Department of Health

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Dear Dr Buckman

General Medical Services – Contractual Changes 2013/2014

I am writing further to Ben Dyson's letter of 23rd October 2012, which made clear the Government's commitment to pursue changes to the General Medical Services contract for April 2013 should it not be possible to reach a satisfactory negotiated agreement.

I am now writing to provide you with an initial draft, as an attachment to this letter, of the General Medical Services Statement of Financial Entitlements Directions 2013 (SFE) and a draft of The Primary Medical Services (Directed Enhanced Services) Directions 2013 (DES Directions). These reflect the proposals in **Annex A**, together with some changes flowing from the Health and Social Care Act 2012. I am sending these now to provide sufficient time to consult GPC on the details on these changes.

I should emphasise that the proposed changes are intended to maintain current levels of investment in general practice. Most of the proposed changes concern improvements to the Quality and Outcomes Framework (QOF).

There are proposed amendments to the section covering the operation of correction factor payments to apply from 2014/15, which will enable the NHS Commissioning Board to take forward the proposals developed by GPC and NHS Employers of phasing the changes over a seven-year period beginning in April 2014. We will also be discussing with other stakeholders with an interest in PMS agreements how best to achieve a similar outcome for PMS.

We are also proposing a new vaccination and immunisation programme for rotavirus and shingles which is planned for implementation from 1 September 2013.

I attach at **Annex A** a full explanation of the details of the proposed changes.

The Department understands that NHS Employers has consulted with the GPC recently or in the past on each of the changes proposed in line with the negotiating 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 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, 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 SFE. I attach at **Annex B** a draft SFE which includes the proposed changes. Where items in this draft are in square brackets it indicates that these areas are still under consideration. Some of these outstanding areas relate to consequential changes from the Health and Social Care Act 2012 and some are draft updating changes. The draft does not include all of the detailed provisions relating to the proposed changes in Annex A, for example on the patient participation scheme. When these sections of the SFE are amended we will send copies to you. I should also be clear that the drafts provided are subject to further legal checks and final decisions following the outcome of consultation.

The SFE amendments do not yet take account of any uprating of investment to GMS contractors for 2013/14 as this will now depend on the decisions that Government will make following the request from the BMA that the Doctors and Dentists Review Body make recommendations on gross uplift.

The Department proposes to direct the NHS Commissioning Board to put in place a new Directed Enhanced Service to be offered to practices to improve care and services 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.

It will be the responsibility of the NHS Commissioning Board to develop the detailed specification for this new enhanced service and the Board will want to work with GPC and other interested stakeholder groups such as the RCGP in doing so. However, for completeness, we believe it appropriate to attach at **Annex C** a draft of the proposed DES Directions. These contain provisions directing the NHS Commissioning Board from April 2013. These draft Directions also include for a further year the DESs that currently exist.

Despite the period of negotiation that has already passed, the Department is prepared to offer a further period of discussions on the changes proposed in

these documents. We hope that negotiations between NHS Employers and the GPC might continue to see if an acceptable agreement can be reached.

If a negotiated agreement cannot be reached, and subject to further consideration of the outcome of the consultation on the attached directions, the Department proposes to introduce the changes described in this letter so as to support ongoing improvements in patient care and services.

The Department remains happy to meet with you, along with other stakeholders that we will also be consulting with, but please note that the consultation period on the proposals set out in Annex A will **close on 26 February 2013**. The Department will then consider any representation made during the consultation period and make final decisions to allow GP contractual changes to come into effect from 1 April 2013.

You will be aware that a separate consultation has been launched on the changes proposed to the NHS Pensions Regulations. I understand that you have been copied into the letter that Julie Badon sent to Mark Porter on 20 November 2012 which launched the consultation.

The consultation document includes a proposal to transfer responsibility for payment of locum superannuation contributions to the employing body, bringing this responsibility into line with all other superannuation payment responsibilities. Although the consultation on the NHS Pension Scheme Regulations is separate to the GMS negotiations, it is worth noting that it includes a proposal that the PCO administered funding that currently pays for locum superannuation will be transferred into GMS Global Sum funding.

Please note that we will continue separate discussions regarding the NHS (Primary Medical Services) (Miscellaneous Amendments and Transitional Provisions) Regulations 2012. These are the changes to the regulations as a result of the Health and Social Care Act 2012. We have received your comments of 13 November 2012 and we will respond to you shortly on the points that you have raised. We will also be consulting you separately on the Patient Choice Scheme Directions which will simply reflect the agreement reached earlier in the year to allow patients who are registered under the current scheme to remain registered pending the outcome of the evaluation.

I am copying this letter to Frank Strang, Lisa Dunsford, Eugene Rooney and Stephen Golledge.

Yours sincerely

Richard Armstrong
Head of Primary Medical Care
Commissioning Development Directorate

Annex A

Explanation of the proposed GMS Contract Changes

Securing equitable funding in GMS contractual arrangements: 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 redistribution of Correction Factor payments between contractors. To support that proposal, 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 March 2014, will 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 will cease. Correction factor resources released in this way will be reinvested into Global Sum payments so as to benefit all practices, not just those in receipt of correction factor payments.

2. Separate to these provisions, the NHS Commissioning Board (NHS CB) will, 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.

Application of GP Contract Uplift: 2013/14

3. In light of the GPC's wish not to accept the 1.5% gross funding uplift offered as part of a negotiated settlement, the Government will consider any recommendation made by the Doctors and Dentists Review Body (DDRB) as part of this year's independent pay review process. The Department will make final decisions on the level of contract uplift once the DDRB has made its recommendations (expected before the end of this consultation period). The Department remains committed to treating independent GP contractors like other public-sector funded staff with the intent of delivering up to a 1% pay increase.

4. The Government remains committed to enabling fair and equitable distribution of funding to GP practices. Applying equally an uplift for 13/14 to all practices would not support movement towards fair funding, as those practices with highest funding levels would receive a higher cash uplift than practices that do not receive any Correction Factor payments (under the Minimum Practice Income Guarantee). The Department therefore proposes to apply any uplift partly to Global Sum payments and partly to other payments, prioritising narrowing the funding gap between practices, while providing some uplift to all practices. We will make final decisions on the relative investment between practices in the light of the DDRB's recommendations.

5. This approach would support the common objective of making further progress towards equitable funding across contractors and reducing the number of practices receiving correction factor payments.

Changes to the Quality and Outcome Framework

6. As set out in Ben Dyson's letter of 23 October, the Department proposes to make a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. In summary these are as follows:
   - implement all the NICE recommendations for changes to QOF, partly funded from NICE recommended retirements and partly from the resources freed up by discontinuing the organisational domain of QOF;
   - raise upper thresholds for existing indicators to reflect the current achievement of the 75th centile of practices and so benefit more patients in receiving evidence-based care that will save more lives and enhance quality of care for people with long term conditions. In order to make sure that the workload for practices is manageable, we propose a phased approach, with this increase to threshold levels applied to 20 indicators in 2013/14 and remaining indicators in 2014/15. From 2015/16 onwards thresholds would continue to rise as average achievement rises to support continuous quality improvement, but with thresholds set at a level that all practices should in principle be able to achieve;
   - 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 unnecessary emergency admissions, referrals and A&E attendances by improving care for patients. Make clear that these are for one further year and will be reviewed to decide whether they should continue beyond that year;
   - remove the remaining organisational indicators that are not retained in QP or moved into the Public Health Domain. The organisational indicators 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 a new Directed Enhanced Service that will be offered to all GP practices;
   - remove the current overlap of QOF years by reducing the time period for most indicators from 15 months to 12 months;
   - reform the list size weighting (Contractor Population Index) so that the price of a QOF point is transparent and remove the year on year inflationary effect of the weighting from 2014/15 onwards.

New indicators

7. The Department proposes 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 recommendations include the following improvements for patients:
   - tighter blood pressure control targets for people with hypertension leading to an increase in quality years of life for those patients;
   - prescribing of cholesterol lowering medicines to prevent cardiovascular disease in people diagnosed with hypertension who are at high risk of events such as heart attacks and strokes;
   - advice to increase physical activity for people with hypertension;
   - referral to rehabilitation for people with chronic obstructive pulmonary disease and heart failure to improve their health and quality of life;
   - a thorough assessment of people newly diagnosed with depression examining their mental, physical and social needs and follow up review within 10-35 days of diagnosis;
   - improved support for cancer patients;
   - improved care for patients with rheumatoid arthritis;
   - referral to structured education and dietary advice for patients with diabetes to prevent complications and ill-health and advice for male patients with diabetes who have erectile dysfunction.

8. The new and improved indicators will be partly funded by accepting NICE recommendations for retiring indicators from the Clinical Domain which 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.

9. **Appendix 1** sets out the details of the proposed new and replacement indicators and the proposed thresholds and points. For ease of reference, the Appendix uses the current indicator wording, which is subject to amendment to implement the proposals on indicator time periods and to clarify indicator definitions.

Public Health Domain

10. 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 the GPC at a meeting with the health departments, NICE and NHS Employers on 6 June and then by the negotiating parties.

11. Following those discussions and the further negotiations, the Department proposes 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. **Appendix 2** sets out details of the rationale and the areas and indicators proposed to move into the Public Health Domain.

12. 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 PHE (in consultation with the Devolved Governments). The amount invested in 2013/14 in the Public Health Domain (not the percentage of QOF) will remain the same (£188m), unless there is 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.

Quality and Productivity Indicators

13. The Department proposes to retain for a further year the current Quality and Productivity indicators that reward practices for work to reduce unnecessary emergency admissions, outpatient referrals and A&E attendances by improving care for patients. 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.

14. In 2013/14, this will mean practices working with NHS CB Local Area Teams and clinical commissioning groups on improvements in the management of patients in primary care to avoid clinically inappropriate use of secondary care.

15. We propose, however, to streamline these indicators so that the administrative requirements on practices and the NHS CB are reduced. We also propose to make clear that these indicators are currently limited to one further year in 2013/14. The NHS CB would need to review whether there is a continued need for these indicators in 2014/15.

Organisational Domain and Patient Experience Domain

16. 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 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 and partly to invest in a new Directed Enhanced Service (see below). In order to avoid having a total number of points in QOF which is not a whole

number, it is proposed that 0.5 points from MAN03 should be moved to QP11.

17. The Department proposes to retain the current Patient Experience Domain.

Raising thresholds

18. 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.

19. Most thresholds are set at 40-90%, but a few upper thresholds are as low as 50% of patients (practice earn the full rewards if only half of the eligible patients benefit). Upper thresholds were intended to reflect higher levels of achievement, but thresholds have not kept up with actual achievement. National average achievement is currently above the upper thresholds for all indicators. This means there is no incentive for practices to improve.

20. As set out in the original agreement between the NHS Confederation and the BMA on the GP contract in 2003 (the Blue Book), upper thresholds should be set “based on evidence of the maximum practically achievable level to deliver clinical effectiveness”[1]. The Department proposes therefore that the evidence of what is practically achievable should be based on the latest data available on achievement of the 75th centile of practices. This would ensure that QOF supports 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.

21. In order to make sure that the increase in workload for practices is manageable, we propose that this change should be phased over two years in 2013/14 and 2014/15. 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.

22. In 2013/14 we propose to raise the upper payment thresholds for 20 indicators with the best research evidence[2] that they save lives. These indicators would have upper thresholds raised to the achievement of the 75th centile of practices measured in 2011/12. Lower thresholds would be set 40 percentage points below the upper thresholds to encourage continuous quality improvement for practices achieving below the upper

[1] New GMS Contract 2003. Published by NHS Confederation Feb 2003, page 22, para 3.28

[2] The UK pay-for-performance programme in primary care: estimation of population mortality reduction. R Fleetcroft et al. Published in British Journal of General Practice Sept 2010.

threshold. **Appendix 3** sets out the 20 indicators affected in 2013/14, with the current and proposed new thresholds (and shows current average achievement by practices in England).

23. This would encourage most practices to improve towards the performance of the 75th centile of practices in order to increase the number of patients who benefit from potentially life-saving interventions, particularly in more deprived areas. Practices will 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. We do not therefore believe there is any incentive to over-treat patients inappropriately as GPC have suggested.

24. In 2014/15, the Department proposes to raise the thresholds for all fraction indicators where there is data available on achievement (including the 20 indicators affected by the 2013/14 change). This would follow the same methodology as in 2013/14, i.e. raising the upper payment thresholds for all fraction indicators up to the achievement of the 75th centile of practices measured in the latest year for which data is available, which will be 2012/13. The lower thresholds would be set 40 percentage points below the upper thresholds to encourage continuous quality improvement for practices achieving below the upper threshold.

25. As in 2004, when the QOF was first introduced, we believe practices can and will rise to meet the proposed new reward thresholds and this would therefore lead to further benefits to patients in terms of improved health outcomes.

26. From 2014/15 onwards, thresholds for all fraction indicators that continue in QOF would be raised each year using the 75th centile of practice performance as the benchmark, according to the most recent data available on previous years' performance, with the lower threshold being set 40 percentage points below the upper threshold. As there is a two-year time-lag between data on achievement and the QOF year for which thresholds are set, this would only apply to indicators that are maintained or have only minor changes for at least three years.

27. 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;
    - lower thresholds should be set to encourage continuous quality improvement for practices achieving below the upper threshold.

<u>Technical changes to QOF</u>

28. The Department proposes to make two other technical changes:

a) removing the overlap between QOF years that means that some patients are only receiving annual checks once every two years;

b) 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.

a) Removing the overlap between QOF years

29. On introduction of the QOF, additional time to achieve indicators was incorporated into most QOF indicators. Generally, the time factor added was three months, so that the period for achieving indicators is 15 months instead of 12 months, or 27 months instead of 24. The original intention was to recognise that it may be difficult to ensure that all patients attend for review within the intended time-scale. However, QOF is an annual reward scheme with achievement assessed and payment due at 31 March at the end of each financial year. Therefore, the additional time is added to the beginning of the time-period, three months before the start of the relevant financial year (January-March), with the result that the time-period of each ‘QOF year’ overlaps by three months with the period of the previous ‘QOF year’.

30. The result is incoherent because practices do not have longer at the end of the year to catch up with patients they were not able to see. Exception reporting rules already allow for the fact that it is not possible to achieve 100%. The over-lapping time-periods therefore do not benefit practices and add unnecessary complexity to QOF business rules. More importantly, they are detrimental to good patient care because:

- a practice may receive two annual payments for a process carried out once during a two-year period if it is from January-March. There is no method of preventing this unless we remove the overlap;
- if a patient is excepted from an indicator during January to March using a general exception code, this excepts the patient from the whole clinical area for two years;
- the time elapsed between first and second review for patients can therefore be significantly longer than the intended twelve to fifteen months – up to two years or more on the basis of sampling done using GP research databases.

31. The Department therefore proposes 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 propose to remove year-end overlaps for exception reporting for all indicators through changes to the business rules. **Appendix 4** contains a spreadsheet of the indicators that would be amended. This includes new

NICE indicators that would need to be amended, but excludes indicators from the current set that are proposed to be retired or replaced.

32. The NHS CB will be encouraged to carry out further work during 2013 in consultation with the GPC on other technical anomalies in the QOF to ensure a more transparent and consistent approach in the future to the benefit of patients. We suggest this should cover:

    - replacing ill-defined general codes for exceptions with specific codes to record accurately the clinical reason for the exception (including informed dissent) and avoid patients being automatically excepted from a whole clinical area by use of a general code for one indicator;
    - developing a consistent and transparent approach to complex indicators (for example indicators that require action within a certain time-period linked to diagnosis). The aim would be to ensure that no patients would be omitted altogether because they are diagnosed in the last quarter.

b) Reform the list size weighting

33. On an almost annual basis since 2005, there has been discussion to update the Contractor Population Index (CPI) weighting within the QOF to reflect changes to average practice list size. GPC have refused to discuss such updating and to reform the list size weighting so that the price of a QOF point is transparent.

34. The current reward of a QOF point is now around 16% 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 in 2013/14 by 16% to recognise the actual price that is paid to the average practice. At the same time we propose to reform the 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 is transparent. This would be a cost neutral change in 2013/14.

35. 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.

Other presentational amendments to QOF

36. The Department proposes 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 will include only the information that is necessary to establish clearly entitlements to payments. More detailed information (including clinical rationale and guidance on verification of achievement) will be published separately in guidance for England developed by NHS Employers (NHSE) in consultation with NICE, NHS CB and the GPC;

- the ordering of areas and indicators within the Domains will be rationalised to make it easier for readers to follow. NHSE have consulted NICE on proposed changes;
- the indicators will be re-numbered in accordance with the order in which they appear. This will 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 NHS CB and the other parties.

Directed Enhanced Services

New Directed Enhanced Service

37. A new Directed Enhanced Service will be developed by the NHS CB to offer to practices on a preferred basis. This will be funded from £120m of resources released from ending QOF organisational indicators. To support this, and to commit the £120m released resources to be available to practices on a preferential basis, the Department proposes that the Secretary of State will direct the NHS CB to establish a new specified enhanced service. The direction is cast in general terms under a Promoting Quality and Innovation Scheme in order to give the NHS CB flexibility:
    - to work with stakeholder organisations to develop a detailed service specification for each enhanced service under the umbrella scheme;
    - in doing so, to consider the workload implications for practices and opportunities for phasing in requirements; and
    - to determine the specific financial rewards that should apply in each year based on the service specification requirements, whilst ensuring the overall £120m funding released from QOF is available for practices to earn.

38. It will be for the NHS CB to decide on the operational detail required to establish the enhanced services under the scheme but the Department's expectations on what could be achieved will inform this and these are set out in **Appendix 5**. In summary:

    (a) Risk Profiling and Care Management: this will seek to encourage GP practices to coordinate and manage the care of frail older people and other high-risk patients (including patients with mental ill health) predicted to be at significant risk of unscheduled hospital admission. This might require regular risk profiling by practices to identify patients most at risk and have a multidisciplinary approach to case management for a proportion of patients identified. The proportion of patients supported in each practice will be agreed locally in conjunction with the clinical commissioning group so as to recognise that every practice has a different patient need but that every avoidable admission will effectively represent both better care to that individual as well as reduced pressure on the local care system.

(b) Case Finding for Patients with Dementia: to reward practices for having a proactive approach to the assessment of at-risk patients who may be showing the early signs of dementia. This will be undertaken through an initial enquiry followed by a specific test. It will support improvement in the prompt diagnosis of patients with the condition so that they can be brought into the care pathway earlier. The scope of at-risk patients will be refined during the consultation to be carried out by the NHS CB.

(c) Remote Care Monitoring: to encourage GP practices to establish remote care monitoring arrangements for patients with long-term but relatively stable conditions and thereby reduce unnecessary patient attendances at the practice, which will benefit both practices and patients. We recognise that introduction needs to be manageable in the early years. The aim would be to address a single national disease area such as hypothyroidism in the first year while planning for a further locally agreed priority area to be established for the second year. The NHS CB will wish to consider using the first year funding to support practices to implement remote care monitoring for hypothyroidism as well as identifying a further local priority area and the patients who would benefit and preparing for implementation. We envisage that such an approach should provide practices with the confidence to tackle conditions that are more complex in future years, extending the benefits to more patients and further expanding capacity for practices by reducing unnecessary routine attendances.

(d) Improving Online Patient Access: to reward practices that improve online access to services for their registered patients. The specific aim will be to reward practices that enable current IT functionality of systems that support online patient booking of appointments, online ordering of repeat prescriptions (including, eventually electronic prescription service), and online access for patients to test results and medical records and who promote greater usage of these services by their patients. We envisage a phased approach, with a focus on certain online services in 2013/14 and a further group of services in 2014/15, in order to moderate workload and because some GP systems do not yet have functionality to deliver all the services proposed. This will also enable the NHS CB to continue collaborative work with RCGP to identify how best to implement these services and realise potential benefits for patients and for the NHS. These latter benefits in future years are expected to include reduced administrative workload for GP practices and reduced administration costs for the wider NHS.

Existing Directed Enhanced Services

39. The Department proposes to continue with the following current schemes:

a) Extended Hours Scheme
The current Extended Hours Access Scheme Directed Enhanced Service which encourages GP practices to offer their patient extended opening hours is due to come to an end on 31 March 2013. We

propose that this will ‘roll over’ for a further year, to run from 1 April 2013 to 31 March 2014.

b) Patient Participation Scheme
The current two-year Patient Participation Scheme Directed Enhanced Service, which encourages GP practices to set up Patient Reference Groups and seek patients’ views through the use of local patient surveys, is due to come to an end on 31 March 2013. We propose that there will be a new one-year scheme from 1 April 2013 to 31 March 2014 (by when the NHS CB will have determined the best means for introducing the Friends and Family Test in general practice).

c) Alcohol Related Risk Reduction Scheme
The current Alcohol Directed Enhanced Service, which encourages case finding in newly, registered patients and provision of simple brief advice, is due to come to an end on 31 March 2013. We propose to extend this for a further year, to run from 1 April 2013 to 31 March 2014.

d) Learning Disabilities Health Check Scheme
The current Learning Disabilities Health Check Directed Enhanced Service, which encourages practices to identify patients aged 18 and over with the most complex needs and to offer them an annual health check, is due to come to an end on 31 March 2013. Again, we propose that this should continue for at least a further year, to run from 1 April 2013 to 31 March 2014. The NHS CB plans to minimise the validation burden for payments under the clinical DESs and is proposing that these schemes should be managed from next year through the Calculating Quality Reporting System. This would allow automation of the payments payable to providers of the Learning Disabilities Health Check DES and we propose this can best be achieved by streamlining the Register Agreement Payment and Health Check Completion payments into a single Quarterly Health Check Completion Payment.

40. In practice, all the above schemes will be implemented as new DESs, where contractual arrangements will be agreed between the NHS CB and any practices who wish to participate in these Schemes. Revised Directions to the NHS CB and SFE amendments for these DESs are included at Annex B.

Amendment to Item of Service payments

41. 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.

42. The proposed changes 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 we believe this would now be far too complicated as to be practicable or indeed transparent to practices. The target payments will therefore remain unchanged until the new 1 dose Men C cohort is in scope of the target payment age 2 cohort (i.e. 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.

43. We propose 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 catch up programme for patients aged 71 to 79.

44. In both cases, the new immunisations can be given within existing planned patient appointments so we believe the proposed payments are reasonable and reflect the additional practice work involved.

Appendix 1

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

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
Hypertension	NM36	The percentage of patients with hypertension aged 16 to 74 years in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 15 months	40-90	3
Hypertension	NM37	The percentage of patients with hypertension aged 16 to 74 years who score 'less than active' on GPPAQ in the preceding 15 months, who also have a record of a brief intervention in the preceding 15 months	40-90	3
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
Heart Failure	NM48	The percentage of patients with heart failure diagnosed within the preceding 15 months with a record of an offer of referral for an exercise based 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
COPD	NM63	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
Total points new indicators				**63**

Replacement Indicators

Area	ID	Replace	Indicator wording	Thresholds	Points
CVD Primary Prevention	NM26	PP1	In 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 sta tins (unless there is a contraindication)	40-90	10
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
Hypertension	NM53	BP5	The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less	40-80	45
Hypertension	NM54	BP5	The percentage of patients with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less	44-84	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 the preceding 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
Cancer	NM62	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
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					**139**

Total number of points required for new and replacement indicators	**202**

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
NM53 replaces BP5	55	The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less
NM54 replaces BP5		The percentage of patients with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 150/90 or less
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**	

Summary of points being reused in contract

NICE recommendations for QOF: point calculations	Points	£m
Points required for new indicators	63	75.6
Points required for replacement indicators	139	166.8
Total points required	**202**	**242.4**
Points available from retirements due to replacement	137	164.4
Points available from retirements	28	33.6
Total points available from clinical domain	165	198.0
Points required from organisational domain	**37**	**44.4**

Changes to Organisational Domain	Points	£m
Total points available	**254**	**304.8**
Points continuing in existing QP scheme	100	120.0
Points to be moved to Public Health Domain	17	20.4
Points required for NICE indicators	37	44.4
Total points re-used	**154**	**184.8**
Points available for transfer into enhanced services	**100**	**120.0**

New QOF points breakdown	Points	£m	%
Clinical	610	732.0	68%
Public health (includes Additional Services)	157	188.4	17%
Quality and productivity	100	120.0	11%
Patient experience	33	39.6	4%
Total	**900**	**1080**	

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 NHS CB 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).

Appendix 3

PROPOSED INCREASES IN THRESHOLDS FOR 2013/14

ID 2011/12	ID 2012/13	ID 2013/14	Existing thresholds		Current average achievement	New thresholds	
			lower	upper	%	lower	upper
CHD6	CHD6	CHD002	40	71	90	53	93
CHD8	CHD8	CHD003	40	70	80	45	85
CHD9	CHD9	CHD005	40	90	94	56	96
CHD12	CHD12	CHD004	40	90	93	56	96
CHD14	CHD14	CHD006	40	80	95	60	100
STROKE10	STROKE10	STIA006	40	85	91	55	95
STROKE12	STROKE12	STIA007	40	90	94	57	97
BP5	BP5	HYP002	40	70	80	44	84
DM15	DM15	DM006	40	80	90	57	97
DM18	DM18	DM010	40	85	91	55	95
DM26	DM26	DM007	40	50	70	35	75
DM27	DM27	DM008	40	70	78	43	83
DM28	DM28	DM009	40	90	88	52	92
DM30	DM30	DM002	40	71	90	53	93
DM31	DM31	DM003	40	60	71	38	78
COPD8	COPD8	COPD007	40	85	94	57	97
HF3	HF3	HF004	40	80	91	60	100
CKD3	CKD3	CKD002	40	70	76	41	81
AF3	AF6	AF003	40	90	94	57	97
SMOKE4	SMOKE6	SMOK005	40	90	93	56	96

Appendix 4

INDICATORS AFFECTED BY REMOVAL OF YEAR-END OVERLAP

The table below lists the indicators which are proposed for change to remove year-end overlaps. The first column shows the 2012/13 QOF ID or, for new indicators, the NICE ID where available and also the proposed new ID for 2013/14. The indicator wording in column two is the current wording (either in the 2012/13 QOF or NICE recommendation). Further consideration is being given to clarify QOF indicator wording for 2013/14, for example to ensure that the time period intended is clear on the face of the indicator.

Column three identifies the wording that needs to change in the indicator to remove the overlap (further wording changes may be required for clarification). Column four indicates whether a business rules change is required. Where the business rule change is to the time period, then this will include an equivalent change to the time period for exceptions (except for new diagnosis/new registration). Where only a change to exceptions is required, this is indicated in column four. This change would applies to all exception criteria except new diagnosis/new registration, which do not overlap with the previous year.

Indicator ID old and new	Indicator Description	Wording	Business rules
AF5 AF002	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1)	15 to 12 months	15 to 12 months
AF6 AF003	In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy	15 to 12 months	15 to 12 months
AF7 AF004	In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy		Exceptions 15-12 months
ASTHMA10 AST004	The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months	15 to 12 months	15 to 12 months
ASTHMA8 AST002	The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility		Exceptions 15-12 months
ASTHMA9 AST003	The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	15 to 12 months	15 to 12 months
BP5 HYP002	The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less		Exceptions 15-12 months
NM53 HYP003	The percentage of patients under 80 years old with hypertension in whom the last recorded blood pressure (measured in the preceding 9 months) is 140/90 or less		Exceptions 15-12 months

NM36 HYP004	The percentage of patients with hypertension aged 16 to 74 years in whom there is an annual assessment of physical activity, using GPPAQ, in the preceding 15 months	15 to 12 months	15 to 12 months
NM37 HYP005	The percentage of patients with hypertension aged 16 to 74 years who score ‘less than active’ on GPPAQ in the preceding 15 months, who also have a record of a brief intervention in the preceding 15 months	15 to 12 months	15 to 12 months
NM45 CAN002	The percentage of patients with cancer diagnosed within the preceding 15 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis		Exceptions 15-12 months
CHD12 CHD004	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March		Exceptions 15-12 months
CHD14 CHD006	The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin		Exceptions 15-12 months
CHD6 CHD002	The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	15 to 12 months	15 to 12 months
CHD8 CHD003	The percentage of patients with coronary heart disease, whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less	15 to 12 months	15 to 12 months
CHD9 CHD005	The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	15 to 12 months	15 to 12 months
CKD3 CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less	15 to 12 months	15 to 12 months
CKD5 CKD003	The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB)		Exceptions 15-12 months
CKD6 CKD004	The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the preceding 15 months	15 to 12 months	15 to 12 months
COPD10 COPD004	The percentage of patients with COPD with a record of FEV1 in the preceding 15 months	15 to 12 months	15 to 12 months
COPD13 COPD003	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	15 to 12 months	15 to 12 months
COPD15 COPD002	The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry		Exceptions 15-12 months
COPD8 COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March		Exceptions 15-12 months
NM46 COPD005	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	15 to 12 months	15 to 12 months

NM47 COPD006	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	15 to 12 months	15 to 12 months
DEM2 DEM002	The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	15 to 12 months	15 to 12 months
DEM4 DEM003	The percentage of patients with a new diagnosis of dementia recorded between the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register		Exceptions 15-12 months
NM49 DEP001	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		Exceptions 15-12 months
NM50 DEP002	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		Exceptions 15-12 months
NM59 DM005	The percentage of patients with diabetes who have a record of a urine albumin:creatinine ratio test in the preceding 15 months	15 to 12 months	15 to 12 months
DM15 DM006	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)		Exceptions 15-12 months
DM17 DM004	The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5 mmol/l or less.	15 to 12 months	15 to 12 months
DM18 DM010	The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March		Exceptions 15-12 months
DM21 DM011	The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months	15 to 12 months	15 to 12 months
DM26 DM007	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	15 to 12 months	15 to 12 months
DM27 DM008	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	15 to 12 months	15 to 12 months
DM28 DM009	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	15 to 12 months	15 to 12 months
DM29 DM012	The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	15 to 12 months	15 to 12 months
DM30 DM002	The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less.	12 months	15 to 12 months
DM31 DM003	The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less	12 months	15 to 12 months
NM28 DM013	The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the preceding 15 months	15 to 12 months	15 to 12 months

NM27 DM014	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		Exceptions 15-12 months
NM51 DM015	The percentage of male patients with diabetes with a record of being asked about erectile dysfunction in the preceding 15 months	15 to 12 months	15 to 12 months
NM52 DM016	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	15 to 12 months	15 to 12 months
EPILEPSY8 EP002	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	15 to 12 months	15 to 12 months
EPILEPSY9 EP003	The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months	15 to 12 months	15 to 12 months
HF2 HF002	The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment		Exceptions 15-12 months
NM48 HF003	The percentage of patients with heart failure diagnosed within the preceding 15 months with a record of an offer of referral for an exercise based rehabilitation programme		Exceptions 15-12 months
HF3 HF004	The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication		Exceptions 15-12 months
HF4 HF005	The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers		Exceptions 15-12 months
LD2 LD002	The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)	15 to 12 months	15 to 12 months
MH10 MH002	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	15 to 12 months	15 to 12 months
MH11 MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	15 to 12 months	15 to 12 months
MH12 MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months	15 to 12 months	15 to 12 months
MH13 MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months	15 to 12 months	15 to 12 months

MH16 MH008	The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years		MH general exceptions only from 15-12 months
MH17 MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months		Exceptions 15-12 months
MH18 MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months		Exceptions 15-12 months
MH19 MH004	The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months	15 to 12 months	15 to 12 months
MH20 MH005	The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months	15 to 12 months	15 to 12 months
OB1 OB001	The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months	15 to 12 months	15 to 12 months
OST2 OST002	The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent		Exceptions 15-12 months
OST3 OST003	The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent		Exceptions 15-12 months
PAD2 PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken	15 to 12 months	15 to 12 months
PAD3 PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	15 to 12 months	15 to 12 months
PAD4 PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in preceding 15 months) is 5.0mmol/l or less	15 to 12 months	15 to 12 months
NM26 CVD-PP001	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)	15 to 12 months	15 to 12 months
PP2 CVD-PP002	The percentage of patients 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	15 to 12 months	15 to 12 months
SH2 CON002	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months	15 to 12 months	15 to 12 months

SH3 CON003	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within 1 month of, the prescription		Exceptions 15-12 months
SMOKING5 SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months	15 to 12 months	15 to 12 months
SMOKING6 SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months	15 to 12 months	15 to 12 months
SMOKING7 SMOK001	The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months	27-24 months	27-24 months
SMOKING8 SMOK004	The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months	27-24 months	27-24 months
STROKE10 STIA006	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March		Exceptions 15-12 months
STROKE12 STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken	15 to 12 months	15 to 12 months
STROKE13 STIA002	The percentage of new patients with a stroke or TIA who have been referred for further investigation.		Exceptions 15-12 months
STROKE6 STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	15 to 12 months	15 to 12 months
STROKE7 STIA004	The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 15 months	15 to 12 months	15 to 12 months
NM60 STIA005	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	15 to 12 months	15 to 12 months
THYROID2 THY002	The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months	15 to 12 months	15 to 12 months
NM56 RA003	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	15 to 12 months	15 to 12 months
NM57 RA004	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	27-24 months	27-24 months
NM58 RA002	The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months	15 to 12 months	15 to 12 months

Appendix 5

DRAFT SERVICE SPECIFICATIONS FOR NHS CB TO DEVELOP

ENHANCED SERVICE FOR A RISK PROFILING AND CARE MANAGEMENT SCHEME

Aim of scheme to be established under Directions

1. A Risk Profiling Scheme, the underlying purpose of which is to coordinate and manage the care of frail older and other high risk patients (including patients with mental ill health) predicted to be at significant risk of unplanned hospital admission.

Possible requirements for the NHS CB to consider

2. Directions would not include any minimum requirements for plans entered into between the NHS CB and primary medical care contractors.

3. However the Department might expect the minimum terms of such schemes to include specifications similar to the following:

    a. that the contractor carries out regular risk profiling of its registered patients who are predicted to be at significant risk of unplanned hospital admission. Where available, this list can be produced using a risk profiling tool procured by a clinical commissioning group (or a commissioning support service acting on behalf of a CCG);

    b. that the contractor when setting the parameters for its risk profiling activities at (a) includes patients with mental ill health;

    c. that the contractor identifies and assesses from this list an agreed percentage of patients for whom case management (care coordination and planning) could minimise future unplanned hospital admissions;

    d. that the agreed percentage of patients identified for case management is agreed with the NHS CB;

    e. that the contractor participates in regular multidisciplinary integrated care team meetings to achieve a shared multidisciplinary approach to the case management of each patient that seeks to reduce the risk of future unplanned hospital admissions;

    f. that the contractor has a nominated lead professional who is responsible for each patient identified for case management under such arrangements including undertaking a specified review of each patient's case management in light of their clinical and care needs at specified frequency;

    g. the monitoring and payment arrangements for the contractor agreeing and meeting its obligations under the plan.

[ENDS]

ENHANCED SERVICE FOR A DEMENTIA CASE FINDING SCHEME.

Aim of scheme to be established under the Direction

1. A Dementia Case Finding Scheme, the underlying purpose of which is to put in place a proactive approach to the assessment of patients who may be showing the early signs of dementia to support improvement in the prompt diagnosis and care of patients with the condition.

Possible requirements for the NHS CB to consider

2. Directions would not include any minimum requirements for plans entered into between the NHS CB and primary medical care contractors.

3. However the Department might expect the minimum terms of such schemes to include specifications similar to the following:

   a. that the contractor undertakes to make an offer and (where accepted) provide an initial assessment for dementia to all at-risk patients on the contractor's patients list.

   b. that for the purposes of the Scheme at-risk patients will be defined by the NHS CB but might expect to include:
      - patients aged 60 and over with CVD, stroke, peripheral vascular disease and diabetes;
      - patients with learning disabilities;
      - patients with long term neurological conditions (such as Parkinson's disease);
      - all other patients aged 75 and over.

   c. that the initial assessment offered to at-risk patients shall comprise:

      i. initial questioning to establish whether there are any concerns about memory;

      ii. administering (where the outcome of (i) prompts) a more specific test to detect for any early signs of dementia, for example 'GPCog' (The General Practitioner assessment of Cognition).

   d. that the assessment is to be carried out by suitably trained and experienced healthcare professionals;

   e. that if as a consequence of the assessment the patient is suspected as having dementia the contractor shall:

      i. offer to refer to specialist services such as a Memory Assessment Service or Memory Clinic for a further assessment

and diagnosis of dementia and its cause;

ii. respond to any other identified needs arising from the assessment that relate to the patient's symptoms;

iii. provide any treatment that relates to the patient's symptoms of memory loss which may be required under the contractor's primary medical services contract;

iv. be cognisant of the needs of the carers of a person with dementia identified in this way and provide any advice or support needed.

f. that the contractor will record in the patient record relevant entries including nationally advised Read Codes to indicate that the assessment was undertaken and where applicable that a referral was made;

g. that the contractor agreeing to this scheme will have completed all activities required under the scheme within two years of taking up the scheme;

h. include clear monitoring and payment arrangements for the contractor agreeing and meeting its obligations under the plan.

[ENDS]

ENHANCED SERVICE FOR A REMOTE CARE MONITORING SCHEME

Aim of scheme to be established under Directions

1. A Remote Care Monitoring Scheme, the underlying purpose of which is to put in place remote care monitoring arrangements for patients with long-term conditions.

Possible requirements for the NHS CB to consider

2. Directions would not include any minimum requirements for plans entered into between the NHS CB and primary medical care contractors.

3. However the Department would expect the minimum terms of such schemes to include specifications similar to the following:

   a. that the contractor agrees to put in place remote care monitoring arrangements to support the treatment and care for patients diagnosed with the long term conditions prescribed. Where available, the remote care monitoring arrangements can be supported by services procured by a clinical commissioning group (or a commissioning support service acting on behalf of a CCG);

   b. that for the purposes of this Scheme the prescribed long term conditions are:

      i. for plans in place in 2013/14 patients diagnosed with hypothyroidism;

      ii. for plans in place in 2014/15 patients diagnosed with hypothyroidism plus one additional condition agreed locally as a priority area.

   c. that the contractor proactively offers and (where accepted) provides remote care monitoring arrangements to all patients on the contractor's list diagnosed with the prescribed long term conditions;

   d. that the contractor supports patients signed up to remote care monitoring schemes by providing the necessary information and tuition to support successful participation;

   e. that the contractor's remote care monitoring arrangements will include as a minimum:

      i. for plans in place in 2013/14 to:

         1. provide the required test results at such frequencies relevant to the patient's condition, provided in a manner agreed with the patient other than by face to face consultation;

2. monitor and discuss those test results in a manner agreed with the patient other than by face to face consultation, which may include provision of test results by correspondence where no further action or treatment is required;

3. identify the local priority area for 2014/15 and the test results required for the purposes of managing that local priority area, including how they are to be monitored by the contractor in a manner agreed with the patient other than by face to face consultation.

ii. for plans in place in 2014/15 to:

1. implement the requirements set out in the contractor's plans at 2(e)(i).

f. that the contractor records in the patient record whether the offer of remote care monitoring arrangements was accepted using the nationally prescribed Read Code and updates the patient record as appropriate to their ongoing management under those arrangements;

g. include clear monitoring and payments arrangements for the contractor agreeing and meeting its obligations under the plan.

[ENDS]

ENHANCED SERVICE FOR IMPROVING ONLINE PATIENT ACCESS TO PRIMARY MEDICAL SERVICES

Aim of scheme to be established under Directions

1. An Improving Online Patient Access Scheme, defining the underlying purpose of which is to encourage primary medical care contractors to enable prescribed online functionality for their registered patients and undertaking a proactive approach to promoting its usage by registered patients

Possible requirements for the NHS CB to consider

2. The DES Directions would not include the minimum requirements for plans entered into between the NHS CB and primary medical care contractors.

3. However the Department would expect the minimum terms of such schemes to include specifications similar to the following:

    a. that the contractor puts in place arrangements necessary to support the prescribed online access for its registered population;

    b. that for the purposes of this DES the prescribed online functionality includes:

        a. in the first year of the DES:

            i. online booking of appointments with a general medical practitioner;
            ii. online ordering of repeat prescriptions; and
            iii. identifying and making available selected test results to patients online.

        b. in the second year of the DES:

            i. the prescribed online functionality at (b)(a),
            ii. identifying and making available further test results to patients online
            iii. secure electronic communication with the practice; and
            iv. online access to medical records.

    c. that the contractor proactively offers and (where accepted) provides online access to the prescribed services to patients on the contractor's list;

    d. that the contractor supports patients taking up the offer of online access to the prescribed services by providing the necessary information so that they can avail themselves of such services;

e. that the contractor for the purposes of online ordering of repeat prescriptions under (b)(b)(i) (ie from 2014/15) will utilise the Electronic Prescription Service by offering patients making such requests the opportunity for their prescription be issued electronically direct to a pharmacy of their choice;

f. include clear monitoring and payments arrangements for the contractor agreeing and meeting its obligations under the plan.

[ENDS]

ANNEX B

General Medical Services Statement of Financial Entitlements Directions 2013 – SEE SEPARATE ATTACHMENT

ANNEX C

The Primary Medical Services (Directed Enhanced Services) Directions 2013 – SEE SEPARATE ATTACHMENT