMS contractors, from April 2013, to identify and agree the basis for implementing actions to achieve equitable and fair core funding between GMS and PMS contractors over a seven-year period starting from April 2014.
Government response

14. The Government has been clear that it wishes to move to a system that rewards GP practices fairly and consistently for the number of patients on their list, with an appropriate weighting for factors such as age and deprivation. In the light of the responses, the Government remains committed to this aim.

15. The Government’s intention, echoed in a number of the consultation responses, is that the proposals will need to be taken forward in a carefully managed way, informed by sufficient modelling to allow the effects to be properly considered.

16. It will be the responsibility of the NHS CB to ensure that equitable funding is effectively managed and delivered over the seven-year period from April 2014.

17. From April 2014, Minimum Practice Income Guarantee (MPIG) correction factor payments for any practice (as at 31 March 2014) will be phased out incrementally over a seven-year period – and the released correction factor resources reinvested into weighted capitation (‘global sum’) payments – so that by the end of this seven-year period all practices will receive the same weighted price per patient.

18. It will be for the NHS CB to consider with the GPC and other stakeholders how to handle the very small number of significant outlier practices for which different contracting arrangements may need to be considered to ensure appropriate services for their local population.

19. For 2013/14, all practices will receive the same 1.32% contract uplift. All of this uplift will be channelled into increases into Global Sum Equivalent payments.

20. For its part, the NHS CB has committed to commence discussions with PMS practices from April 2013 with a view to identifying and agreeing the basis for implementing similar actions to achieve equitable core funding between GMS and PMS contractors on the basis of standard weighted capitation funding.

21. Finally, the negotiating parties agreed in 2011 to continue their work to review the current ‘Carr-Hill’ funding formula to identify how it might be improved so as to take better account of patient and population needs factors such as deprivation factors. Recommendations on changes to the formula should be in place to inform decisions for 2014/15.
Locum superannuation

22. Following recent consultation on changes to the Pensions Regulations, GP locums will, from April 2013, be responsible for paying their own employer superannuation payments.

23. As a result of this decision, the funding that PCTs currently incur in meeting GMS locum employer superannuation costs will be transferred to GMS practices so that, assuming locums increase their fees to cover these employer superannuation costs, GP practices can meet those costs as the ‘employer’ of the locum. This is in line with every other employer’s responsibility.

24. In its consultation response the GPC, whilst opposing the changes to the Pensions Regulations, suggested that – assuming the changes went ahead – this funding should be distributed to practices through increasing Global Sum Equivalent payments, and the Department has adopted this suggested approach.

25. The combination of the contract uplift, of 1.32%, and the locum employer superannuation funding both being added to GMS Global Sum Equivalent payments will provide all GMS practices with an increase of 1.47%.

QUALITY AND OUTCOMES FRAMEWORK

26. The Department proposed a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. In summary these were as follows:

- implementing all the NICE recommendations for changes to QOF;
- raising thresholds for existing indicators in line with the 75th centile of achievement to ensure more patients receive evidence-based care that will save more lives (phased over two years);
- setting up a Public Health Domain in the QOF, as originally proposed in the 2010 Public Health White Paper;
- retaining for a further year the Quality and Productivity (QP) indicators that reward practices for work to reduce unnecessary emergency admissions, referrals and A&E attendances by improving care for patients;
- removing the remaining organisational indicators that represent basic standards that all practices will be expected to meet as part of CQC registration. The money released would be used partly to fund the NICE recommendations and partly to invest in new enhanced services offered to all GP practices;
- removing the current overlap of QOF years by reducing the time period for most indicators from 15 months to 12 months;
- reforming the list size weighting (Contractor Population Index) so that the price of a QOF point is transparent and to remove the year-on-year inflationary effect of the weighting from 2014/15 onwards.

**New indicators**

**Proposals**

27. The Department proposed to implement in full in 2013/14 all the NICE recommendations for improvements to QOF, including those made in 2011 that were not implemented in the 2012/13 QOF. The new and improved indicators would be partly funded by accepting NICE recommendations for retiring indicators from the Clinical Domain that no longer need to be incentivised (because they are being replaced or are already embedded in clinical practice) and partly by retirements of indicators from the Organisational Domain.

**Summary of responses**

28. The GPC expressed concern that the new indicators could significantly skew workload towards patients with specified conditions at the expense of other patient care or services. They said that the indicators would lead to more ‘box ticking’ at the expense of holistic care of patients. In addition GPC argued that three of the indicators were unworkable due to secondary services not being available universally (diabetes structured education, and rehabilitation services for patients with heart failure or chronic obstructive pulmonary disease). They also requested changes to some of the indicators. Annex A sets out the Department’s detailed responses to GPC’s comments on NICE’s recommendations. The FDA expressed similar concerns.

29. The RCN expressed support for the implementation of NICE recommendations, as did the NHS CB. The NHS CB, however, suggested deferring implementation of indicators where referral service availability is currently low.

**Government response**

30. Improving patient care is our priority. Our changes aim to help GPs and GP practices manage their workload at the same time as making improvements to care for patients. Our proposals are designed overall to reduce the amount of administrative box ticking by removing basic organisational indicators and focusing incentives on direct patient care.

31. NICE developed the proposed indicators and piloted them with practices for six months. There is good evidence that these indicators will improve health and outcomes for patients\(^1\). As part of their consideration NICE took into account the expected impact on primary care workload. We

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\(^1\) Details of piloting, evidence base, costing and cost effectiveness analyses are on NICE’s website at [http://www.nice.org.uk/aboutnice/qof/indicators.jsp](http://www.nice.org.uk/aboutnice/qof/indicators.jsp)
have considered GPC’s arguments carefully but we do not accept that the new indicators will have a profound impact on primary care workload or should distort patient services (see detailed analysis at Annex A).

32. In most cases, the indicators build on annual reviews for patients with long-term conditions for whose care practices are already rewarded through existing QOF indicators. These existing areas of care are predominantly provided by practice nurses. For example, advice on physical activity for patients with hypertension is already part of care that is rewarded through QOF – the new physical activity indicators allow practices to target this activity better.

33. Nevertheless, we are proposing to make some changes to the NICE recommendations in order to meet concerns expressed by the GPC and FDA.

34. We propose to respond to concerns about lack of availability of referral services for diabetes structured education, pulmonary rehabilitation and cardiac rehabilitation. In the case of diabetes, services were already available to 60% of practices in 2011 (during the NICE pilot) and practices can provide structured education in house provided they meet the required standards. We propose, therefore, to continue to implement this indicator in 2013/14 in order to incentivise practices to make this service available to as many patients as possible. However, because it may not be possible at least in the short term to identify a suitable service that all patients could attend, we will request new exception codes to identify where a secondary service is not available. We would expect practices to explore fully with their clinical commissioning group whether or not a suitable service could be commissioned for a patient either locally or within a reasonable distance prior to deciding to except them on the basis that the services was unavailable.

35. In the case of pulmonary and cardiac rehabilitation, we recognise that availability of services is currently low nationally (available to around 10% of practices in 2012). We therefore propose to defer introduction of the indicators until 2014/15 to give practices time to work with CCGs to ensure these NICE recommended services are available to patients by that time, either in their locality or within reasonable distance.

36. For the indicators where concern has been expressed about primary care workload we are proposing a combined response to help manage the initial impact:
   - phasing in thresholds for the two new indicators to reward advice on increasing physical activity for patients with hypertension over two years;
   - increasing points for those indicators and also for the new intermediate outcome indicator for blood pressure control for patients aged 79 or under with hypertension, using the points released from pulmonary and cardiac rehabilitation.
The details of these changes are set out in **Annex A**.

37. We are also proposing modifications and clarifications to certain indicators, having taken further advice from NICE. Details are also set out at **Annex A**.

**Public Health Domain**

**Proposals**

38. The 2010 Public Health White Paper, and the subsequent consultation on commissioning public health services, proposed that at least 15% of the value of the current QOF would be devoted to evidence based public health and primary prevention indicators from 2013.

39. The Department proposed to move the current indicator areas that are mainly related to public health functions into a new Public Health Domain, following the rationale and selection of indicators already agreed with the GPC. This will result in just over 15% of current QOF points moving into the proposed Public Health Domain (157 points worth £188m) as a resource neutral change.

40. The Public Health Domain would continue to operate as an integral part of the QOF within the GP contract. All of the QOF payment rules in operation at this time would operate equally and as appropriate for the Public Health Domain. The priorities for the Public Health Domain would, from April 2013 onwards, be decided by Public Health England (PHE) (in consultation with the Devolved Governments). The amount invested in 2013/14 in the Public Health Domain (not the percentage of QOF) would remain the same (£188m), unless there was new investment. Any shift in investment between the Public Health Domain and the rest of the QOF would need to be agreed by PHE and the NHS CB.

**Summary of responses**

41. These proposals were supported by all stakeholders who responded. GPC said they would expect the negotiations for this Domain to remain within the current QOF sub group, as currently set up between the GPC, NHS Employers and NICE, with the inclusion of PHE as from April 2013. The FDA requested reassurance that the resource allocated to the Public Health Domain of the QOF would be available to general practice and not diverted to other providers.

**Government response**

42. We welcome the positive response to these proposals.

43. We need to clarify a possible misunderstanding about the process. NICE are independent of Government and the negotiating parties. They make
recommendations that are then considered by the negotiating parties who meet in the QOF sub group. We expect that this process and the current membership of the QOF sub group to continue as now. NHS CB will be responsible for the QOF in England from April 2013 and will arrange for NHS Employers to negotiate on its behalf with the GPC. PHE will set priorities for the QOF Public Health domain with NICE continuing to manage the process of developing and recommending indicators.

44. The Public Health Domain remains part of QOF and the GP contract and as such only available to primary medical care providers delivering care and services to a population registered with that practice.

**Quality and Productivity Indicators**

**Proposals**

45. The Department proposed to retain for a further year the current Quality and Productivity indicators. These indicators, worth around 100 points (or £120m), incentivise practices to work with commissioners to improve management and integration of care for patients across the primary/secondary care interface.

46. We proposed to streamline these indicators so that the administrative requirements on practices and the NHS CB were reduced and to make clear that these indicators would be limited to one further year in 2013/14. The NHS CB would need to review whether there was a continued need for these indicators in 2014/15.

**Summary of responses**

47. GPC broadly agreed with retaining the QP indicators for a further year, but expressed disappointment that the risk profiling indicators discussed in plenary negotiations did not replace the emergency admissions indicators in QP.

**Government response**

48. We welcome GPC’s broad agreement to these proposals. The emergency admissions indicators in the QOF reward practices for carrying out internal and external reviews of data on emergency admissions and participation in the development and implementation of commissioning or service design improvements aimed at reducing avoidable emergency admissions. The proposals for risk profiling are aimed at identifying individual patients at risk of emergency admission and co-ordinating their care in the community more effectively. Although both initiatives are aimed at reducing unplanned hospital admissions by improving quality of primary care, they approach the problem in different and complementary ways.
Organisational Domain and Patient Experience Domain

Proposals

49. The Department proposed that three indicators in the Organisational Domain would move to the Public Health Domain. The Quality and Productivity indicators would be retained for a further year in a Quality and Productivity Domain. We also proposed retaining the current Patient Experience Domain.

50. We proposed to remove the remaining organisational indicators, which represent basic organisational standards that from April 2013 all GP practices will be expected to meet as part of CQC registration. The money released would be used partly to fund the NICE recommendations being implemented and partly to invest in a new Directed Enhanced Service available to GP practices.

Summary of responses

51. The GPC expressed significant concern at the removal of funding from QOF. They argued that practices would not be able to sustain the additional workload involved in taking part in the new enhanced services, leading to reduction in routine access and other services. They maintained that QOF is not simply an incentive scheme and includes GP basic pay. In addition, they argued that some of the organisational indicators would not be covered by CQC registration. They urged consideration of the option of retaining more of the QOF Organisational Domain with remaining resources transferring into Global Sum but unweighted by patient need.

52. The FDA also argued that recycling would increase pressure on practices. The NAPC felt that CQC registration only covers basic standards and argued that high quality management should be recognised. The NHS CB and the RCN supported the proposals, though RCN expressed concern as to whether CQC would identify poor practice in terms of nurses’ education and training.

Government response

53. The QOF is a voluntary incentive scheme that rewards GP practices for improving quality of care for patients. The organisational indicators that we propose to remove have remained unchanged since 2004/05. We are not aware of any evidence of improvement in patient health as a result of practices confirming each year that they continue to achieve these indicators. Under our proposals, practices will no longer have to tick boxes to show they are meeting these requirements. Instead, practices that are well managed will be rewarded more directly for improving quality of care and outcomes for patients.
54. Improving patient care is our priority. Our changes aim to help GPs manage their workload at the same time as making improvements to care for patients. The proposed enhanced services will reward practices for adopting new approaches, for instance to enable them to provide remote care monitoring and on-line bookings and repeat prescriptions. Not only will this improve services for patients, but it will also help practices to focus face-to-face contact where it is most needed. The £120m proposed for recycling into enhanced services is under 2% of total payments to practices.

55. We mapped the organisational indicators against CQC essential standards in consultation with CQC. All of the organisational indicators that are proposed for removal are covered by CQC essential standards even where the detail of the evidence required is not exactly the same. CQC will look for evidence of implementation in practice and not simply the existence of manuals or protocols. As regards the indicators that GPC considered not to relate directly to CQC standards:

- Education 6 (review of complaints) – CQC will expect this to be done regularly to ensure learning;
- Management 1 (access to child protection information) – specific non-compliance with CQC standards if not met;
- Management 9 (protocol for identification of carers) – CQC will want the provider to demonstrate that they identify and refer carers, not just that they have a protocol;
- Management 10 (written procedure manual on staff employment policies) – CQC will be looking for evidence that procedures are implemented and effective, not just on the shelf;
- Education 5 (staff attended training for basic life support skills) – for CQC the provider must demonstrate competence to respond in emergencies.

56. As regards the RCN’s concerns about nurses’ training, CQC will expect providers to demonstrate that they implement appropriate appraisal that supports development and reflects professional standards where relevant.

Raising thresholds

Proposals

57. The Department proposed that thresholds for continuing fraction indicators should be based on the latest data on the achievement of the 75th centile. This would represent the top of the inter-quartile range of achievement, a level that should be practically achievable for all practices. The Department explained that the purpose was to support continuous quality improvement year on year up to the level that is practically achievable and enable more patients to benefit, therefore improving health and saving more lives.
58. In order to make sure that the increase in workload for practices would be manageable, we proposed that this change should be phased over two years in 2013/14 and 2014/15. In 2013/14, thresholds would be raised for the 20 indicators with best evidence that they save lives. In 2014/15 thresholds for all continuing fraction indicators would be raised. From 2015/16 onwards thresholds would continue to rise as achievement rises to support continuous quality improvement for patients until performance reaches the maximum practically achievable.

59. The details of the methodology proposed for setting upper and lower thresholds were set out in the consultation letter. Annex B lists the 20 indicators affected in 2013/14, with the existing and proposed new thresholds and shows the latest data on average achievement by practices in England.

Summary of responses

60. The GPC objected to raising thresholds on the basis that it would disadvantage practices financially, could put patient care at risk and would reduce patient choice. They challenged the evidence for saying that contractors stop treating patients once they have reached a particular threshold, and said that practices would need to aim higher than a 90% threshold to meet it. GPC instead proposed increases of five percentage points in thresholds for nine QOF indicators. GPC also called for a recognition that, if thresholds were increased, exception reporting would increase.

61. The FDA advised that practices might not seek to reach new thresholds if they considered that workload would be disproportionate and suggested that there would be increased exception reporting. They requested a delay to implementation to April 2014. The NAPC also pointed to the danger of a disincentive if the effort required is too great and asked for incremental improvement to be rewarded.

62. The RCN expressed concern about the effect on nurses’ workload and suggested a case-by-case approach for each indicator. They wanted lower thresholds to be kept closer to the current level and suggested introducing a QOF indicator for difficult to reach patients.

63. The NHS CB supported the Government’s proposals.

Government response

64. There is strong evidence that improvements in care incentivised by the QOF started to plateau from 2006/07, when the average practice reached the upper thresholds for achievement. Raising upper

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thresholds regularly to reflect what is already being achieved by 25% of practices will benefit more patients and can help to save lives. The GPC’s proposed upper thresholds for nine indicators would leave those thresholds well below average practice achievement in 2011/12, thus not incentivising improvement. In fact, 60% of practices or more achieved at or above GPC’s proposed thresholds in 2011/12.

65. The effect on patients of not raising thresholds was addressed in the National Audit Office’s 2012 report on adult diabetes services³. The risk of developing diabetic complications can be reduced if patients achieve recommended treatment standards to control blood glucose, blood pressure and cholesterol levels. However, fewer than one in five people with diabetes are achieving recommended standards for controlling all three of these levels. The Department estimates that up to 24,000 people die each year from avoidable causes related to their diabetes. The NAO report noted that “Although there were annual increases in the percentage of patients achieving the recommended intermediate health outcomes under the Quality and Outcomes Framework from 2004-05 to 2006-07, achievement has since plateaued. For example, between 2006-07 and 2009-10, achievement of one blood pressure standard increased by 1.9 per cent, which suggests that the initial effect of the incentive has reduced.”

66. To help GP practices manage their workload, we are proposing the threshold increase would be introduced over two years. It is not the intention of our proposals to reduce payments to practices. The aim is to increase the proportion of patients who benefit from QOF interventions and therefore to make qualitative efficiency gains.

67. It is hard to understand how raising thresholds could put patient care at risk and threaten patient choice. It should lead to more patients being offered and receiving the care they need, which could be life-saving. The QOF exception rules mean that practices can except patients from an indicator for a number of defined reasons, including if they refuse a treatment or if it is not clinically appropriate, and GP practices will not be penalised.

68. We would not, however, expect overall rate of exception reporting to increase significantly (i.e. the percentage of patients excepted from indicators) as a result of performance increasing. Exception reporting should be based on specific criteria that apply to individual patients. Our analysis of 2011/12 data shows that overall the exception reporting rate does not increase as performance increases. Research in 2008 showed that GP practices in deprived areas achieved high scores without high rates of exception reporting, and the differences in scores between

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affluent and deprived areas are small and of relatively little clinical significance. Analysis of the 2011/12 data shows that the average exception reporting rate was only 0.31 of a percentage point higher for practices in the most deprived areas as compared to those in the least deprived.

69. **Annex B** shows the 2011/12 average achievement for the 20 indicators affected in 2013/14. The difference between 2011/12 average achievement and the proposed 2013/14 upper threshold is on average just over four percentage points. As in 2004, when the QOF was first introduced, we believe practices can and will rise to the challenge of meeting the new reward thresholds and that this will lead to further benefits to patients in terms of improved health outcomes.

70. The RCN was concerned about the risks of a blanket approach and together with NAPC wanted to maintain incentives for lower performing practices. The methodology proposed is to set thresholds for each indicator in relation to the performance of the 75th centile against that particular indicator. This means moving away from a blanket approach where most upper thresholds are set at 90%. Setting lower thresholds forty percentage points below the new upper threshold in each case ensures that there continue to be incremental incentives for the range of practices achieving below the 75th centile.

**Removing the overlap between QOF years**

**Proposals**

71. The Department proposed to remove overlapping time-periods from most indicators measuring processes or intermediate targets, by reducing the time-periods from 15 to 12 months or from 27 months to 24 months. Cross-year time periods will be maintained for indicators that require action following new diagnosis to ensure patients diagnosed in the last quarter and excepted from the indicator due to the new diagnosis/new registration exception rule are picked up in the following financial year. We also proposed to remove year-end overlaps for exception reporting for all indicators through changes to the business rules.

**Summary of responses**

72. GPC, FDA and NAPC all objected to this proposal on the basis that it would lead to loss of flexibility for GPs and would require recall in less than 12 months resulting in greater interference in patients' lives.

73. The RCN supported the removal of the overlap of QOF on the basis that “this has the potential to be abused by practices to artificially increase

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their funding”. However, they were concerned about the impact that removing this could have on struggling practices and suggested a phased approach.

**Government response**

74. We need to tackle this anomaly as there is evidence of some patients going for up to 27 months without reviews that are supposed to be annual – and practices getting paid as though they were carrying out annual reviews because of the way QOF works. An analysis of sample patient records\(^5\) shows, for example, that for asthma, 12% of patients did not receive a second review until 18-27 months after their first one. For diabetes HbA1c reviews, 7.5% of patients had reviews between 16 and 27 months apart. Under the way QOF currently works, practices would not be alerted by the clinical systems to this problem unless they carried out a bespoke audit based on patient specific data.

75. We recognise that this change may lead to a small shift in workload to enable practices to ensure that patients who were last reviewed at the end of the previous financial year receive their next review before the end of the current financial year. However, provided that practices have been inviting patients annually for their reviews, it should not lead to an overall increase in workload taking one year with another.

76. There is no method of preventing annual payments to practices for patients who have had reviews more than two years apart unless we remove the year-end overlap altogether. Phasing is not, therefore, a valid option in this case.

**Reform the list size weighting**

**Proposals**

77. The current actual value of a QOF point is now around 17% higher than the stated face value of each point because the list size weighting no longer reflects average practice list size but rather reflects the position in 2002. The Department therefore proposes to increase the face value price of a QOF point from £133.76 in 2012/13 to £156.92 in 2013/14 to recognise the actual price that is paid to the average practice. At the same time we propose to reform the Contractor Population Index (CPI) weighting so that from 2013/14 onwards it is based on the actual average practice list size at the start of the last quarter before the financial year in question so that the price of QOF continues to be transparent. This would be a cost neutral change in 2013/14 (i.e. practices would in reality receive the same cash per point in 2013/14 as they did in 2012/13).

\(^5\) An analysis was carried out for the Department by the Health and Social Care Information Centre using the IMS Disease Analyser research database of GP patient records from 01/04/2009 to 31/03/2010 and 01/04/2010 to 31/03/2011.
78. In 2014/15, the CPI weighting would be based on the actual average practice list size at 1 January 2014. The price per point would be dependent on the settlement of the GP contract for 2014/15.

Summary of responses

79. GPC have requested assurance that the overall population increases are reflected in the value of QOF points in future years.

Government response

80. As proposed in the consultation letter, the price per point in 2014/15 and subsequent years would be dependent on the settlement of the GP contract. It would be for the negotiating parties to discuss whether the price per point should increase in future to reflect any population increase (or vice versa), taking into account the overall context of the pay round.

NEW DIRECTED ENHANCED SERVICE

81. The Department of Health proposed to remove the remaining organisational indicators from the Quality and Outcomes Framework. The money released would be used partly to invest in a new Directed Enhanced Service (DES).

82. The Department proposed to direct the NHS CB through a new DES to put in place four new enhanced services to be offered to all practices to promote quality and innovation in the care and services they deliver for their patients in the following areas:
   - improving diagnosis of at-risk patients for dementia;
   - care for frail older people or seriously ill patients (including mental ill health);
   - enabling patients to have on-line access to practice services such as booking appointments, ordering and accessing repeat medicines, accessing test results and in future accessing their medical records;
   - supporting people with long-term conditions to monitor their health remotely.

83. The NHS CB would develop the detailed specification for this new enhanced service.

Summary of responses

84. A number of detailed comments were received from stakeholders on the draft service specifications attached to the consultation letter.
**Dementia**

85. The GPC criticised this service specification on the basis that there is no new funding, as resources for this will come from removed QOF organisational indicators, that there are major workload implications and that screening is not supported by evidence. The GPC proposed alternative arrangements to focus on care arrangements for people already diagnosed with dementia. The FDA agreed with these points and in addition said that a diagnosis of dementia has a stigma attached to it, while secondary treatments are lacking or hard to access. The NAPC was generally approving; the RCN was broadly supportive, but concerned about insufficient resources and would like staff training to be included. The NHS CB was supportive, but indicated that it would wish the specification for 2013/14 to be based on clinical risk groups.

**Risk Profiling**

86. The GPC criticised this outline service specification on the basis that there is no new funding, as resources for this will come from removed QOF organisational indicators, that there are major workload implications and that this work should replace QP indicators in QOF. The FDA criticised it on the basis that it recycled money from QOF and therefore required practices to work twice as hard. However, FDA was in other ways supportive in that if practices used it properly, it would be an extremely exciting and innovative approach. The NAPC generally approved, feeling it would be beneficial if introduced appropriately. NAPC did have some concern about resources: cost, requirement for skilled assessment of data, CCGs follow up of social care issues. The RCN was broadly supportive, but concerned about insufficient resources. RCN also considered that staff training should be included and it will need more integration and better communication between those involved in the care pathway. The NHS CB was supportive, and wanted CCGs to have a key role in designing schemes to reflect local priorities.

**On-line access**

87. The GPC criticised this outline service specification on the basis that there is no new funding, as resources for this will come from removed QOF organisational indicators, and that practices are ill-equipped for this. It supported the underlying aims of the specification but expressed concerns about workload, the potential for misuse, and breaches of confidentiality. The FDA criticised it on the basis that it recycled money from QOF and therefore required practices to work twice as hard and that it would increase pressure on over-stretched services. The FDA did consider that practices’ experience of practices of online services so far is positive, although it expressed concern over the issue of test results. The FDA would encourage incentivising IT improvements with protections for practices without adequate systems due to lack of investment by PCTs. The NAPC considered there was poor evidence of
the benefit of improving on-line access. The RCN was broadly supportive, but concerned about insufficient resources. RCN also considered that staff training should be included. The NHS CB was supportive. It indicated that it would wish to take a two-phase approach, with online booking of appointments and repeat prescriptions in the first phase.

Remote care monitoring

88. GPC criticised this element of the proposed DES on the grounds that there was no new funding, as resources come from removed QOF organisational indicators, that there would be workload implications in setting up systems and uncertainty about the cost, quality and safety of telehealth interventions. The FDA objected to recycling money from QOF and therefore requiring practices to work twice as hard. It considered it would increase pressure on over-stretched services and cause loss of morale. However, it commended the initiative, as IT, timing and patient acceptance allowed. The NAPC generally approved.

89. The RCN was broadly supportive but expressed concern at insufficient resources and would like to see staff training included. The RCN considered that this was not suitable for all patients and that the first condition monitored should be COPD, not hypothyroidism. The NHS CB was supportive, but would want to support a range of long-term conditions, not just hypothyroidism.

Government response

90. As we proposed in the consultation letter, the Department will now proceed to direct that the NHS CB establish, develop and maintain the four new enhanced services from 1 April 2013 under a new Directed Enhanced Service to promote innovation and quality.

91. It is the responsibility of the NHS CB to develop the detailed specifications and the Department of Health has passed these responses to the NHS CB to inform its plans.

92. The Department has carefully considered the responses to the consultation and remains committed to the underlying aims and intentions of the schemes.

Dementia

93. The Department remains committed to directing the NHS CB to put in place arrangements to enable a proactive approach to the assessment and diagnosis of patients with dementia. The anticipated arrangements for case finding for a symptomatic condition such as dementia in at risk patients is very different from screening for symptom-less conditions (such as breast cancer or bowel cancer, for example). The Department does not therefore regard the proposals as constituting screening.
94. The Department does recognise that improving diagnosis and support for people with dementia and issues of stigma require a system wide improvement. That is why improving diagnosis of dementia is a priority for the NHS as a whole which we have set out in the Government’s mandate to the NHS CB and which the Board has subsequently confirmed as a priority in its planning guidance for the NHS. The direction on the NHS CB will ensure general practice has a key role to play in supporting these improvements including making significant improvements to the current dementia diagnosis rate of just 45%.

95. The Department welcomed the engagement of GPC in suggesting alternative proposals for a dementia enhanced service. The Department did not, however, consider these proposals would support improvements in diagnosis. GPC’s proposals set out what GP practices are largely already doing to support patients diagnosed with dementia, including in some cases duplicating what they are paid for through QOF (e.g. to keep an accurate dementia register). Some interesting aspects such as health checks for carers were noted but are for the NHS CB to consider.

**Risk profiling**

96. The Department intends to direct the NHS CB to put in place arrangements to encourage GP practices to manage and coordinate care of patients predicted to be at risk of emergency hospital admission.

97. Consultation responses, while mixed, acknowledged this is something which if done effectively can support the effective management of people who are seriously ill or at risk of becoming seriously ill. The direction will give the NHS CB the flexibility to design (through CCGs if it wishes) schemes that reflect existing good practice in this area.

98. As indicated earlier we do not support GPC’s proposals that risk profiling approach should replace specific sections of the QOF QP domain. The risk profiling approach is aimed at identifying individual patients and coordinating their care in the community more effectively while the relevant part of the QOF QP domain is about service design improvements. They are complementary ways of approaching the objective of reducing unnecessary emergency admissions to hospital by improving quality of primary care.

**On-line access**

99. The Department intends to direct the NHS CB to put in place arrangements to encourage GP practices to improve patient online access.

100. The Government’s mandate to the NHS CB includes the aim of achieving a significant increase in the use of technology to help people manage their health and care. The enhanced service requirements will
support the NHS CB in this regard. The Department agrees with the NHS CB’s suggested approach to phased implementation. We recognise this may address some of the concerns expressed and does not require changes to the legal directions to the Board.

101. The Department welcomed the engagement of GPC in suggesting alternative proposals for an IM&T enhanced service, which included bringing together plans for online patient access and remote care monitoring into a single scheme. However, the Department did not consider these proposals on their own would sufficiently improve patient online access. The scope of the GPC’s proposals was more about enabling functionality rather than promoting actual use (i.e. making available to anyone who requests).

Remote care monitoring

102. The Department remains committed to directing the NHS CB to put in place arrangements to encourage GP practices to establish systems to enable patients with long term conditions to manage and monitor their condition other than by necessarily attending the practice.

103. The Government’s mandate to the NHS CB includes the aim of achieving a significant increase in the use of technology to help people manage their health and care. The Department’s expectations have been modified in view of the consultation responses to reflect that preparatory work may need to take precedence in 2013/14 and that the focus may be on supporting a range of long term conditions rather than any single long term condition. However, this does not require changes to the legal directions to the Board.

104. As noted above, the GPC suggested bringing together plans for online patient access and remote care monitoring into a single scheme. It is for the NHS CB to decide on how it implements and specifies its plans under the legal directions. However, the Department does not consider it necessary to revise the legal directions as the aims for patient online access and remote care monitoring are sufficiently distinct from one another.

VACCINATIONS AND IMMUNISATIONS

Proposals

105. The consultation proposed to introduce a new item of service fee of £7.63 for a completed course of rotavirus vaccine for infants from the start of this new programme from September 2013 (now July 2013). In addition, it proposed to introduce a new item of service fee of £7.63 to make payments for routine shingles immunisation for patients aged 70. The NHS CB will be responsible for introducing any confirmed shingles catch up programme for patients aged 71 to 79.
Summary of Responses

106. The NHS CB supported the proposal for a new vaccination and immunisation programme for rotavirus and shingles. The NHS CB also noted that the SFE does not make provision for a shingles catch up programme and that they would need to secure arrangements for this, for example through an enhanced service. GPC expressed the view that the proposed fees were too low and should be revised to take account of increased expenses, for example postage, and indicated that some practices would struggle to deliver these services for the proposed item of service fee.

Government Response

107. It is not a requirement that GP practices should write out to their patients to offer these new immunisation services. They will predominantly be able to give the immunisations to patients presenting for existing immunisations under the national programmes (e.g. rotavirus vaccine can be given to children attending for routine childhood immunisations at age 2 and 3 months, shingles vaccine to patients attending for ‘flu immunisation or opportunistically). These proposals will therefore be implemented as outlined in the consultation document.
ANNEX A

RESPONSES TO GPC’S DETAILED COMMENTS ON NICE RECOMMENDATIONS FOR QOF

Availability of referral services

1. GPC argued that DM014, COPD006 and HF003 are unworkable because referral services are not widely available.

2. We will request new exception codes for secondary service not available to apply to DM014 (diabetes structured education) in 2013/14 and to COPD006 (pulmonary rehabilitation) and HF003 (cardiac rehabilitation) when they are introduced in 2014/15.

3. We propose to postpone implementation of COPD006 and HF003 until 2014/15. In the meantime we will reallocate the points released (a total of 10) to new indicators for patients with hypertension where primary care workload is a particular concern to stakeholders (HYP003 – new blood pressure intermediate outcome for patients aged 79 or under – and HYP004&005 – questionnaire and advice on physical activity).

Workload in primary care

4. GPC object to HYP003, HYP004, HYP005 and BP001 on the basis that the workload implications are so profound they could skew care. Also GPC consider the tighter blood pressure target in HYP003 would risk increasing the number of patients suffering adverse effects from polypharmacy, including potentially dangerous hypotension. Our detailed analysis of these arguments is below.

HYP003 (% patients aged 79 or under with hypertension whose last BP reading is ≤140/90 mmHg)

5. We are accepting NICE’s recommendation to retain the old BP5 (HYP002) as well as new HYP003 so that practices are still rewarded for achieving BP of 150/90 mmHg or less for all their patients, including those aged 79 or under for whom they do not achieve HYP003.

6. NICE’s cost effectiveness statement finds that HYP003 is highly cost effective. NICE estimated that nationally 324,024 patients who are not being treated to the required level would need improved treatment each year. The main costs are due to additional drugs. The total additional cost would be £20m a year nationally, of which £9m would be due to one additional monitoring consultation with the GP per patient, per year. The £20m additional cost is completely off-set by the cost of cardiac arrests avoided.

7. As regards risk of over-treatment, NICE’s target for most patients with hypertension is 140/85mm/Hg. Practices should treat all individual
patients according to NICE guidelines and their clinical judgement. NICE’s advice on age range and thresholds takes account of the need to set an audit standard in QOF that does not assume that each patient can safely achieve the recommended target. On top of these safeguards, practices are in addition able to exception report patients on the basis of contra-indication, medicine not tolerated, maximum tolerated dose or treatment clinically inappropriate, for example due to extreme frailty.

HYP004 & HYP005 (annual physical activity questionnaire and brief advice for patients with hypertension).

8. NICE guidelines found that brief interventions in primary care are cost-effective. The NICE cost-impact statement for HYP003&004 states:
   - GPPAQ takes approximately 30 seconds to fill in and can be completed by patients waiting for appointments.
   - It then takes a maximum of 1–2 minutes to transfer the responses to the electronic template and analyse the result. The template will automatically assign a Physical Activity Index.
   - The delivery of lifestyle advice on increasing physical activity already forms part of care for all patients with hypertension rewarded through current QOF indicator PP2. This will be replaced by HYP004.
   - There are 7.3m people with hypertension. 50% would be expected to be identified as ‘less than active’ and will require a brief intervention by a GP or practice nurse at the end of a consultation.
   - Pilot data suggest the delivery of brief intervention by GPs or practice nurses involved a 1–2 minute discussion at the end of a consultation.
   - The estimated annual cost on basis of 50/50 interventions carried out by a GP/practice nurse is £4.8m in England.

BP001
9. NICE’s recommendation would bring the lower age range of patients who have a record of blood pressure in the last five years down from 45 to 40 to bring it into line with the age range for NHS Health Checks. The NICE cost statement says that “an amendment to the age limit … is not expected to be associated with any significant costs. It is anticipated that GP practices will opportunistically check blood pressure in all adults presenting at the practice as part of standard care.”

Conclusion
10. In summary we do not accept the premise that the introduction of these new indicators will lead to a profound impact on practice workload or distortion of patient care. Nevertheless, in view of the concerns expressed we are proposing a combined response to help manage the initial impact:
11. In 2013/14, for HYP003, the number of points will be 50 instead of 45, for HYP004 the number of points will be 5 instead of 3 and for HP005 the number of points will be 6 instead of 3. The upper thresholds for both HYP004 and HYP005 will be 80 in 2013/14 and will rise to 90 in 2014/15.

Modifications to indicators

12. GPC have asked for various modifications to indicators or guidance. Our detailed analysis and response is set out below.

DM015 (asking annually about erectile dysfunction in male patients with diabetes).

13. GPC have questioned whether men should be asked about erectile dysfunction (ED) annually, when all treatment options have been discounted. We propose to ask NICE to review the construction of the indicator for 14/15 and 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. There is no need to amend the indicator in 2013/14. The QOF guidance on how to initiate these sensitive discussions will be based on advice from NICE.

CAN002 (patients diagnosed with cancer have a review within 3 months of diagnosis)

14. As requested by GPC, the QOF guidance will make clear that while it is preferable that a review should be face-to-face in most cases, making contact with a patient over the telephone will meet the requirements for this indicator. The guidance will also advise that where contact is made over the phone, an offer of a subsequent face-to-face review is advised.

CVD-PP001 (treat with statins patients newly diagnosed with hypertension with high CVD risk score).

15. GPC argue that the indicator should look only for a record that the practice has “offered” statins as opposed to a record that a patient is being prescribed statins. Although we understand that NICE was prepared to agree to this amendment, we consider it is important to retain the original NICE recommended indicator because it is the treatment that improves health and not the offer of treatment. Patients may be excepted from the indicator if they do not wish to have treatment.

16. Constructing the indicator in the way NICE originally recommended also supports good practice in record keeping by encouraging practices to record whether or not the intervention took place and that the patient exercised informed dissent if they did not wish to be treated. The use of
codes in QOF that do not record whether an intervention has actually been carried out caused part of the discrepancy between QOF data and National Diabetes Audit data for patients with diabetes receiving recommended checks which was highlighted by the National Audit Office\(^6\).

**DM013 (patients with diabetes given a dietary review annually by a suitably competent professional).**

17. GPC objected to the use of the wording recommended by NICE of “suitably competent professional” on the basis that this would require dietary advice to be given by GPs or diabetic nurses who have done extra training.

18. The NICE briefing paper on the indicator states that “People with diabetes have emphasised the value of access to dietary advice. Poor access to a dietitian or dietary advice was ranked fifth in a list of the top ten concerns received by Diabetes UK from people with diabetes between January and March 2009. A Diabetes UK survey of people with diabetes found 21% wanted better access to advice/appointments about their diet.”

19. Most practices who took part in the pilot said this indicator was "easy to meet and clinically meaningful". NICE assessed that costs were not expected to be significant. The QOF guidance based on NICE’s advice will make clear that “suitably competent” means a healthcare professional with specific expertise and competencies in nutrition. This may include, but is not limited to, a registered dietician who delivers nutritional advice on an individual basis or as part of a structured educational programme. It could also include a practice nurse who has reached level one in the Diabetes UK competency framework for dieticians. Level one is the minimum standard for any staff involved in the healthcare of people with diabetes.

**DEP001 and 002 (a bio-psychosocial review should be completed by the point of diagnosis of depression and patients diagnosed with depression should be reviewed within 10-35 days of the diagnosis).**

20. GPC have indicated that they support these indicators provided that the “point of diagnosis” is defined in guidance and that the date of diagnosis for the purposes of DEP002 is the date of the face-to-face consultation to address the depression, not the date of recording from an outside consultation.

21. The QOF guidance is being drafted with NICE’s advice to make clear that even though the bio-psychosocial assessment (BPA) may be carried out in stages over time, a diagnosis of depression should not be made until it is complete and should be recorded on the same day that the BPA is completed. There will be additional guidance on how diagnosis and follow up should be managed and recorded if the initial

diagnosis is made in secondary care, to ensure that patient care and confidentiality is safeguarded while avoiding practices being penalised due to circumstances outside their control.

RA001, 002, 003, 004 (set up a register of patients with rheumatoid arthritis, carry out an annual review of those patients, including a cardiovascular risk assessment and assessment of fracture risk for appropriate ages)

22. As requested by GPC, NICE have agreed to add in the QOF guidance plasma viscosity as an alternative test to erythrocyte sedimentation rate to determine accuracy of diagnosis.

23. GPC agree with the inclusion of RA003 subject to universal availability of the CVD risk assessment tool adjusted for RA and compatibility with IT systems. However they believe that annual assessment adds little to this indicator and suggest a review period of 3-5 years.

24. NICE anticipate that the QRISK2 tool will be used. QRISK2 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.

25. NICE have recommended annual risk assessment on the basis that this is highly cost-effective. The CVD risk assessment can be carried out at the same time as the annual review rewarded in RA002. The NICE cost assessment states “We have assumed that the CVD risk assessment will be carried out opportunistically as part of the annual RA annual review.” The annual cost range of the CVD risk assessment is £900,000-£1.7m.

Recommended retirements

CKD2 (record blood pressure of patients with chronic kidney disease), EPILEPSY 6 (record seizure frequency of patients on drug treatment for epilepsy) and BP4 (record blood pressure of patients with hypertension)

26. GPC object to these indicators being retired on the basis that the work will still need to be done but without resource to do it. In particular they argue that removing EPILEPSY6 (record of seizure frequency) may mean that practices stop doing epilepsy reviews for all but the most complex of their patients as EPILEPSY8 (seizure free for 12 months) is often clinically unachievable.

27. These retirements were recommended by NICE on the basis that the indicators were all well embedded in clinical practice and no longer needed to be incentivised. QOF is an incentive scheme that rewards GPs for continuously improving quality. The Government’s policy is to focus on measuring the outcomes achieved for patients and to free up healthcare professionals from detailed process measures wherever possible. The fact that an indicator has been retired from QOF does not
mean that GPs should no longer provide clinically necessary care and treatment for patients.
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