Summary of QOF Changes for Practices

The 2020/21 approach to QoF has been revised to reflect the impact of Covid-19 on General Practice. Some indicators will continue to be paid on the basis of practice performance and others will be paid based upon historic achievement. It is expected that QoF will be fully re-instated from 1st April 2021.
Those indicators which will be paid of practice performance are:

1) **Chronic disease**
   CHD / COPD / Stroke-TIA / DM

2) **Cervical screening and Flu vaccination**
   58 points

3) **Maintain disease registers**
   AF / CHD / HF / Htn / PAD / Stroke-TIA / DM / Asthma / COPD / Dementia / SMI / Cancer/ CKD / Epilepsy / LD / Fragility / RA / Palliative / Obesity
   81 points

4) **Optimal prescribing of medications in long-term conditions**
   44 points

5) **Quality Improvement (QI) domains**
   Early cancer diagnosis
   – Demonstrate continuous quality improvement activity focussed on early cancer diagnosis
   – Participate in network activity to share and discuss learning focussed on early cancer diagnosis
   37 points

   Care of people with learning disabilities
   – Demonstrate continuous quality improvement activity focussed on early learning disability
   – Participate in network activity to share and discuss learning focussed on learning disability
   37 points

183 QOF points will be paid based upon recorded practice performance.
310 QOF points will be subject to income protection based upon historical practice performance – subject to other conditions being fulfilled.
567 QOF points are available in 2020/21.

Other conditions that must be fulfilled
Agree with CCG on a plan for QoF population stratification via eDeC (Oct-Nov 2020)
Commit to – referral to weight management programs

Asthma
Keep a register of patients
Diagnosed after 1st April 2006 need PEFR or Spirometry
Aged 14 – 19 and smoking status recorded
Annual review and patients must answer if night symptoms, day symptoms and exercise related problems
Atrial Fibrillation
Keep a register of patients
Patient needs CHA2DS2-VASc in the last 12 months
Patients with CHA2DS2-VASc > 2 need anticoagulant
Cancer Care
Keep a register of patients
Cancer care review within 6 months of diagnosis
Chronic Kidney Disease
Keep a register of patients (over the age of 18 with CKD 3-5
COPD

Keep a register of patients
Spirometry with reversibility between 3 months before diagnosis and 1 year after diagnosis
FEV1 recorded
COPD annual review
MRC dyspnoea score
Exacerbating history
Lung function
Inhaler technique check
MRC score > 3 need O2 saturation recording
Influenza vaccination between 1st August – 31st March
Coronary Heart Disease
Keep a register of patients
BP reading < 150/90
Influenza vaccination between 1st August – 31st March
Patient needs to be taking either Aspirin / Clopidogrel or anticoagulant

Cytology
25 – 64 years of age and has had a cervical smear
Protocol in place for the management of screening (including training, recall and exception reporting)
Protocol for audit of screening and audit of inadequate samples every 2 years
Dementia
Register of patients
Face to face review of care plan
New patients have FBC UE, LFT, TFT, Gluc, B12, Folate, Calcium 12 month before or 6 months after diagnosis
Depression
Patients aged 18 or over with a new diagnosis have a review by a GP within 10 and 56 days of diagnosis
Diabetes
Keep a register of patients (over the age of 17)
Last IFCC < 59
Last IFCC <64

Last IFCC <75
Foot examination and risk classification
Last BP < 150/90
Last BP <140/80
ACEi or ARB if microalbuminuria or proteinuria
Last cholesterol < 5
Influenza vaccination between 1st August – 31st March
Referred to structured education programme within 9 months of entering register
Epilepsy
Register of patients
Hypertension
Register of patients
BP reading < 150/90
Heart Failure
Register of patients

Needs ECHO confirmed diagnosis or coronary angio
ACEi or ARB
B Blocker (Must be bisoprolol, carvedilol or nebivolol)
Learning Disability
Register of patients
Mental Health
Register of patients with
Schizophrenia, psychoses, bipolar disorder or prescribed lithium
Needs personal health plan
Alcohol consumption
BP check
Smear (if eligible female)
Lithium check in therapeutic range
Creatinine and TSH check if on lithium
Obesity

Register of patients aged over 18 with BMI > 30
Osteoporosis
Keep a register of patients –
Age 50-74 with fragility fracture and DEXA confirmed osteoporosis
Age >75 with fragility fracture
Patients in 1) receiving treatment
Patients in 2) receiving treatment
Palliative Care
Keep a register of patients
Review patients on the palliative care register at least every 3 months
Peripheral Vascular Disease
Keep a register of patients
Patient needs to be taking either Aspirin / Clopidogrel or OTC aspirin
BP reading < 150/90
Public Health

Aged > 45 with BP recorded in the last 5 years
Aged 30-75 with CVD risk >20% on statin
Rheumatoid Arthritis
Keep a register of patients (over the age of 16)
Annual face to face review
Sexual Health
Register of women prescribed contraception
Patients given emergency contraception are given information on LARC within 1 month of the prescription
Smoking
Smoking status for anyone with
CHD / DM / CVA / BP / COPD / Asthma / Psychosis / PVD / CKD
Offer support and treatment
Smoking cessation advice
Support with literature and appropriate therapy
Stroke / Transient Ischemic Attack

Keep a register of patients
Diagnosed after 1st April 2014 and referral for investigations between 3/12 before and 1/12 after episode
BP reading < 150/90
TIA or non bleed CVA on antiplatelet or anticoagulant
Influenza vaccination between 1st August – 31st March

September 2020