# GP Contract 2021/22
# Changes to QOF

**Date: 21.4.2020**

Please note, this guide only addressed those areas which have been changed. All other QOF indicators remain as per 2020/21.

## QOF point

- Value of a QOF point increased from £194.83 to £201.16.
- Average population per QOF point increased from 8,799 to 9,085.
- Value of a QOF point per 1,000 patients is static £22.14 (201.16/9.085).

## Asthma

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| 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.<br>• The Business Rules allow contractors to code the number of exacerbations and the assessment of asthma control using the Asthma Control Questionnaire or the Asthma Control Test up to one month before the asthma review is completed.<br>• The provision of a written personalised asthma plan should be recorded on the same day as the asthma review in order to meet the requirements of this indicator. | (based on NM167) | (20) |

## Mental health (MH) Indicator

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| MH001 | The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. | (based on NM167) | (4) |
| MH002 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate, including:<br>• Patient's current health status and social care needs including how needs are to be met, by whom and the patient's expectations.<br>• How socially supported the individual is: eg friendships/family contacts/voluntary sector organisation involvement. | (NICE 2015 menu ID: NM108) | (6) |

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| MH002 (Cont.) | • Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received.<br>• Occupational status – for people being supported by secondary mental health services in England, there is a 65% employment gap compared with the general population. Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work.<br>• 'Early warning signs' from the patient's perspective that may indicate a possible relapse. Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.<br>• The patient's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and wishes around medication. | | |
| 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. | (based on NM17) | (4) |
| MH006 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months. | (based on NM16) | (4) |
| 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. | (based on NM15) | (4) |
| MH011 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White]) or preceding 24 months for all other patients. | (based on NM129) | (8) |
| MH012 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months. | (NICE 2015 menu ID: NM130) | (8) |

## Cancer (CAN)

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| 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) |
| CAN004 | The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis. | (NICE menu 2020 ID: NM205) | (6) |
| CAN005 | The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis. | (based on NM204) | (2) |

## Vaccination and immunisations (VI)

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| VI001 | The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months. | (NICE 2020 menu ID: NM197) | (18) |
| VI002 | The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months. | (NICE 2020 menu ID: NM198) | (18) |
| VI003 | The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years. | (NICE 2020 menu ID: NM199) | (18) |
| VI004 | The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years. | (based on NM201) | (10) |

## Quality Improvement (QI) domain

*These are significant areas of work and practices will need to commence this at the beginning of the financial year.*

**Early cancer diagnosis**

NHS England have provided full details of the revised QOF QI requirements for 21/22. Key points include:

- Practices need to complete the national reporting template and share this with their PCN.
- QI should focus on the following four areas (revised in light of Covid in September 2020):
    - Restoring cervical screening uptake to pre-Covid levels.
    - Building public confidence that general practice and other healthcare settings can be accessed safely.
    - Returning referrals to pre-Covid levels, improving the quality of referrals; and awareness of referral and testing pathways.
    - Having robust and consistent systems in place for safety netting.

Further support with these modules is available on the Cancer Research UK website. Macmillan have also published a very helpful primary care toolkit to support practices with both early cancer diagnosis and improving cancer screening uptake.

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| QIECD005 | The contractor can demonstrate continuous quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. | (27) |
| 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) |

**Care of people with learning disabilities (LD)**

The main aims of the QOF QI module are:

1. Improve the accuracy of the GP register by increasing the identification and coding of people of all ages with learning difficulties. Further guidance from NHS England is available here.
2. Increase uptake of annual health checks. Further guidance is available on the RCGP website.
3. Optimisation of medications in line with the STOMP initiative, with a focus on appropriate prescribing of antipsychotics. Further guidance is available here.
4. Recording the need for and type of reasonable adjustments required. Further guidance from NHS Digital is available here.
5. Consideration of the use of wider support with community LD services and social prescribers.

The 5 steps practices and networks need to take are:

1. Identify areas for improvement by assessing the current quality of care.
2. Create an improvement plan.
3. Implement the plan.
4. GP network peer review meetings.
5. Reporting and verification including completing the QI monitoring template.

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| 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) |
| 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) |

## Indicators no longer in QOF (INLIQ)

There are no changes to the INLIQ extraction from 1 April 2021. The indicators included in INLIQ in 2021/22 are detailed below.

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| 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. |

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| MH008 | The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder 122 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. |