# 2020/21 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF)

Guidance for GMS contract 2020/21 in England

# Contents

# 1. Introduction

## 1.1 Background

The Quality and Outcomes Framework (QOF) is a voluntary scheme within the General Medical Services (GMS) contract. It aims to support contractors to deliver good quality care. Changes to QOF are agreed as part of wider changes to the GMS contract which are negotiated by NHS England and NHS Improvement and the British Medical Association's (BMA) General Practitioners Committee (GPC) England.

We have revised our approach to QOF for 2020/21 to reflect the impact of COVID-19 on general practice. As set out in our letter dated 9 July[1], we recognise that practices will need to reprioritise aspects of care not related to COVID-19 and have modified the QOF requirements for 2020/21 to support this and help release capacity in general practice to focus on COVID-19 recovery.

This guidance details the agreement reached with the GPC England in relation to QOF for the remainder of 2020/21 only and outlines the expectations of practices with regard to the approach to be taken, data recording requirements and payment.

Absent to national agreement to the contrary, QOF will be reintroduced fully from April 2021 and will include agreed changes set out in contract agreements[2].

## 1.2 Purpose of this document

This aim of this document is to provide additional guidance on the interpretation and verification of the QOF indicators for 2020/21 in England and any associated income protection. This will be detailed in the Statement of Financial Entitlements (SFE) which will be updated to reflect these revised requirements. The revised SFE will be available in autumn 2020 and will apply to all QOF achievement calculations and payments in 2020/21.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0569-Second-phase-of-General-Practice-response-to-COVID-19--update-to-GP-contracts-and-income-protection-a.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf

## 1.3 The impact of Covid-19 and supporting vulnerable patients and carers

COVID-19 has had a disproportionate impact upon some of our most vulnerable patients both directly due to the effects of the disease and indirectly due to the impact upon service delivery and economic impact. The revised approach to QOF in 2020/21 aims to release capacity within general practice to focus efforts upon the identification and prioritisation of people at risk of poor health and those who experience health inequalities for proactive review including:

- Those most vulnerable to harm from COVID-19; evidence suggests that this includes patients from BAME groups and those from the 20% most deprived neighbourhoods nationally (LSOAs)
- Those at risk of harm from poorly controlled long-term condition parameters; and,
- Those with a history of missing annual reviews.

The changes also aim to support practices to restore vital care delivery in areas such as screening, implementation of early cancer diagnosis referral guidance and care for patients with a learning disability, with a specific focus upon proactive health checks and seasonal influenza vaccination.

This support to vulnerable patients also requires a greater sensitivity to risk factors for complications of COVID-19 such as age, gender, ethnicity and disability, long-term conditions and modifiable risk factors such as weight. Many of these patients will also be eligible for vaccination against seasonal influenza and again the revised QOF requirements detailed below seek to recognise both the challenges involved with the delivery of the annual flu programme in the current operating climate and the increasing importance of maximising vaccination opportunities.

The Public Health England (PHE) report Beyond the data: Understanding the impact of COVID-19 on BAME groups[3] highlighted an increased risk of death from COVID-19 for people from Black, Asian and Minority Ethnic (BAME) groups. Stakeholder engagement concluded that for many BAME groups a “lack of trust in NHS services and health care treatment resulted in their reluctance to seek care on a timely basis, and late presentation with disease”. Practices should ensure that particular care and attention is taken to ensure that people are provided with care and reassurance to ensure they feel able to seek care in a timely manner in a way that feels comfortable and safe for them to do so. For example, some people may prefer to access their GP via a virtual consultation or face to face and

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

practices should seek to accommodate this as clinically appropriate and culturally competent engagement.

As stated in the GP SOP[4] published 10 August 2020, practices should ensure that patients have clear information about the new ways of working and how to access GP services; this information should be made available in accessible formats to all patients, including those who do not have digital access, and those who have English as a second language.

The GP SOP also states that practices should continue to register new patients, including those with no fixed address, asylum seekers and refugees.

## 1.4 Summary of Changes for 2020/21

In order to support the ongoing response to COVID-19 and the need to proactively target and support our most vulnerable patients during this period we have agreed the following changes for 2020/21:

- Some indicators will continue to be paid on the basis of practice performance. These are:
  - The four flu indicators targeted on patients with coronary heart disease, COPD, stroke/TIA and diabetes – these indicators will have the number of points attached to them doubled;
  - The two cervical screening indicators, which will also have the number of points attached to them doubled.
  - Register indicators and eight indicators related to optimal prescribing of medications to manage long-term conditions.
- The requirements of the Quality Improvement (QI) domain have been amended to focus upon care delivery and restoration of services using QI tools;
- The remaining 310 points will be subject to income protection based upon historical practice performance and subject to practices agreeing an approach to QOF population stratification with their commissioner.

The total points available to practices will remain at 567 points and all payments will be subject to prevalence and list size adjustments.

Further detail of these indicators and their requirements are detailed in the remainder of this guidance.

[4] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/CO485_guidance-and-standard-operating-procedures-general-practice-covid-19.pdf

## 1.5 Queries

Queries regarding the QOF 2020/21 guidance should be sent to england.gpcontracts@nhs.net.

# 2. Summary of all indicators

## 2.1 Indicators to be retained on a conditional basis

A total of 183 of the total 567 QOF points available in 2020/21 will be paid based upon recorded practice performance.

### 2.1.1 Flu vaccination and cervical screening

The points allocated to flu vaccination and cervical screening are doubled in 2020/21 as detailed in Table 1. This has been achieved by reallocating 29 points from other clinical indicators as described in Section 3. This is to highlight the critical importance of restoring these services and the renewed focus upon flu vaccination as part of NHS England and NHS Improvement's recovery plans. Practices are reminded that as part of the Impact and Investment Fund (IIF) for 2020/21, Primary Care Networks (PCNs) will receive additional funding for achievement at a network level between 70% and 77% for flu vaccinations provided to patients aged 65 and over.

The payment formula has also been amended so that instead of points accrual running on a linear scale from 0 points to maximum points between the lower and upper payment threshold, practices will accrue a greater number of points once they achieve the lower payment threshold as detailed in Table 1. This will have the effect of paying practices a higher amount as they reach the lower threshold with the remaining points being achieved in a linear manner between the upper and lower threshold.

Reporting and verification requirements remain unchanged from the 2019/20 QOF guidance[5].

[5] https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

**Table 1**: **Changes to flu vaccination and cervical screening indicators**

| Indicator ID | Indicator | Points allocation 2020/21 | Payment thresholds | Points accrued at lower performance threshold |
|---|---|---|---|---|
| CS005 | The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months | 14 | 45-80% | 3 |
| CS006 | The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months | 8 | 45-80% | 1 |
| COPD007 | The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March | 12 | 57-97% | 3 |
| DM018 | The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March | 6 | 55-95% | 2 |
| STIA009 | The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March | 4 | 55-95% | 1 |
| CHD007 | The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March | 14 | 56-96% | 3 |
| | **Total** | **58** | | |

## 2.1.2 Register maintenance

Accurate and timely diagnosis is a pre-requisite to effective long-term condition management and newly diagnosed patients often require more support from their practice team as they develop self-care skills regarding their diagnosis.

Given the reduced attendance rates in general practice during the peak of COVID-19 activity and the known backlog of symptoms which patients have yet to present to their GP, there may be a proportion of patients who will be given a new diagnosis of a long-term condition. We recognise that in some areas access to diagnostic services may have been disrupted. Where this has occurred, practices are advised to use their clinical judgement in the management of these patients and the point at which they are added to QOF registers.

Practices must maintain accurate disease registers in QOF for 2020/21. The disease registers to be maintained are outlined in Table 2.

The payment of these points is conditional on practices continuing to accurately maintain these registers and for disease prevalence to remain comparable with 2019/20 levels subject to reasonable assessments of the impact of excess COVID-19 related mortality upon practice list size, patient demographics and access to diagnostic services. Verification of this by commissioners will be on an exception basis and it is not expected that this activity will be undertaken for all practices.

**Table 2: Disease register indicators**

| Indicator ID | Indicator | Points |
|---|---|---|
| AF001 | The contractor establishes and maintains a register of patients with atrial fibrillation | 5 |
| CHD001 | The contractor establishes and maintains a register of patients with coronary heart disease | 4 |
| HF001 | The contractor establishes and maintains a register of patients with heart failure | 4 |
| HYP001 | The contractor establishes and maintains a register of patients with established hypertension | 6 |
| PAD001 | The contractor establishes and maintains a register of patients with peripheral arterial disease | 2 |
| STIA001 | The contractor establishes and maintains a register of patients with stroke or TIA | 2 |
| DM017 | The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed | 6 |
| AST005 | The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months | 4 |
| COPD009 | The contractor establishes and maintains a register of:<br>1. Patients with a clinical diagnosis of COPD before 1 April 2020 and<br>2. Patients with a clinical diagnosis of COPD on or after 1 April 2020 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC | 8 |

| | | |
|---|---|---|
| | ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an $FEV_1$/FVC ratio below 0.7 recorded within 6 months of registration); and<br>3. Patients with a clinical diagnosis of COPD on or after 1 April 2020 who are unable to undertake spirometry | |
| DEM001 | The contractor establishes and maintains a register of patients diagnosed with dementia | 5 |
| MH001 | The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy | 4 |
| CAN001 | The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003' | 5 |
| CKD005 | The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5) | 6 |
| EP001 | The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy | 1 |
| LD004 | The contractor establishes and maintains a register of patients with learning disabilities | 4 |
| OST004 | The contractor establishes and maintains a register of patients:<br>1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and<br>2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis | 3 |
| RA001 | The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis | 1 |
| PC001 | The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age | 3 |
| OB002 | The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months | 8 |
| | **Total** | **81** |

### 2.1.3 Prescribing indicators

Payment against the eight indicators listed in Table 3 will be conditional on recorded practice performance given the importance of appropriate pharmacological management to patient outcomes. Reporting and verification requirements remain unchanged from the 2019/20 QOF

guidance[6], unless the indicators are new for this year (HF006) where full clinical guidance is given in Section 4.

**Table 3: Prescribing named medications**

| Indicator ID | Indicator wording | Points | Payment thresholds |
|---|---|---|---|
| AF007 | In those patients with atrial fibrillation with a record of a $CHA_2DS_2$-$VAS_c$ score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy | 12 | 40-70% |
| CHD005 | The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken | 7 | 56-96% |
| HF003 | In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB | 6 | 60-92% |
| HF006 | The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure | 6 | 60-92% |
| STIA007 | The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken | 4 | 57-97% |
| DM006 | The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) | 3 | 57-97% |
| DM022 | The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) | 4 | 50-90% |
| DM023 | The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin | 2 | 50-90% |
| | **Total** | **44** | |

## 2.2 Revised Quality Improvement Domain requirements

The Quality Improvement (QI) Domain requirements for 2020/21 have been amended to support practices to focus on actions to help with the restoration of care delivery in relation to

[6] https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

the previously announced topic areas of early cancer diagnosis and care of people with a learning disability.

The third phase of NHS response to COVID-19 letter[7] dated 31 July 2020 outlined the importance of accelerating the return of non-Covid health services and stated the need to restore full operation of all cancer services. The deaths from COVID-19 reviewed as part of the LeDeR programme report[8] concluded that people with learning disabilities and epilepsy are likely to be at increased risk of death from COVID-19 and called for attention to be paid to protecting these patients.

These revised requirements are not intended to replace QI activity that has already begun in response to the original 2020/21 QI guidance[9] we published earlier in the year. Instead it aims to support practices who need to revise their approach to this domain in-year in response to the pandemic by providing a set of national actions which practices should undertake.

Practices should use QI tools and principles to develop and monitor the impact of their approach to implementing these national actions, including the involvement of patients, carers and communities, where appropriate. For example, practices should set improvement targets and monitor their performance to ensure that progress is being made. The completion of the national actions can be supported by the sharing of best practice across the PCN. PCNs may wish to integrate their quality improvement discussions into regular PCN meetings, rather than holding dedicated meetings for each of the QI topics. We are working with the Royal College of General Practice (RCGP) to provide further guidance to practices on ways to approach delivery of the key actions.

Reporting templates for the QI Domain can be found in Section 6.

### 2.2.1 Early Cancer Diagnosis

| Indicator | Points | Achievement thresholds |
|---|---|---|
| QIECD005. The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance. | 27 | NA |

[7] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf
[8] http://www.bristol.ac.uk/media-library/sites/sps/leder/Summary%20of%20findings%2050%20LeDeR%20reveiws%20of%20deaths%20related%20to%20COVID19.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

| | | |
|---|---|---|
| QIECD006. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings | 10 | NA |

The national quality improvement actions for early cancer diagnosis are focused upon restoration of delivery of screening services with a focus on cervical screening and ensuring patients who require urgent referral are identified, supported and managed in line with NICE guidance[10]. All the specific actions below require an understanding of the inequalities within the practice and network population for whom there may have been a disproportionate drop in activity. Further guidance on place based approaches for reducing health inequalities[11] can be found on the NHS England and NHS Improvement website. Specifically, practices should:

1. continue to focus **on restoring the cervical screening programme** among their registered population, and ensure appointments are offered to women who are eligible and due to be screened. Practices should actively identify women who have had their cervical screening appointment delayed or cancelled due to COVID-19 and ensure that they are offered an appointment. NHS England and NHS Improvement have produced guidance on prioritisation of patients for screening[12]. This may be via a review of local records or final non-responder lists. Practices are encouraged to continue with innovative service developments implemented as part of the pandemic response that have supported improved equitable access;
2. proactively engage with patients, families and carers to **build confidence in primary care** and take action to offer reassurance that general practice and other healthcare settings (including screening) can be accessed safely. Practices are encouraged to address inequalities and to focus on those groups who may experience barriers to accessing services and in which there might be a disproportionate drop in activity. Practices could send a text message or a letter, in various inclusive formats – easy read, plain English and translations to all patients to provide reassurance about accessing general practice. Practices may want to work with local partners to include targeted and culturally competent messages in community newsletters and local media. The key aim of this action is to ensure that all patients receive a consistent message that general practice is open and available to support them. Practices may wish to implement this at a PCN level and could work with local people, community and

[10] https://www.nice.org.uk/guidance/ng12
[11] https://www.england.nhs.uk/ltphimenu/placed-based-approaches-to-reducing-health-inequalities/place-based-approaches-for-reducing-health-inequalities/
[12] https://71633548c5390f9d8a76-11ea5efadf29c8f7bdcc6a216b02560a.ssl.cf3.rackcdn.com/content/uploads/2020/05/140520-NHS-CSP-Restoration-Guidance-v1.0.pdf

faith-based organisations and networks to help understand how best to engage with the diverse needs of their local population;

3. monitor their suspected cancer referral rates and assess if these are returning to their previous levels seen before COVID-19. It is understood that some aspects of the referral pathway will be outside of the control of the practice, however practices are encouraged to reflect and identify where they could improve on:
    a. the **quality of referrals**, including how far implementation aligns with guidance[13], and seeking to support a return to pre-pandemic levels of referral rates;
    b. **awareness of referral and testing pathways**, including the impact of any pathway changes implemented as part of the pandemic response;
4. ensure they have a robust and consistent **system in place for safety netting[14]** supported by high-quality, appropriate and responsive communication and patient information, for patients who:
    a. have been placed on an urgent referral pathway for suspected cancer, **including proactive follow-up of those who do not attend any appointments**;
    b. have not been referred due to the level of risk and or/patient concern;
    c. have been referred on an urgent referral pathway but have been downgraded with the consent of the primary care professional.

This should include practices understanding the status of patients who are/have been safety netted during the pandemic period, and if further action may be required.

Cancer Research UK (CRUK) have provided further information on safety netting[15]. Practices should consider using learning event analysis (LEA) to support actions 3 and 4 and share learning via practice and PCN meetings. Practices may wish to focus LEA activity on areas that have been significantly impacted by the pandemic, for example lung and colorectal referral pathways.

[13] https://www.nice.org.uk/guidance/ng12
[14] Cancer Research UK explain safety netting as a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.
[15] https://www.cancerresearchuk.org/sites/default/files/safety_netting_guide_for_gps_and_practices_11.06.20.pdf

There are a number of national and local resources available to support practices with the implementation of the national actions, including resources provided by Macmillan[16] and information available from local Cancer Alliances[17] to support referrals.

### 2.2.2 Care of people with Learning Disabilities

| Indicator | Points | Achievement thresholds |
|---|---|---|
| QILD007. The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance | 27 | NA |
| QILD008. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings | 10 | NA |

The national quality improvement actions for care of people with learning disabilities are focused upon the restoration of proactive annual health checks and ensuring that seasonal flu vaccination is maximised in this group of people in order to optimise their health and to reduce preventable morbidity and mortality. Specifically, practices should:

1. **review and update their current registers of people with a learning disability** to ensure accuracy. It is crucial that all eligible people are included on the register. The 2019 Learning Disabilities Mortality Review[18] concluded that people from BAME communities are disproportionately likely to have profound and multiple learning disabilities and to die in childhood or early adulthood but there is evidence to suggest that they are under-represented on learning disability registers[19] in general practice. Practices should review if the number of people with learning disabilities from BAME communities is reflective of their local population. Further detail on identifying patients and coding can be found in the NHS England and NHS Improvement Improving identification of people with a learning disability: guidance for general practice guidance[20].
2. develop and implement a plan to restore full operation of **annual health checks for people with a learning disability**. We recognise that some practices may have a

[16] https://www.macmillan.org.uk/coronavirus/healthcare-professionals
[17] https://www.england.nhs.uk/coronavirus/publication/letter-cancer-alliance-information-on-managing-cancer-referrals/
[18] http://www.bristol.ac.uk/media-library/sites/sps/leder/LeDeR_2019_annual_report_FINAL.pdf
[19] https://doi.org/10.1111/jar.12630
[20] https://www.england.nhs.uk/publication/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice/

backlog of reviews and checks to undertake. Practices should use their clinical judgement to prioritise people for review. Virtual health checks may be clinically appropriate, but this should be determined on a patient by patient basis. Based upon current evidence of risk from COVID-19, practices are encouraged to prioritise people who have one or more long-term conditions for an annual health check. As part of the health check, practices should discuss and review any existing Do Not Attempt Cardiopulmonary Resuscitation (DNACR) decisions with the individual or their family to confirm that they understand why this may be appropriate and to confirm whether the DNACR continues to be clinically indicated (the fact that a patient has a learning disability or is autistic should never be the rationale for such a recommendation). Practices should also link in medicines optimisation strategies (e.g. STAMP) where possible. NHS England and NHS Improvement have provided further information on annual health checks[21] on their website.

3. **develop and implement a plan to improve their delivery of flu vaccinations to people with a learning disability for 2020/21**. Practices should review the register and note any requirement for reasonable adjustments. An update to the national flu immunisation programme[22] 2020/21was published on 5 August 2020.

4. record **the need for, and the type of reasonable adjustments** required and evidence that these are being implemented in practice as set out in the Equality Act request[23]. Practices should record the preferred means of communication as required by the Accessible Information Standard[24]. Practices should assess and record if a patient is able to take part in a virtual consultation, what support maybe required, or whether face to face appointments are required (where safe to do so). Practices should also request consent to share information on the patient's summary care records.

5. **review all Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and confirm that they were determined appropriately and continue to be clinically indicated.** It would be reasonable for a clinician to consider, on review, whether a DNACPR may be appropriate, if the patient has significant co-morbidities such that they may not benefit from CPR in any event. Professor Stephen Powis, National Medical Director for NHS England and NHS Improvement, wrote to the NHS system in May 2019[25] reminding staff that learning disabilities should never be used as a cause of death or rationale for a DNACPR recommendation. Guidance from the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing[26] underlines the importance of ensuring high-quality communication, decision

[21] https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/
[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907149/Letter_annualflu_2020_to_2021_update.pdf?UNLID=49567531202081610213
[23] https://www.gov.uk/guidance/equality-act-2010-guidance
[24] https://www.england.nhs.uk/ourwork/accessibleinfo/
[25] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/maintaining-standards-quality-of-care-pressurised-circumstances-7-april-2020.pdf
[26] https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

making and recording in relation to decisions about CPR as an integral part of emergency care planning. **This action should be completed by all practices even if they have already commenced wider QI work.**

Practices are encouraged to consider how people with a learning disability can be supported through their PCN, for example through working with a social prescriber.

NHS England and NHS Improvement have produced a template invitation letter[27] which has been developed with people with lived experience, which can be adapted to help explain to people with a learning disability and their family and carers that the way health checks are carried out may have changed. The RCGP have produced a toolkit Health checks for people with learning disabilities[28] to support practices with completing their annual health checks and the learning disability services in Hertfordshire have created a pathway to completing annual heath checks[29] during the coronavirus pandemic.

Mencap[30] also provide further resources for patients with regards to joining the learning disability register.

Practices may have a local self-advocacy group for people with learning disabilities. They can often help with testing how accessible services are and provide advice and support to improve.

## 2.3 Income protected indicators

Practices will be offered income protection for the remaining 310 points, subject to the delivery of revised and simplified requirements focused upon care delivery to those patients at greatest risk of harm from COVID-19, uncontrolled long term condition parameters and those with a history of missing reviews – with practices being credited with points on the basis of historical achievement. The affected indicators are listed in Table 6. Performance against these indicators will be monitored through CQRS but will not be used for payment purposes. Detailed clinical guidance for those indicators which are new for 2020/21 are included in Section 4.

Where indicator requirements are unchanged from 2019/20 practices should refer to the previously published guidance for details of these. The 2019/20 QOF guidance[31] can be found on the NHS England and NHS Improvement website.

[27] https://www.england.nhs.uk/wp-content/uploads/2020/06/Letter-what-to-expect-from-your-doctor.pdf
[28] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx
[29] https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/learning-difficulties-and-dementia/coronavirus/gp-pathway-for-ahcs-in-covid-v4.docx
[30] https://www.mencap.org.uk/advice-and-support/health/dont-miss-out
[31] https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

We recognise that there may have been changes in access to some diagnostic and specialist services as a result of COVID-19 activities which may mean that this care is not delivered within the usual timescales. Practices should continue to apply their clinical judgement to the appropriate management of affected patients.

**Table 6**: **Income protected indicators**

| Indicator ID | Indicator | Payment thresholds |
|---|---|---|
| AF006 | The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the $CHA_2DS_2$-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous $CHADS_2$ or $CHA_2DS_2$-$VAS_c$ score of 2 or more) | 40-90% |
| CHD008 | The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less | 40-77% |
| CHD009 | The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 46-86% |
| HF005 | The percentage of patients with a diagnosis of heart failure on or after 1 April 2020 which:<br>1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or<br>2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration. | 50-90% |
| HF007 | The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses | 50-90% |
| HYP003 | The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less | 40-77% |
| HYP007 | The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 40-80% |
| STIA010 | The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less | 40-73% |
| STIA011 | The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 46-86% |
| DM012 | The percentage of patients with diabetes, on the register, 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 12 months | 50-90% |

| | | |
|---|---|---|
| DM014 | The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register | 40-90% |
| DM019 | The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less | 38-78% |
| DM020 | The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months | 35-75% |
| DM021 | The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months | 52-92% |
| AST006 | The percentage of patients with asthma on the register from 1 April 2020 with either:<br>1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or<br>2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2020 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration. | 45-80% |
| AST007 | The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan | 45-70% |
| AST008 | The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months | 45-80% |
| COPD010 | The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale | 50-90% |
| COPD008 | The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) | 40-90% |
| DEM004 | The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months | 35-70% |
| DEP003 | The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis | 45-80% |
| MH002 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented | 40-90% |

| | | |
|---|---|---|
| | in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate | |
| MH003 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months | 50-90% |
| MH006 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months | 50-90% |
| CAN003 | The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis | 50-90% |
| RA002 | The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months | 40-90% |
| NDH001 | The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months | 50-90% |
| BP002 | The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years | 50-90% |
| 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 12 months | 50-90% |
| SMOK004 | The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months | 40-90% |
| 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 are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months | 56-96% |

# 3. Income Protection Payments

## 3.1 Conditions of Income Protection

To be eligible for income protection practices will need to:

- Agree a plan for QOF population stratification with their commissioner during October and November 2020. This approach should include the identification and prioritisation of the highest risk patients for proactive review including:
    a. Those most vulnerable to harm from COVID-19; evidence suggests that this includes patients from BAME groups and those from the 20% most deprived neighbourhoods nationally (LSOAs)
    b. those at risk of harm from poorly controlled long-term condition parameters;
    c. those with a history of missing reviews.
- Commit to making referrals to existing and any new weight management programmes and support offers commissioned during the year where this is identified as a key health and wellbeing intervention in these discussions.

Practices will be asked to confirm their approach to population stratification via the General Practice Annual electronic declaration (eDEC) which will be published during October and November 2020.

To note, alerts should be kept active, including for indicators that are income protected. This will help to ensure that practices are able to provide and record opportunistic care, where appropriate to do so including any personalised care adjustments.

NHS England and NHS Improvement will continue to collect achievement data on all indicators including those which are income protected.

NHS England and NHS Improvement are finalising the details of income protection arrangements with GPC England and further guidance will be published soon.

## 3.2 Aspiration payments in 2021/22

Payment against the indicators running on a conditional basis and those subject to income protection will be summed and aspiration payments will be calculated in the usual way using total 2020/21 QOF earnings.

# 4. Detailed clinical guidance for new indicators

(Details of the existing indicators can be found in the 2019/20 QOF guidance[32].)

## 4.1 Heart failure

**HF indicator 005 (based on NM171)**
The percentage of patients with a diagnosis of heart failure on or after 1 April 2020 which:

1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or

2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.

**HF 005.1 Rationale**

The aim of this indicator is to encourage practices to confirm diagnoses of heart failure and establish the underlying causes.

Symptoms and signs suggestive of heart failure are not always sufficient to make a definitive diagnosis and further investigation is usually required to confirm cardiac dysfunction and to identify causes. The NICE guideline for chronic heart failure recommends that the results of serum natriuretic peptides tests should be used to determine whether people with suspected heart failure should be referred onwards. People with raised serum natriuretic peptides should have echocardiography and specialist assessment within 6 weeks, but for those with very high levels this should be done more urgently, within 2 weeks. The NICE guideline for acute heart failure recommends that people with new suspected acute heart failure who have raised natriuretic peptides should have echocardiography within 48 hours of admission to hospital.

**HF 005.2 Reporting and verification**
See indicator wording for requirement criteria. For measurement purposes, three months before the date of diagnosis is defined as 93 days.

**HF indicator 006 (NICE 2019 menu ID: NM173)**
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure.

[32] https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf

**HF 006.1 Rationale**
The NICE guideline for chronic heart failure[33] recommends that beta-blockers licensed for HF are used as first-line therapy in all patients with HF due to LVSD usually defined as heart failure with reduced ejection fraction[34]. It also recommends that treatment with beta-blockers is not withheld solely because of age or the presence of peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials). The British National Formulary (BNF) states that "the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy"[35].

Contractors are advised that patients already prescribed an unlicensed beta-blocker prior to diagnosis of HF due to LVSD do not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded from the indicator denominator.

**HF 006.2 Reporting and verification**
See indicator wording for requirement criteria.
Patients prescribed a beta-blocker unlicensed for heart failure before being given a diagnosis of heart failure will be excluded from this indicator.

**HF indicator 007 (based on NM174)**
The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses.

**HF 007.1 Rationale**
Regular review is associated with improvement in quality of life and a reduction in the need for urgent hospitalisation. NICE guideline NG106 recommends short monitoring intervals if the clinical condition or medication has changed and longer intervals for stable people with heart failure.

**HF 007.2 Reporting and verification**
See indicator wording for requirement criteria.

## 4.2 Asthma

**AST indicator 005 (based on NM165)**

[33] NICE NG106. Chronic heart failure.2018. https://www.nice.org.uk/guidance/ng106
[34] https://www.nice.org.uk/guidance/ng106/chapter/recommendations#heart-failure-with-reduced-ejection-fraction
[35] BNF. http://www.evidence.nhs.uk/formulary/bnf/current

The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months.

**AST 005.1 Rationale**
The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most patients, the diagnosis can be corroborated by suggestive changes in lung function tests.

One of the main difficulties in asthma is the variable and intermittent nature of asthma. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow limitation and reversibility.

Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second ($FEV_1$) but which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma is in doubt.

A proportion of patients with COPD will also have asthma e.g. they have large reversibility – 400 mls or more on $FEV_1$ – but do not return to over 80 per cent predicted and have a significant smoking history. These patients will be recorded on both the asthma and COPD registers.

**Children**
A definitive diagnosis of asthma can be difficult to obtain in young children. Asthma is to be suspected in any child with wheezing, ideally heard by a health professional on auscultation and distinguished from upper airway noises.

In school children, bronchodilator responsiveness, PEF variability or tests of bronchial hyperactivity may be used to confirm the diagnosis, with the same reservations as above.

Focus the initial assessment in children suspected of having asthma on the:

- presence of key features in the history and examination
- careful consideration of alternative diagnoses.

It is well recognised that asthma is a variable condition and many patients will have periods when they have minimal symptoms. It is inappropriate to attempt to monitor symptom-free patients on no therapy or very occasional therapy.

This produces a significant challenge for the QOF. It is important that resources in primary care are targeted to patients with the greatest need – in this instance, patients who will benefit from asthma review rather than insistence that all patients with a diagnostic label of asthma are reviewed on a regular basis.

It is for this reason that the asthma register is constructed annually by searching for patients with a history of asthma, excluding those who have had no prescription for asthma-related drugs in the preceding 12 months.

Further information - SIGN guideline 153. SIGN and BTS. British guideline on the management of asthma. 2016[36].

**AST 005.2 Reporting and verification**
See indicator wording for requirement criteria.

Part of the register criteria for asthma is based on appropriate prescribing of therapies. From October 2014, the Business Rules were updated to exclude drug therapies licensed only for use in patients with a diagnosis of COPD as they are not licensed as a treatment for asthma.

Patients with asthma whose sole asthma medication is one associated with COPD will no longer appear on the QOF asthma register. Patients receiving additional, appropriate asthma treatment such as short-acting bronchodilators or steroid inhalers will remain on the register. Practices may wish to review the records of any patients affected by this change to review their asthma treatment however, a change in prescribing should only be done where clinically appropriate.

**AST indicator 006 (based on NM166)**
The percentage of patients with asthma on the register from 1 April 2020 with either:

1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or

2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2020 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration.

**AST 006.1 Rationale**
The aim of this indicator is to encourage use of objective tests to confirm asthma diagnosis, and subsequently improve accuracy of diagnosis and reduce incidences of patients receiving inappropriate care. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing.

[36] http://www.sign.ac.uk/assets/sign153.pdf

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations[37]. It is crucial that diagnostic spirometry is performed to published quality standards[38],[39].

An adults (aged 17 and over) should be diagnosed, if they have symptoms suggestive of asthma and:

- a FeNO level of 40 parts per billion (ppb) or more with either positive bronchodilator reversibility or positive peak flow variability or bronchial hyperreactivity, or
- a FeNO level between 25 and 39 ppb and a positive bronchial challenge test, or
- a positive bronchodilator reversibility and positive peak flow variability irrespective of FeNO level.[40]

If an adult, young person or child with symptoms suggestive of asthma cannot perform a particular test, try to perform at least 2 other objective tests. Diagnose suspected asthma based on symptoms and any positive objective test results.

More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

**If another diagnosis is more likely**

If an alternative diagnosis is suspected, investigation and management are to follow guidelines for that condition.
Further information about the diagnosis of asthma is provided in the National Guideline Asthma: diagnosis, monitoring and chronic asthma management.[41]

**Co-morbidity: asthma and COPD**

A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility[42].

**AST 006.2 reporting and verification**

See indicator wording for requirement criteria. For measurement purposes, three months prior to diagnosis is defined as 93 days.

[37] BTS/SIGN clinical guideline 153. Management of Asthma http://www.sign.ac.uk/guidelines/fulltext/153/index.html
[38] Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes S, Small I. Diagnostic spirometry in primary care: Proposed standards for general practice compliant with ATS and Euro Respiratory Society recommendations: a General Practice Airways Group document in association with the Association for Respiratory Technology & Physiology and Education for Health. PCRJ. 2009; 18:130-47. http://dx.doi.org/10.4104/pcrj.2009.00054
[39] Association for respiratory technology and physiology. A guide to performing quality assured diagnostic spirometry. http://www.artp.org.uk/
[40] NICE national guidance NG80 Asthma: diagnosis, monitoring and chronic asthma management. 2017. http://www.nice.org.uk/guidance/ng80
[41] [41] NICE national guidance NG80 Asthma: diagnosis, monitoring and chronic asthma management. 2017. http://www.nice.org.uk/guidance/ng80
[42] NICE NG115. COPD in over 16s: diagnosis and management. 2018. http://guidance.nice.org.uk/NG115.

**AST indicator 007 (based on NM167)**
The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan.

**AST 007.1 Rationale**
This indicator aims to encourage the use of validated asthma questionnaires, recording of the number of exacerbations, and written action plans in annual asthma reviews. These reviews can help identify people at increased risk of poor outcomes and allow them to use information from their review to self-manage their asthma and maximise their future health.

The BTS/SIGN clinical guideline[43] proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

QOF explicitly requires an assessment of asthma control using a validated asthma control questionnaire using the Asthma Control Questionnaire[44] or Asthma Control Test[45], a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan.

If the asthma appears to be uncontrolled, take in account the possible reasons below before adjusting medicines:

- alternative diagnoses
- smoking (active or passive)
- poor inhaler technique
- lack of adherence
- occupation exposures
- psychosocial factors
- seasonal or environmental factors

For more information on asthma management and recommendations made to prevent deaths from asthma in the future, see the National Review of Asthma Deaths (NRAD) [46]

**AST 007.2 Reporting and verification**
See indicator wording for requirement criteria.
The Business Rules require that contractors code the review and the assessment of asthma control using the Asthma Control Questionnaire or the Asthma Control Test, the number of exacerbations and the provision of a written personalised asthma plan recorded on the same day in order to meet the requirements of this indicator.

[43] BTS/SIGN clinical guideline 153. Management of asthma. 2016. http://www.sign.ac.uk/guidelines/fulltext/141/index.html
[44] https://www.qoltech.co.uk/acq.html
[45] https://www.asthma.com/additional-resources/asthma-control-test.html
[46] https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths

**AST indicator 008 (based on NM168)**
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months.

**AST 008.1 Rationale**
There are very few studies that have considered the question of whether smoking affects asthma severity[47]. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control[48].

This indicator aims to encourage general practice to ask children and young people aged 6 to 19 years with asthma about their exposure to tobacco and second-hand smoke. Support can then be offered to patients and the people they live with to understand the risks of smoking and exposure to secondhand smoke for those with asthma, and how to access smoking cessation services.

**AST 008.2 Reporting and verification**
See indicator wording for requirement criteria.

## 4.3 Chronic Obstructive Pulmonary Disease (COPD)

**COPD indicator 009 (based on NM169)**
The contractor establishes and maintains a register of:

1. Patients with a clinical diagnosis of COPD before 1 April 2020 and;
2. Patients with a clinical diagnosis of COPD on or after 1 April 2020 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an $FEV_1$/FVC ratio below 0.7 recorded within 6 months of registration); and
3. Patients with a clinical diagnosis of COPD on or after 1 April 2020 who are unable to undertake spirometry.

**COPD 009.1 Rationale**
The aim of this indicator is to encourage practices to maintain a register of patients with a diagnosis of COPD and to use that register of patients to inform the care they deliver, including objective testing to support diagnosis of COPD as recommended in NICE guidance NG115: Chronic obstructive pulmonary disease in over 16s: diagnosis and management[49]. Linking diagnosis and objective testing to entry onto the QOF COPD disease register aims to contribute towards a reduction in both misdiagnosis and the risk of overtreatment in people with COPD.

[47] https://erj.ersjournals.com/content/41/3/716
[48] Price et al. ClinExp Allergy 2005; 35: 282-287
[49]NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018 updated 2019 https://www.nice.org.uk/guidance/ng115

**COPD 009.2 Reporting and verification**
See indicator wording for requirement criteria. Patients with clinical diagnoses of COPD and no record of objective tests will not be excluded from the register but the expectation is that, over time, the proportion of patients with spirometry in the diagnostic range will increase relative to those without spirometry recorded.

Where patients have co-existing COPD and asthma, they will be included on both disease registers. Approximately 15 per cent of patients with COPD will also have asthma.

**COPD indicator 0010 (NICE 2019 menu ID: NM170)**
The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale.

**COPD 0010.1 Rationale**
This indicator aims to encourage the use of recording of number of exacerbations and assessments of breathlessness in annual COPD reviews. Understanding the frequency of exacerbations can help when creating personalized management plans, identifying triggers and avoiding future exacerbations.

In making assessments of the patient's condition as part of an annual review and when considering management changes, it is essential that health care professionals record:

- number of exacerbations
- the degree of breathlessness (Medical Research Council [MRC] dyspnoea scale).

A tool such as the COPD Assessment Test (CAT) could be used to assess current health status.

Additionally, there is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. Where a patient is prescribed an inhaled therapy, their technique is to be assessed during any review.

The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available in the NICE guideline on COPD, section 1.1, diagnosing COPD table one.

**COPD 0010.2 Reporting and verification**
See indicator wording for requirement criteria.

## 4.4 Non-Diabetic Hyperglycaemia

**NDH indicator 001 (NICE 2017 menu ID: NM150)**
The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months

**NDH 001.1 Rationale**
NICE Guidance (PH38[50]) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes and indicators are available on the NICE menu to support this activity. Despite this there is wide variation in the monitoring of people with NDH.

The aim of this indicator is to promote early identification of when people cross the threshold into the Type 2 diabetes category, as it is associated with reduced CVD event rate and lower mortality in the individuals identified. Criteria for diagnosing diabetes are discussed in the diabetes section of this guidance.

**NDH 001.2 Reporting and verification**
See indicator wording for requirement criteria.

The register for the purpose of calculating the APDF is defined as all patients aged 18 or over with a record of non-diabetic hyperglycaemia or pre-diabetes, which has not been superseded by a diagnosis of diabetes recorded prior to the beginning of the financial year.

[50] NICE guidance PH38: Type 2 diabetes: prevention in people at high risk
http://www.nice.org.uk/guidance/ph38

# 5. Indicators no longer in QOF (INLIQ)

There are no changes to the INLIQ extraction from 1 April 2020. The indicators included in INLIQ in 2020/21 are detailed below.

| Indicator ID | Indicator description |
|---|---|
| CHD003 | The percentage of patients with coronary heart disease whose last measured cholesterol (measured in the preceding 12 months) is 5 mmol/l or less |
| CKD002 | The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less |
| 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 12 months |
| NM84 | The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists |
| CVD-PP002 | The percentage of patients diagnosed with hypertension (diagnosed after or on 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet |
| DM005 | The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months |
| DM011 | The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months |
| EP002 | The percentage of patients 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months |
| EP003 | The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months |
| LD002 | The percentage of patients on the learning disability register with Down's syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months |
| MH004 | The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months |

| | |
|---|---|
| MH005 | The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months |
| MH007 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months |
| MH008 | The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. |
| PAD002 | The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less. |
| PAD003 | The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) I 5 mmol/l or less |
| PAD004 | The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken. |
| RA003 | The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months |
| RA004 | The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment toll adjusted for RA in the preceding 24 months |
| SMOK001 | The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months |
| STIA005 | The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less |
| THY001 | The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine |
| THY002 | The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months |

# 6. Quality Improvement Reporting Templates

## 6.1 Early Cancer Diagnosis

It is anticipated that the responses noted here should total 1 A4 sides in Arial font size 11.

| **Practice name and ODS code** |
|---|
| |
| What issues did the practice identify with the quality of referrals for early cancer diagnosis? |
| |
| What actions did the practice take to build confidence in primary care and to reassure patients that general practice can be accessed safely? |
| |
| What action did the practice take to support restoration of the cervical screening programme? |
| |
| What changes did the practice make to their system for safety netting? |
| |
| How many patients who had not attended any appointments were proactively followed up? |
| |
| What changes will/ have been embedded into practice systems to ensure early cancer diagnosis in the future? |
| |
| If applicable, how did the network peer support meetings and patient participation group influence the practice's QI plans and understanding of early cancer diagnosis? |
| |

## 6.2 Care of People with Learning Disabilities

It is anticipated that the responses noted here should total 1 A4 sides in Arial font size 11.

| **Practice name and ODS code** |
| --- |
| |
| What actions did the practice take to ensure that the register is accurate and that BAME patients are accurately represented? |
| |
| What actions did the practice take to support restoration of annual health checks for patients with a learning disability? |
| |
| How many flu vaccinations were provided at practice level to people with a learning disability in 2019/20? How many flu vaccinations have been provided for 2020/21? |
| |
| What percentage of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) have been reviewed to ensure that they were determined appropriately and continue to be clinically indicated? |
| |
| What changes will/ have been embedded into practice systems to ensure improved care of people with learning disabilities in the future? |
| |
| If applicable, how did the network peer support meetings or patient participation groups influence the practice's QI plans and understanding of the care of people with learning disabilities? |
| |

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This publication can be made available in a number of other formats on request.


Publication approval reference: