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| **From Eugene Rooney**  **Director of Primary Care & Commissioning** | DeptHSSPS-rgb_hr |

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| Dr Tom Black  Chairman  NIGeneral Practitioners Committee  British Medical Association  BMA House  16 Cromac Place  Cromac Wood  Ormeau Road  Belfast  BT7 2JB | Room D4.16  Castle Buildings  Stormont BELFAST BT4 3SQ  Tel: 028 90522123  Fax: 028 90523425  Email: eugene.rooney@dhsspsni.gov.uk  Your Ref:  Our Ref: DH1/13/  Date: 29 January 2013 |

Dear Dr Black

# General Medical Services – Contractual Changes 2013/2014

Further to my letter dated 24th October, which explained our commitment to pursue changes to the General Medical Service Contract for April 2013, should no satisfactory negotiated agreement be able to be reached, I am now writing to provide you with a draft of the proposed revised Statement of Financial Entitlement that would apply for 2013/14. This should provide sufficient time to consult with GPC Northern Ireland on the details of the changes to directions which are attached to this letter.

I should emphasise that the proposed changes are intended to maintain current levels of investment in General Practice. The majority of the proposed changes focus on specific changes to the Quality and Outcomes Framework (QOF). The proposed changes include the following:

* invite the Doctors and Dentists Review Body (DDRB), as GPC has proposed, to make a recommendation on uplift and, following consideration of their recommendation, reach a decision on GP pay and practice expenses of up to 1.5%;
* deliver equitable core funding between GP practices over a seven year period starting in April 2014 to reflect the proposals that GPC and NHS Employers have developed. The Department welcomes the progress that has been made in identifying a new approach to achieving equitable core funding for GP practices. The Department is content to accept the suggested approach of phasing the changes from 2014/15;
* incorporate the changes that GPC have indicated they would accept to the Quality and Outcomes Framework (QOF), and also introduce the majority of the new or replacement clinical indicators recommended by the National Institute of Health and Clinical Excellence (NICE); and raise QOF thresholds so that more patients benefit from care that enhances quality of life and reduces mortality; and
* discontinue QOF Organisational Domain indicators which the Department considers reflect basic standards of good organisational practice that should not need financial incentives, and use the resources released from these indicators to help pay for the additional QOF indicators recommended by NICE.

It is not proposed to make changes to the QOF review dates, however, this will be dependent on further discussions regarding the capacity for software suppliers to apply different business rules for NI within required timescales and reasonable costs. A full explanation of the details of the changes we propose is provided in Annex A.

It is important to emphasise the need for all sectors of Health and Social Care, including General Practice, to be fully committed to the Minister’s reforms to be taken forward through the delivery of Transforming Your Care (TYC). The Quality and Outcomes Framework (QOF) within the Contract is aimed at resourcing and rewarding quality care and it is through this work that all GPs can help contribute to delivering TYC, specifically through the achievement of the Quality and Productivity Indicators and the reduction of hospital attendances and admissions; and via the achievement of the Clinical Indicators and the management of long term conditions, ensuring that patients are cared for in the most appropriate setting. The involvement of General Practice is essential to the successful implementation of these reforms and the delivery of safe and effective Health and Social Care services.

In addition, and in support of TYC, there is the need to ensure that General Practice is fully engaged in the provision of appropriate Connected Health solutions. The benefits to the Health and Social Care Services of Connected Health solutions are potentially significant with the provision of better information on the patient enabling health care professionals to provide more effective and co-ordinated care, and for patients to manage better their own conditions. It provides scope for managing aspects of the increasing burden of chronic disease which could help reduce the pressures on health and social care services. General Practice should be adopting Connected Health solutions where appropriate to improve the quality of care to patients and reduce avoidable pressures on the health system.

In this context, we will work to link Connected Health directly to the provision of specific enhanced services aimed at improved chronic condition management. This will be progressed through the development of the Clinical Priorities for 2013/14.

The Department is hopeful that an acceptable agreement can be reached with GPC in relation to these proposed changes. In the absence of such an agreement, however, and subject to the outcome of the consultation process, the Department would propose to introduce the changes detailed in this letter. The Department will be guided by the principle of allowing contractual arrangements for GPs to evolve in ways that: reflect best, evidence-based practice; improve health outcomes; reduce inequalities; empower patients; and promote local clinical leadership and innovation.

The Department understands that the NHS Employers has consulted with the GPC on each of the changes proposed in line with the mandate given by the Department. We are satisfied that, in doing so, NHS Employers has listened to, responded to and fully considered alternative proposals put forward by the GPC. After careful consideration and having studied the records of past meetings and correspondence between NHSE and GPC negotiators on each of these issues, the Department considers that it is now reasonable, in the absence of an agreed settlement, for the Department to consult on the proposed changes set out in this letter and attachments.

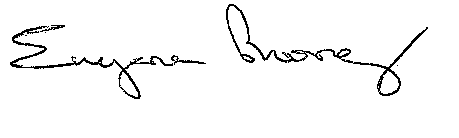
The changes that the Department proposes to introduce from 1 April 2013 would require changes to the Statement of Financial Entitlements, but not to the Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004. I attach at Annex B a draft Statement of Financial Entitlements which identifies the proposed changes for 2013/14. These amendments do not yet take account of any uprating of investment to GMS contractors for 2013/14 as these will now depend on the decisions that will be made following the request from the BMA that the Doctors and Dentists Review Body make recommendations on the gross uplift to apply. The uplift once approved would be applied to Global Sum payments made to GMS contractors, along with a minimum uprate to current Global Sum Equivalent payments to GMS practices.

The Department would be willing to have further discussions on the changes proposed in these documents. In the absence of an acceptable agreement being reached, and subject to considering the outcome of the consultation on the attached directions, it is proposed to introduce the changes described in this letter so as to support ongoing improvements in patient care and services.

We are willing to meet with you, together with the HSC Board, with whom we will also be consulting. It is important to note however that the consultation on these proposals will close on 22nd March 2013. The Department will then consider any representation made during the consultation period and will then make final decisions, to allow GP contractual changes to be made to come into effect from April 2013.

I am copying this letter to Frank Strang, Lisa Dunsford, Richard Armstrong and Stephen Golledge.

Yours sincerely



# EUGENE ROONEY

Director of Primary Care

**Annex A**

**Explanation of the proposed GMS Contract Changes**

**Application of GP Contract Uplift 2013/14**

1. In light of the GPC’s stated desire not to accept the assured 1.5% gross funding uplift offered as part of reaching an agreed negotiated settlement, the Department will consider any recommendation made by the Doctors and Dentists Review Body (DDRB) as part of this year’s independent pay review process. Any decision by the Minister on the level of contract uplift will be determined once the DDRB have made their recommendations (expected before the end of this consultation period). Decisions reached will be in-line with the continued commitment to treat independent GP contractors like other public-sector funded staff with the intent of delivering up to 1% pay increase for General Practitioners.
2. The Department is clear that any uplift should all be applied through increases to core practice funding. While no increases will be applied to QOF, the portion of contract uplift funding relating to these income streams will be used to deliver a minimum uplift to all practices through a % increase to each practice’s Global Sum Equivalent.
3. It is not possible to state the level of minimum increase all practices would receive as this partly depends on decisions following DDRB recommendations, expected by February 2013.

**Securing equitable funding in GMS contractual arrangements from 2014/15 and beyond**

1. The proposed 'contract variation' delivers on the commitment to implement GPC’s suggested approach of phasing the changes over a seven-year period, beginning in 2014/15, along with MPIG Correction Factor payments redistributed between contractors. To support that agreement, a provision has been introduced which states that the value of the annual MPIG correction factor payments made to any practice, as part of their entitlement as at 31/03/2014, 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.

**Changes to the Quality and Outcome Framework**

1. As set out in the letter of 24 October to GPC NI, it is proposed to make a number of changes to the Quality and Outcomes Framework in order to secure further health improvements for patients. In summary, these are as follows:

* Implement the majority of the NICE recommendations for changes to QOF, partly funded from NICE recommended retirements and partly from retirements from existing investment in the organisational domain of QOF;
* Raise upper thresholds for a number of existing indicators to reflect the existing achievement of practices and so benefit more patients in receiving care that will save more lives. However, in order to make sure that the workload for practices is manageable, it is proposed to phase the number of indicators that would see an increase to threshold levels over two years: in 2013/14 and 2014/15. From 2015/16 onwards thresholds would continue to rise gradually;
* Set up a Public Health Domain in the QOF, as originally proposed in the 2010 Public Health White Paper. This would include relevant indicators from the Clinical, Additional Services and Organisational Domains;
* Retain for a further year the Quality and Productivity (QP) indicators that reward practices for work to reduce any unnecessary emergency admissions, referrals or A&E attendances and improve care for patients. The wording for QP indicators 6, 7, 9 and 10 will be amended to include target dates in line with QP indicators 12 and 13; and
* Remove organisational indicators, except for some Medicines Management indicators, QP indicators and those moved into the Public Health Domain. The organisational indicators represent basic standards and there would be a requirement within the Contract to meet Clinical Governance standards agreed by the HSC Board. The funding released would be used partly to fund the NICE recommendations and the remainder would be transferred to the core of the Contract in recognition of the ongoing work in maintaining these standards.

**New Domains, indicators and areas**

1. It is proposed to implement in 2013/14 the majority of all the NICE recommendations for improvements to QOF, The recommendations include the following evidence based indicators:

* Tighter blood pressure control for people with hypertension leading to an increase in quality years of life for those patients;
* Prescribing of cholesterol lowering medicines in people diagnosed with hypertension who are at high risk of events such as heart attacks and strokes;
* Advice for people with hypertension to increase physical activity;
* Referral to rehabilitation for people with chronic obstructive pulmonary disease or heart failure ;
* For people newly diagnosed with depression assessment of their mental, physical and social needs and review within 10-35 days of diagnosis;
* Improved support for cancer patients;
* Improved care for patients with rheumatoid arthritis;
* Patients with diabetes referred for structured education and dietary advice to reduce complications and ill-health. Screening of male patients with diabetes for erectile dysfunction and provision of advice.

1. The new and replacement indicators would be partly funded by accepting NICE recommendations for retiring indicators from the Clinical Domain and partly by retirements of indicators from the Organisational Domain.
2. A document setting out the details of the proposed new and replacement indicators and the proposed thresholds and points is in attached **Appendix 1**.

**Public Health Domain**

1. 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. The proposals for setting up the Public Health Domain were discussed with GPC at a meeting with the health departments, NICE and NHS Employers on 6 June and then subsequently by the negotiating parties.
2. Following those discussions and the further negotiations, it is 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 £7.1m) as a resource neutral change. Details of the rationale and the areas and indicators proposed to move into the Public Health Domain are attached at **Appendix 2**.
3. 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 (for example, the prevalence weighting would apply to indicators from the Clinical Domain and the target population factor to indicators from the Additional Services Domain). The priorities for the Public Health Domain would, from April 2013 onwards, be decided by Public Health England (in consultation with the Devolved Governments). There would no longer be scope for shifting investment between the Public Health Domain and the rest of the QOF, without the explicit approval of PHE and the Health and Social Care Board.

**Quality and Productivity Indicators**

1. It is proposed to retain for a further year the current Quality and Productivity indicators that reward practices for work to identify unnecessary emergency admissions, outpatient referrals or A&E attendances and improve care for patients. These indicators, worth around 100 points, incentivise practices to work with commissioners to improve management and integration of care for patients across the primary/secondary care interface.
2. In 2013/14, this would mean practices working with local commissioning groups to enhance the management of patients in primary care and thus reduce the use of secondary care facilities.
3. It is proposed that the wording for the QP indicators would be amended to include target dates in line with other QP indicators; firstly to evidence that each practice has contributed fully to external meetings and secondly that pathways are proposed in time for implementation. The amendments would mean the inclusion of 31st July for QP 6 and QP 9 in line with QP 12; and 30th September for QP 7 and QP 10 in line with QP13.
4. It is also proposed to make clear that these indicators are time limited for a further year in 2013/14.

**Organisational Domain**

1. Under these proposals, 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 propose to remove the remaining Organisational indicators, which represent basic organisational standards, whilst retaining 23 points attached to specific indicators for Medicines Management (NM6, NM10 and NM11). The funding released will be used partly to fund the NICE recommendations and the remaining points, (83), would transfer to the core of the contract.
2. This would be firmly embedded in core funding and thereby provide additional stability of income for practices. The requirements themselves would no longer be optional; instead there would be an expectation that they will apply to the whole of general practice. The organisational indicators represent basic standards and there would be a specific requirement within the Contract for practices to meet clinical Governance standards agreed by the HSC Board.
3. The current Patient Experience Domain is proposed to remain.

**Raising thresholds**

1. Most QOF indicators reward practices according to the percentage of eligible patients who benefit from the indicator. These “fraction” indicators have upper and lower payment thresholds based on percentages of patients. Practices do not earn points until they exceed the lower threshold. They then earn a steadily increasing percentage of the points available up to the upper threshold at, or above which, they earn 100% of the points available.
2. Most thresholds are set at 40-90%. Upper thresholds were intended to reflect higher levels of achievement.

1. In 2013/14 we propose to raise the upper and lower payment thresholds for 23 indicators. For 22 indicators the upper threshold would rise by 5% and the lower threshold by 20%, whilst for DM26 the upper threshold would rise by 5% and the lower threshold will rise by 10%. **Appendix 3** sets out the 23 indicators affected in 2013/14, with the current and proposed new thresholds.
2. Practices would continue to be able to exception report patients under the existing criteria, including where the interventions are clinically inappropriate or for patients who exercise informed dissent.
3. In 2014/15, it is proposed to raise the thresholds for all fraction indicators (including the 23 indicators affected by the 2013/14 change). This would follow the same methodology as in 2013/14, i.e. raising the upper and lower payment thresholds for all fraction indicators by a flat percentage unrelated to upper quartiles in NI.
4. We expect that NICE will continue to advise on the thresholds for new indicators and for any replacement indicators which represent a significant change, using available evidence on baseline performance and workload implications for practices, and in line with the following assumptions:

* Upper thresholds should be set based on evidence of the maximum practically achievable level in the year concerned; and
* Lower thresholds should be set to encourage continuous quality improvement for practices achieving below the upper threshold.

**Quality and Outcomes Framework: Review dates**

1. It is not planned to make any changes to the QOF review dates. However, the decision not to implement the QOF review dates changes will be dependent on the capacity for software suppliers to apply different business rules for NI within required timescales and reasonable costs.

**Other (presentational) amendments to QOF**

1. It is proposed to make the following presentational improvements to Annex D of the Statement of Financial Entitlement (which covers the QOF):

* The Statements of Financial Entitlements Directions would include only the information that is necessary to establish clearly entitlements to payments;
* The ordering of areas and indicators within the Domains would be rationalised to make it easier for readers to follow. NHSE have consulted NICE on proposed changes; and
* The indicators would be re-numbered in accordance strictly with the order in which they appear. This would effectively re-set QOF numbering for 2013/14 to make the QOF easier to follow. In future years the practice of allocating a new number to indicators that are replacements could be resumed, depending on what is agreed between the Department and the other parties.

**Amendment to Item of Service payments**

1. We propose to introduce changes to the contract to accommodate delivery of vaccination and immunisation recommendations made by the Joint Committee for Vaccination and Immunisation (JCVI) which are planned for introduction from 1 September 2013. The revised SFE amendments are included at Annex B.
2. The changes detailed introduce a new item of service fee of £7.63 for a completed course of rotavirus for infants from the start of this new programme from September 2013. Having proposed and considered instructing on changes to the SFE to substitute Rotavirus for Men C in the target payments system this would be too complicated as to be practicable or indeed transparent to practices. The target payments would therefore remain unchanged until the new 1 dose Men C cohort is in scope of the target payment age 2 cohort (ie 2015/16) and propose an adjustment is made then to reflect in the target payments a reduction from one 2 dose to 1 dose Men C.
3. We propose to also introduce a new item of service fee of £7.63 to make payments for Shingles immunisation for elderly patients.
4. In both cases of the new immunisations to be introduced the immunisations can be given within existing planned patient appointments so the proposed payments are reasonable and reflect the additional practice work for the immunisations to be undertaken.

**Clinical Priorities 2013/14**

1. Clinical Priorities for 2013/14 will be developed by the Department in consultation with the HSC Board and GPC NI.

**Appendix 1**

**Summary of proposed new and replacement indicators and the proposed movement of points.**

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| --- | --- | --- | --- | --- |
| **New indicators** | | | | |
| **Area** | **ID** | **Indicator wording** | **Thresholds** | **Points** |
| Diabetes Mellitus | NM27 | The percentage of patients newly diagnosed with diabetes in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months of entry on to the diabetes register | 40-90 | 11 |
| Diabetes Mellitus | NM28 | The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the preceding 15 months | 40-90 | 3 |
| COPD | NM46 | The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months | 40-90 | 5 |
| COPD | NM47 | The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme | 40-90 | 5 |
| Diabetes Mellitus | NM51 | The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 15 months | 40-90 | 4 |
| Diabetes Mellitus | NM52 | The percentage of male patients with diabetes who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months | 40-90 | 6 |
| Rheumatoid Arthritis | NM55 | The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis | N/A | 1 |
| Rheumatoid Arthritis | NM56 | The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months | 40-90 | 7 |
| Rheumatoid Arthritis | NM57 | The percentage of patients aged 50-90 years with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 27 months | 40-90 | 5 |
| Rheumatoid Arthritis | NM58 | The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months | 40-90 | 5 |
| **Total points new indicators** | | |  | **52** |

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| **Replacement indicators** | | | | | |  |  |  | | |
| **Area** | **ID** | | | **Replace** | | **Indicator wording** | **Thresholds** | **Points** | | |
| CVD Primary Prevention | NM26 | | | PP1 | | In those patients with a new diagnosis of hypertension aged 30-74 years, 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 agreed risk assessment tool) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins (unless there is a contraindication) | 40-90 | 10 | | |
| Cancer | NM45 | | | Cancer 3 | | The percentage of patients with cancer diagnosed within the preceding 15 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis | 50-90 | 6 | | |
| Depression | NM49 | | | DEP 1&6 | | The percentage of patients with a new diagnosis of depression in the preceding 1st April to 31st March who have had a bio-psychosocial assessment by the point of diagnosis | 50-90 | 21 | | |
| Depression | NM50 | | | DEP 7 | | The percentage of patients with a new diagnosis of depression (in the preceding 1 April to 31 March) who have been reviewed within 10-35 days of the date of diagnosis | 45-80 | 10 | | |
| Diabetes Mellitus | NM59 | | | DM13 | | The percentage of patients with diabetes who have a record of a urine albumin:creatinine ratio test in the preceding 15 months | 50-90 | 3 | | |
| Stroke | NM60 | | | Stroke 8 | | The percentage of patients with a stroke shown to be non- haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in thepreceding 15 months) is 5mmol/l or less | 40-65 | 5 | | |
| Blood pressure | NM61 | | | Records 11& 17 | | The percentage of patients aged 40 years and over with a blood pressure measurement recorded in the preceding 5 years | 50-90 | 15 | | |
| Diabetes Mellitus | NA | | | DM15 | | The percentage of patients with diabetes with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists) | 57-97 | 3 | | |
| CVD Primary Prevention | NA | | | CVD PP2 | | The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: smoking cessation, safe alcohol consumption and healthy diet. | 40-75 | 5 | | |
| Mental Health | NA | | | MH10 | | The percentage of patients on the register who have a comprehensive care plan documented in the preceding 15 months agreed between individuals, their family and/or carers as appropriate. | 40-90 | 6 | | |
| **Total points replacement indicators** | | | | | | | | **84** | | |
| **Total number of points required for new and replacement indicators** | | | | | | | | **136** | | |
| **Points released by retirements** | | | | | | | | | |
| **Retirements due to replacement** | | | | | | | | | |
| **QOF ID** | | | **12/13 Points** | | **NICE indicator wording** | | | | |
| NM26 replaces PP1 | | | 8 | | In those patients with a new diagnosis of hypertension aged 30-74 years, 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 agreed risk assessment tool) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins (unless there is a contraindication) | | | | |
| NM45 replaces Cancer 3 | | | 6 | | The percentage of patients with cancer diagnosed within the preceding 15 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis’ | | | | |
| DEP 1 | | | 6 | | The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on 1 occasion during the preceding 15 months using two standard screening questions | | | | |
| NM49 replaces DEP6 | | | 17 | | The percentage of patients with a new diagnosis of depression in the preceding 1 April to 31 March who have had a bio-psychosocial assessment by the point of diagnosis | | | | |
| NM50 replaces DEP7 | | | 8 | | The percentage of patients with a new diagnosis of depression in the preceding 1 April to 31 March who have been reviewed within 10-35 days of the date of diagnosis | | | | |
| NM59 replaces DM13 | | | 3 | | The percentage of patients with diabetes who have a record of an albumin:creatinine ratio (ACR) test in the preceding 15 months | | | | |
| NM60 replaces Stroke 8 | | | 5 | | 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 15 months) is 5mmol/l or less | | | | |
| NM61 replaces Records 11 | | | 10 | | The percentage of patients aged 40 years and over with a blood pressure measurement recorded in the preceding 5 years | | | | |
| NM61 replaces Records 17 | | | 5 | |
| DM15 | | | 3 | | The percentage of patients with diabetes with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists) | | | | |
| CVD PP2 | | | 5 | | The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: smoking cessation, safe alcohol consumption and healthy diet. | | | | |
| MH 10 | | | 6 | | The percentage of patients on the register who have a comprehensive care plan documented in the preceding 15 months agreed between individuals, their family and/or carers as appropriate. | | | | |
| **Total** | | | **137** | |  | | | | |
| **Retirements** | | | | |  | | | | |
| **QOF ID** | | **12/13 Points** | | | **Indicator Wording** | | | | |
| CHD10 | | 7 | | | The percentage of patients with coronary heart disease who are currently treated with a beta-blocker | | | | |
| CKD2 | | 4 | | | The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months | | | | |
| DM10 | | 3 | | | The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months | | | | |
| DM2 | | 1 | | | The percentage of patients with diabetes whose notes record BMI in the preceding 15 months | | | | |
| DM22 | | 1 | | | The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months | | | | |
| EPILEPSY 6 | | 4 | | | 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 | | | | |
| BP4 | | 8 | | | The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding nine months | | | | |
| **Total** | | **28** | | |  | | | | |
| **Total released by retirements** | | **165** | | |  | | | |

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| **Points retained in OD - Medicines Management**   |  |  |  | | --- | --- | --- | | **QOF ID** | **13/14 points** | **Indicator wording** | | NM6 | 7 | The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing. | | NM10 | 7 | The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change. | | NM11 | 9 | A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%. | | **Total** | **23** |  |   **Summary of points being reused in contract** |  |  |  |
| **NICE recommendations for QOF: point calculations** | **Points** | **£m** |  |
| Points required for new indicators | 52 | 2.4m |  |
| Points required for replacement indicators | 84 | 3.8m |  |
| **Total points required** | **136** | **6.2m** |  |
| Points available from retirements due to replacement | 82 | 3.7m |  |
| Points available from retirements | 28 | 1.3m |  |
| Total points available from clinical domain | 110 | 5m |  |
| **Points required from organisational domain** | **26** | **1.2m** |  |
|  |  |  |  |
| **Changes to Organisational Domain** | **Points** | **£m** |  |
| **Total points available** | **254** | **11.6m** |  |
| Points continuing in existing QP scheme | 100 | 4.5m |  |
| Points to be moved to Public Health Domain | 17 | 0.8m |  |
| Points required for NICE indicators | 26 | 1.2m |  |
| **Total points re-used** | **143** | **6.5m** |  |
| **Points Retained – Medicines Management** | **23** | **1.0m** |  |
| **Points available for transfer into core Contract** | **88** | **4.0m** |  |
| **New QOF points breakdown** | **Points** | **£m** | **%** |
| Clinical | 604 | 27.5m | 66% |
| Public health (includes Additional Services) | 157 | 7.1m | 17% |
| Quality and productivity | 100 | 4.5m | 11% |
| Organisational Domain | 23 | 1.0m | 2% |
| Patient experience | 33 | 1.5m | 4% |
| **Total** | **912** | **41.6m** |  |

**Appendix 2**

**PROPOSALS FOR SETTING UP A PUBLIC HEALTH DOMAIN IN QOF**

1. The proposed rationale for including indicators in the Public Health Domain was set out in a letter from Richard Armstrong dated 13 February 2012 and discussed with the GPC at a meeting with the Department of Health on 6 June and subsequently by the negotiating parties. The rationale is as follows:
   * where a clinical area is mainly related to diagnosis and management of existing disease it should remain within the main body of QOF;
   * where an area is mainly related to screening, case-finding or prevention of disease in otherwise healthy individuals or to lifestyle interventions (e.g. obesity, physical exercise, smoking, alcohol, sexual health) it should be placed in the Public Health Domain;
   * clinical areas should not be split between the NHS and PH Domains, but there needs to be consultation between NHSCB and Public Health England where an area mainly relates to one domain but has indicators or aspects of indicators that relate to the other.
2. A list of the areas which are proposed to be moved to the Public Health Domain is as follows:
   * + Cardiovascular disease primary prevention
     + Obesity
     + Smoking
     + Cervical screening
     + Child health surveillance
     + Maternity services
     + Contraception
3. In addition the following indicators would be moved to the Public Health Domain from the Organisational Domain:
   * + New NICE indicator NM61 replacing Records 11 and 17 (blood pressure recording)
     + Information 05 (smoking cessation strategy).
4. The following QOF payment rules will apply to the Public Health Domain:
   * The list size weighting (CPI) applies to the whole of QOF, including the Public Health Domain;
   * Exception reporting rules will apply to all fraction indicators as appropriate;
   * The prevalence weighting (Adjusted Practice Disease Factor set out at Annex F to the SFE) will apply to all indicators where the target population consists of patients on a disease register (i.e. all indicators moved from the Clinical Domain except smoking indicators for patients aged 15 and over);
   * The additional services calculations (Target Population Factor and length of additional service obligation set out at Annex E to the SFE) will apply to all indicators where the target population consists of patients in the additional services target populations (i.e. all indicators moved from the Additional Services Domain);
   * Indicators where the target population is the practice list, or patients on the practice list above a certain age, will only have the list size weighting applied (CPI) and will not have either the prevalence weighting or additional services calculations applied (i.e. smoking cessation strategy, smoking indicators for patients aged 15 and over and blood pressure recording).

**PROPOSED INCREASES IN THRESHOLDS FOR 2013/14 Appendix 3**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Existing Thresholds** | | **Proposed Thresholds** | |
| **Indicator ID 12/13** | **Indicator ID 13/14** | **Current Lower Threshold CLT** | **Current Upper Threshold CUT** | **CLT+20=PLT** | **CUT+5= PUT** |
| CHD6 | CHD002 | 40 | 75 | 60 | 80 |
| CHD8 | CHD003 | 45 | 70 | 65 | 75 |
| CHD9 | CHD005 | 50 | 90 | 70 | 95 |
| CHD12 | CHD004 | 50 | 90 | 70 | 95 |
| CHD14 | CHD006 | 45 | 80 | 65 | 85 |
| STROKE10 | STIA006 | 45 | 85 | 65 | 90 |
| STROKE12 | STIA007 | 50 | 90 | 70 | 95 |
| BP5 | HYP002 | 45 | 80 | 65 | 85 |
| DM15 | DM006 | 45 | 80 | 65 | 85 |
| DM18 | DM010 | 45 | 85 | 65 | 90 |
| DM26 | DM007 | 40 | 50 | 50 | 55 |
| DM27 | DM008 | 45 | 70 | 65 | 75 |
| DM28 | DM009 | 50 | 90 | 70 | 95 |
| DM30 | DM002 | 45 | 71 | 65 | 76 |
| DM31 | DM003 | 40 | 65 | 60 | 70 |
| COPD8 | COPD007 | 45 | 85 | 65 | 90 |
| HF3 | HF004 | 45 | 80 | 65 | 85 |
| CKD3 | CKD002 | 45 | 70 | 65 | 75 |
| AF3\*6 | AF003 | 50 | 90 | 70 | 95 |
| SMOKING4\*6 | SMOK005 | 50 | 90 | 70 | 95 |
| STROKE6 | STIA003 | 40 | 75 | 60 | 80 |
| STROKE8 | STIA005 | 40 | 65 | 60 | 70 |
| DM17 | DM004 | 40 | 75 | 60 | 80 |

**ANNEX B**

**[To include draft Statement of Financial Entitlement (excluding Annex D)**