

QOF Quality and Productivity (QP) Indicators

**Supplementary Guidance and Frequently asked Questions for the
Health and Social Care Board and Practices in Northern Ireland**

July 2011

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Introduction

This document is intended to assist the Health and Social Care Board (the Board) and practices in understanding and working through the new QP indicators, building on the information in the 2011/12 QOF guidance.

The detailed 2011/12 QOF guidance is available at:

<http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF2011-12.aspx>

Summary of QP indicators

Prescribing		
	Indicator	Points
QP1	The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the Board three areas for improvement and produces a draft plan for each area no later than 30 June 2011 (or within 2 months of the delivery of the data whichever is later)	6
QP2	The practice participates in an external peer review of prescribing with a group of practices and agrees plans for three prescribing areas for improvement firstly with the group and then with the Board no later than 30 September 2011 (or within 5 months of the delivery of the data whichever is later).	7
QP3	The percentage of prescriptions complying with the agreed plan for the first improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
QP4	The percentage of prescriptions complying with the agreed plan for the second improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
QP5	The percentage of prescriptions complying with the agreed plan for the third improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5

Outpatient Referrals		
	Indicator	Points
QP6	The practice meets internally to review the data on secondary care outpatient referrals provided by the Board	5
QP7	The practice participates in an external peer review, with practices within the group of practices, to compare its secondary care outpatient referral data and proposes areas for commissioning or service design improvements to the Board.	5
QP8	The practice engages with the development of and follows three agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate referrals and produces a report of the action taken to the Board no later than 31 March 2012	11

Emergency Admissions		
	Indicator	Points
QP9	The practice meets internally to review the data on emergency admissions provided by the Board	5
QP10	The practice participates in an external peer review, with practices within the group of practices, to compare its data on emergency admissions and proposes areas for commissioning or service design improvements to the Board	15
QP11	The practice engages with the development of and follows three agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the Board no later than 31 March 2012	27.5

Prescribing indicators QP1 to QP5

The five prescribing indicators require that practices review their prescribing to ensure that it is clinically appropriate and cost-effective and then choose three areas of their prescribing in which to make improvements. The three areas chosen must be different to those for Medicines 6 and Medicines 10.

This section provides a step-by-step guide, together with a worked example to help practices and the Board.

Step 1: QP1 - Practice internal review of prescribing

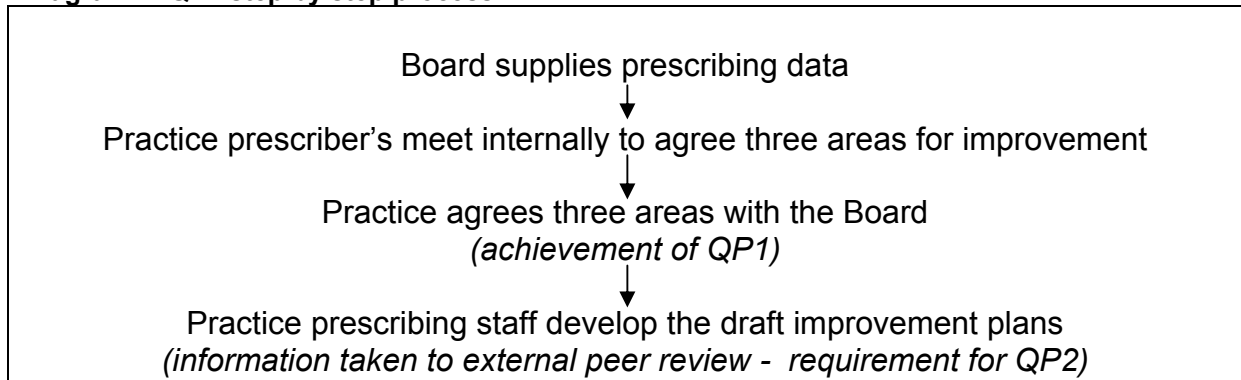
The indicator requires that practices undertake an internal review of their prescribing to identify three areas for improvement. These areas should be agreed with the Board. To achieve this, the Board is required to supply practices with data on their prescribing.

In NI, the COMPASS prescribing report is provided on a quarterly basis to each practice. It contains practice specific prescribing data across the majority of therapeutic areas and includes locality, LCG area and NI averages. This report can be used to inform initial discussions within the practice. Additional data is available from Medicines Management Advisers on request.

Once the data are received, all the prescribers in the practice should meet to discuss and reflect on their prescribing performance taking account of clinical appropriateness and cost-effectiveness (making suitable allowance for individuals unavoidably absent from the practice). The practice will identify three areas in which they wish to make improvements and agree these areas with the Board no later than 30 June 2011 (or within 2 months of the delivery of the data whichever is later). In selecting the three areas, practices should consider local circumstances and focus on those areas of expenditure that are significant throughout the year and which offer the greatest opportunity for improved clinical and cost-effective improvements.

Once the three areas have been agreed, the practice will need to develop draft improvement plans to set out how they plan to improve their prescribing clinically and make it more cost-effective. The draft plans will need to be produced no later than 30 June 2011 (or within 2 months of the delivery of the data whichever is later) and these plans will then be discussed, agreed and finalised at the peer review meeting (step 2).

Diagram 1: QP1 step by step process



Step 2: QP2 - External peer review and agreement of improvement plans

The peer review group must consist of a minimum of six practices. A group may only be made up of less than six practices if agreed with the Board and taking into account local geography and historical groups of practices. During the peer review, practices will be required to compare their prescribing behaviours with that of the other practices in the group. Therefore, practices should take this to account when developing their improvement plans.

The peer review group may be the same one as that used for the outpatient referrals and emergency admissions indicators, providing the criteria for QP7 and QP10 are met i.e. similar referral routes or care pathways.

The meetings will be attended by at least 2 representatives (including one GP), from each practice. Each practice will present their draft improvement plans (drafted in QP1) for each of the three areas to the group and either amend or agree the plans. The areas do not have to be the same across the group of practices although they could be e.g. each practice could identify one or more different areas for improvement. The plans should then be agreed with the Board no later than 30 September 2011 (or within 5 months of the delivery of the data whichever is later). Where the plans have the full support of the group of practices and focus on improving the cost effectiveness of prescribing, it is expected that the Board will normally agree to the plans.

Practices will need to clearly identify the following information in the plan:

- The three improvement areas agreed with the Board in QP1.
- How achievement for each of the three areas will be measured. This must include a clear definition of what the numerator and denominator will be for each of the three areas.
- What the thresholds are - see below for further information on how to set the thresholds.
- Details of how practices intend to deliver the changes set out in the plan.

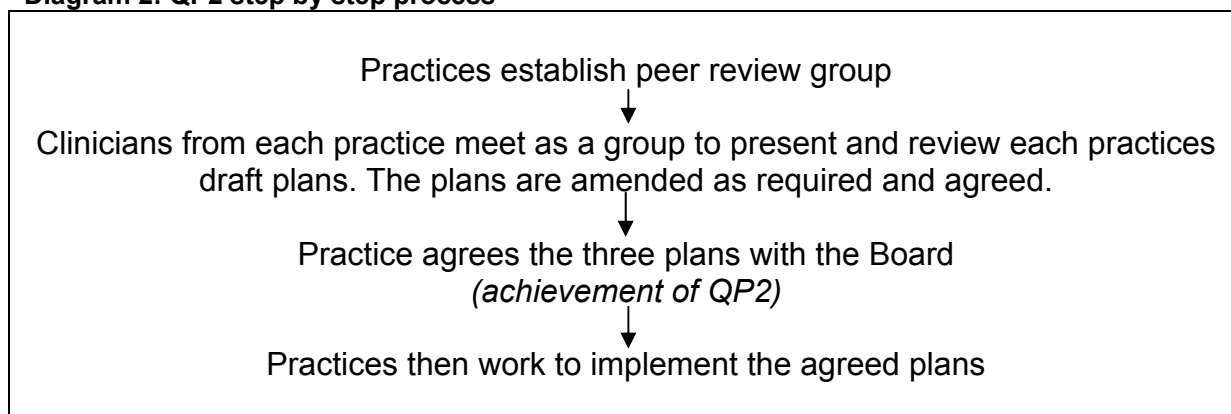
An exemplar template has been provided by the HSCB to facilitate the return of this information.

The upper threshold for each improvement area should normally be set using the 75th centile of achievement nationally for the quarter ending on 31 December 2010 using prescribing data. The upper threshold may not be set higher than this but the Board may agree to set it lower in light of local circumstances.

The lower threshold must be set 20 percentage points below the upper threshold and represents the start of the scale and a points value of zero.

In circumstances where practices are considered to already be achieving a high standard of performance in all areas of prescribing (i.e. where there is very limited scope for the practice to improve) then if agreed with the Board, the focus of the practice reviews and subsequent improvement plan can be on the practice maintaining its prescribing performance. This would need to be clearly set out in the plans agreed with the peer group and Board. For the purposes of achievement, the Board and practice will need to be mindful that the maximum number of points is achieved by a practice matching the performance of the upper threshold, rather than improving on their previous performance.

Diagram 2: QP2 step by step process



Step 3: Achievement of indicators QP3 to QP5

Indicators QP3 to QP5 are the indicators that measure practice achievement against the improvement plans as agreed in QP2. Achievement is calculated using the prescribing data for the period 1 January to 31 March 2012 (quarter four).

From 1 October 2011, the Board must provide monthly data to practices on achievement against the three areas in the plan. Practices may use these data to monitor their prescribing behaviours against their plans.

Outpatient Referrals and Emergency Admissions indicators QP6 to QP11

The outpatient referrals and emergency admissions indicators require that practices engage with the development of and follow three care pathways in the management and treatment of their patients. The aim is to provide improved care options for patients in order to avoid inappropriate referrals and emergency admissions.

During the external peer review, practices should identify any areas for commissioning or service design improvements which are then raised with the Board when the report is submitted. This could include suggestions about how a referral management centre is used and if there are any processes that could be improved.

In the event that there are no areas for improvement, the practice should state this in their report. However, evidence should be provided that the practice has adequately carried out the external peer review.

As with the prescribing indicators, the indicators for outpatient referrals (QP6 and QP7) and emergency admissions (QP9 and QP10) require that a practice undertakes an internal review followed by a peer review.

Internal review (QP6 and QP9)

The Board is required to supply practices with data on secondary care referrals and emergency admissions which a practice reasonably requires to conduct the review(s). In order to assist the Board in supplying the relevant information to a practice, it may be helpful for the practice and the Board to initially discuss what data is available and how the Board will supply the relevant information. In doing this, both the practice and the Board will be clear about the expectations regarding the level of data available and when it will be supplied.

The internal review should take place at least once during the year, with the range of clinicians working in the practice. At the meeting, the practice should identify and discuss any apparent anomalies in referral patterns or explore the reasons for emergency admission, with reference to existing care pathways in order to identify areas where improvements might be made. The output of this review must be made available to the group of practices taking part in the external review.

Practices are required to produce and submit a report to the Board no later than 31 March 2012 that summarises the discussions that have taken place.

External peer review (QP7 and QP10)

The peer review group must consist of a minimum of six practices. A group may only be made up of less than six practices if agreed with the Board and taking into account local geography and historical groups of practices.

At the meeting each practice should be represented by at least one GP. During the peer review, practices should compare their practice data with comparable data from practices in the group to determine why there are any variances and where it may be appropriate to amend management and/or treatment arrangements. For the purpose of QP7, the focus of the review should be to reflect on referral behaviour and whether clinicians can learn from the data to improve their referral practices. In doing this, practices should consider their referrals within the context of how to reduce unnecessary hospital attendances either by following care pathways more closely or through the use of alternative care pathways. Similarly, for QP10 the focus of the review should be on how practices can amend or improve their treatment and management of patients in primary care to help avoid emergency admissions.

Practices could also use the opportunity to recommend to the Board any areas of commissioning or service redesign, that would enable more effective management of patients in the community and which could help reduce inappropriate referrals or unnecessary hospital attendances or admissions.

Practices are required to produce and submit a report to the Board by no later than 31 March 2012. The report should detail what practices took part in the external review, what discussions took place (this may be in the form of notes/minutes of the meeting) and what areas have been proposed for commissioning or service design improvements.

Referrals where cancer is suspected

The outpatient referrals indicators must not have a negative impact on achieving early diagnosis of cancer. All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed. Using evidence based referral guidance for suspect cancer ensures that people are referred appropriately. NICAⁿ has produced Referral Guidance for suspect cancer which is based on NICE referral guidelines. At all times the emphasis must be on speedier diagnosis even if it turns out that the patient does not have cancer. A negative diagnosis does not mean that the referral was unnecessary, an unnecessary referral is one where the GP could reasonably and effectively have met the patient's needs, in a timely fashion, without referring them for an outpatient appointment. This is extremely unlikely to be the case where cancer is suspected.

Guidance on cancer referrals can be found at:-

<http://www.nice.org.uk/CG027>

NICAⁿ (2007) Referral Guidance for Suspect Cancer

<http://www.cancerni.net/files/file/ReferralGuidanceMay2007.pdf>.

Delivery of improvements along the care pathways (QP8 and QP11)

Three different pathways must be developed for indicators QP8 and QP11 respectively and where possible should focus on long term conditions. As such, three pathways will be developed for avoiding inappropriate outpatient referrals and three for avoiding emergency admissions.

The Board, working with peer groups are expected to lead the development of the six care pathways in working with the practice groups. Where the Board and peer group consents, this can be in consultation with the LMC. . If the Board decides to commission a new pathway that improves quality or productivity but which involves new and additional workload for primary medical care beyond essential services and outside that required for the achievement of these QOF indicators, then it should resource it separately as a commissioning exercise. GPs in the practice must actively respond to the development process.

Achievement of these indicators will be awarded on the basis that practices have engaged in the development of and delivered care along the six care pathways.

Practices are required to produce and submit a report to the Board no later than 31 March 2012. The report should summarise the action taken, information about which care pathways were followed and changes in patterns of referral or rates of emergency admissions.

Frequently asked Questions

1. Are the improvement areas for QP1 and QP2 the same?

Yes, the improvement areas for QP1 and QP2 are the same. For QP1 the practice must review their data (as provided by the Board), choose and agree with the Board three areas for improvement. They must also develop draft plans for making improvements in these three areas. For QP2, the practice presents the improvement plan to the peer review group where it is finalised and agreed. As part of the development of the plan, the practice must identify what is to be measured for each of the three areas. The plans then need to be agreed with the Board.

2. What happens if a practice has good prescribing levels across all areas and it is difficult to identify areas for improvement?

In such circumstances, the Board and practice may agree to choose three areas of prescribing where the practice will maintain a standard (i.e. the practice continues to achieve above the upper threshold). This would need to be clearly set out in the plans agreed with the peer group and the Board. For the purposes of achievement, the Board and practice will need to be mindful that the maximum number of points is achieved by a practice matching the performance of the upper threshold, rather than improving on their previous performance.

3. Will there be any national direction of which areas should be measured?

The Board has provided a number of suggested indicators and targets as a basis for applying the QoF indicators in NI. However, practices may wish to focus on alternative areas. It is important that chosen areas are those that will offer the greatest opportunity for clinical effectiveness and/or productivity savings.

4. How will agreement between the Board and practice be reached to ensure practices look at the areas for greatest opportunity?

The Board is required to sign off the areas chosen by the practice. The QOF guidance (page 164) states that practices should focus on areas of expenditure that are significant throughout the year and which offer the greatest opportunity for improved clinical effectiveness and productivity savings. However agreed areas should take into account the availability of data for a chosen area, and should avoid frequent short-term changes to prescriptions that could leave patients confused about their medication.

5. Do practices within a peer review group have to review the same three areas?

No, practices in the peer review group do not have to consider the same three areas. However, practices may choose to select the same three areas to focus on as it would allow the peer review group and/or the Board to provide the necessary focused support to achieve the goals. If practices do choose to focus on the same three areas, then they need to ensure the areas selected offer the greatest opportunity for improved clinical effectiveness or productivity savings.

6. Is there local flexibility to agree measurements that may be different to number of prescriptions, such as cost, ADQs, APUs?

No. The guidance/SFE clearly states that the measurements must be number of prescription items.

7. As these indicators are restricted to the measurement of prescription items, how can inappropriate prescribing lengths be addressed?

It is expected that practices will use appropriate prescribing lengths relevant to the individual patient.

8. Are community based prescribing staff to be included in the internal peer review meetings?

Any staff member who prescribes on behalf of and within a practice's prescribing budget, should be invited to the internal review meeting. However, if staff are unable to or do not wish to participate in the review, then it is expected that the practice will at least inform them of the outputs of the review to ensure they prescribe in accordance with the practice plans.

Community based staff who do not prescribe from within a practice's budget do not need to be invited or involved in the internal review meeting.

9. What is the definition of a care pathway?

For the purposes of these QP indicators a care pathway is a defined process of diagnosis, treatment and care for a defined group of patients during a defined period.

10. How is the actual delivery of a care pathway to be funded?

If the delivery of a care pathway requires additional work beyond that provided under essential services, then the funding for this work should be resourced

separately from outside the QOF indicators. The Board needs to decide first of all whether it should commission the care pathway – will it increase quality or productivity in services for patients?

11. Do the care pathways for QP6 to QP11 have to be newly developed or can they be ones that are currently in development at the time the indicators were published?

The QOF guidance/SFE is clear that the pathways to be developed should be new. However, where a pathway is still in the development stages and allows the opportunity for practices to engage in development, then subject to agreement between the Board and practice, this would be acceptable.

12. Do practices always have to follow care pathways in the treatment of patients if it is not clinically appropriate to do so?

Practice must follow the agreed care pathways in the treatment of their patients, unless in individual cases they can justify clinical reasons for not doing this.