NHS Circular:
PCA(M)(2013) 06

Health and Social Care Integration Directorate
Primary Care Division

The Scottish Government

Dear Colleague

Update on Scottish QOF Framework 2013/2014 Guidance for NHS Boards and GP Practices

Summary

1. Following the issuing of Guidance to NHS Boards and GP Practices in PCA(M)2013)2 on 1st May 2013, we have received a number of helpful queries that we would wish to address and to clarify the agreement between the Scottish Government and the Scottish General Practitioners Committee of the BMA. An update on this guidance is included in **Annex A**.

2. The content of this circular has been agreed with the Scottish General Practitioners Committee (SGPC).

3. It is important to note that there are differences between the guidance produced in Scotland and that which has been issued in England; the full Scottish guidance can be found on the NHS web-site by following the link:
http://www.sehd.scot.nhs.uk/pca/PCA2013(M)02guide.pdf

4. The guidance is necessarily long but a summary of the changes, is enclosed in **Annex B** and may assist practices in determining those areas that require early consideration.

5. This update should be read in conjunction with the full guidance document. The Scottish Statement of Financial Entitlement for 2013/2014 will be issued when finalised.

6. Internal Review Reporting Template is included at **Annex C**

Action

7. NHS Boards are asked to bring this update to the attention of all GP contractors.

02 July 2013

Addresses

For action

Chief Executives NHS Boards

Primary Care Leads NHS Boards

For information

Scottish General Practitioners Committee

NHS National Services Scotland

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Yours sincerely

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Annex A

Frequently Asked Questions

1. What is required of practices in DEP001 in relation to completing a bio-psychosocial assessment?

A clinical bio-psychosocial assessment (BPA) should consider physical, psychological and social aspects of the condition as outlined under guidance on p111 of the full Scottish QOF guidance. However, for the purposes of the contract, these aspects need not be individually coded or recorded on a template within the GP case record.

It is sufficient to record that a BPA has been made, using the Read code

- 38G5. Biopsychosocial Assessment

and this should be entered on the same day as the depression diagnosis is made.

If a patient is considered unsuitable for BPA or declines this, then Read codes are available to exclude them:

- 8IET. Biopsychosocial assessment declined
- 9NSA. Unsuitable for biopsychosocial assessment

Templates that give structure to the BPA and that can be given to patients for completion are available and practices may use these if they wish, but these are not mandatory and do not form any part of the contractual requirement around this indicator. Neither is it necessary to record if a structured tool, such as PHQ-9, has been used as part of this assessment.

2. Why has the indicator relating to referral to pulmonary rehabilitation now gone when compared to previous correspondence?

This indicator was not implemented following the conclusion of the English consultation on imposition of the contract. As this was not implemented in England, it became clear that doing so in Scotland would prove impractical and it was agreed with SGPC to implement CVD-PP003(S) instead.

Early correspondence emphasised that the contained information was not finalised and could be subject to change.

3. When will the tools for CVD-PP003(S) be available?

The Scottish Physical Activity Screening Questionnaire (Scot-PASQ) is available to use now.

Physical Activity - Scottish Questionnair

It is expected that for all patients who are given lifestyle advice as part of the indicator CVD-PP002(S), one of the following codes are used:

- 67H.. Lifestyle counselling
- 67H8. Lifestyle advice regarding hypertension

Of those who receive lifestyle advice on increasing physical activity, this advice should be given utilising Scot-PASQ.

When practices complete this assessment using Scot-PASQ, the Read code

- 68L.. Exercise status screening

should be entered in the case record.

Practices will make a declaration of achievement (*Yes or No*) against the indicator CVD-PP003(S) at the end of year. This may be subject to normal post-payment verification procedures by examining the case record for evidence that the relevant patients have received this advice utilising the Scot-PASQt. It would be expected that at least 90% of the records examined would have a record of the Scot-PASQ having been utilised.

Practices should ensure on each occasion that they Read code that Scot-PASQ has been used, that they have recorded the answers to the relevant Scot-PASQ questions (1, 2 or 3) in the patient record.

4. Which tool should be used to assess cardiovascular disease risk in patients?

Both ASSIGN and QRISK2 will be accepted in the business rules for assessment of cardiovascular disease risk and therefore for meeting QOF requirements.

Only the ASSIGN tool uses data that is specific to the Scottish population (Scottish Index of Multiple Deprivation) and using the QRISK2 tool, where the data is specific to England, may falsely estimate the risk for patients. Practices are therefore recommended to use ASSIGN.

An expert group has examined the applicability of the ASSIGN tool to patients with rheumatoid arthritis (RA) and have advised that the risk conferred by this has an equivalence to that of diabetes mellitus when using the tool.

As a consequence ASSIGN2 is being developed to reflect these changes but in the meantime ASSIGN scoring tools may be used to estimate risk in RA by using Diabetes as a proxy for this condition.

Practices should not enter Diabetes codes to patients' records where that patient does not have diabetes purely for the purpose of making computer system internal calculators work, even temporarily. Instead practices should use the on-line ASSIGN tool for risk assessment in RA and check the 'diabetes' check box as a proxy for RA.

This can be found at:
http://www.assign-score.com/

This will provide a valid score. It may be entered to clinical systems using the ASSIGN Read Code:

38D6.00 Assessing cardiovascular risk using SIGN score

And this will be valid for QOF reporting.

ASSIGN calculators are embedded into some GP IT systems. At present these systems will not use a diagnosis of RA to inform the internal calculation of the ASSIGN score. Suppliers will be changing their calculators to reflect the new guidance in due course.

Exception reporting:

When appropriate, patients may be exception reported by using the codes:

- 9OH9. Cardiovascular disease risk assessment declined
- 81AK. Cardiovascular disease high risk review declined

In addition, the Read code

- 9NSB. Unsuitable for QRISK2 cardiovascular disease risk assessment

May be used as a proxy code for those felt to be unsuitable for assessment by ASSIGN or QRISK2. A code that is specific to unsuitable for assessment by ASSIGN will be requested but if agreed would not be available until late in the year.

5. How many case note reviews should be done in total for QI001(S)

Each practice should conduct 2 rounds of structured case note review using the NES Primary Care Trigger Tool. Each of these rounds should consist of 25 case notes, resulting in a total of 50 case notes over the course of the year. These rounds of review should be conducted at least 3 months apart.

The case notes reviewed should be drawn from the following groups who have been identified as being at higher risk of adverse event:

- Patients on DMARD therapy
- Patients with diagnosis of LVSD
- Patients on warfarin therapy
- Patients with a higher SPARRA score eg over 40

- Recent admissions with COPD
- Care home residents
- Patients on chronic district nursing caseload
- Patients aged 75 years on 6 or more medications

When conducting each round of case note review, if 5 patient safety incidents have been detected before all 25 records have been reviewed, then it is usually not necessary to review the remaining records. Conversely, if five patient safety incidents have not been detected, it is not necessary to undertake more than 25 case note reviews.

6. What codes should be used in the QP domain for the High Risk Patients work?

New Read codes were released on 1st April that will assist recording in this domain. The recommended codes are:

List of 5% of patients in the practice predicted to be at significant risk of emergency admission or unscheduled care

- 13Zu At risk of emergency hospital admission

Patients identified as likely to benefit from an anticipatory care plan

- 8CMM Has anticipatory care plan

Patients who have received a polypharmacy review

- 8B31B Polypharmacy medication review

Also in relation to High Risk Patients:

Whilst it has always been the expectation/understanding (of Scottish Government and SGPC) that Anticipatory Care Planning and Poly-pharmacy would require a face to face consultation, by at least one member of the primary care team, it is acknowledged that this is not made explicit in either the Scottish QOF Guidance, or earlier communication to practices on this subject. However, it is still the expectation that a face to face consultation would be required, given the nature of the likely discussion e.g. place of care, determination of capacity, with exceptions from this in only the most unusual of circumstances.

Using a SPARRA risk threshold of between 20% and 60% will generate a cohort of around 5% of patients in the practice to fulfil the QP006 indicator. Working down from an ‘upper ceiling’ of those with a 60% risk score will enable the practice to improve outcomes for people most likely to benefit from an Anticipatory Care Plan and a poly-pharmacy review. Practices may also identify patients who are not within this band but whom they feel will benefit from an ACP by using local intelligence and discussion with colleagues.

This will complement other local ACP initiatives that target cohorts with greater than

60% SPARRA risk. In fact individuals with SPARRA risk less than 60% are more likely to be engaged with the practice team than active on the community nursing caseload. Interventions at this level of risk represent earlier intervention likely to reduce escalation of dependency and to optimise adherence to medicines.

7. Do I have to submit a full 8 point audit in order to achieve indicator MM002(S)?

It is recognised that 8 point audit, as described in guidance from NES, is the optimal method but that timescales within this first year, particularly in relation to obtaining the second round of data, may make this impractical. It is, therefore, acceptable to submit a minimum of 5 point audit during 2013 / 14.

The following link is to a template, produced by NES, that may be helpful:
http://www.gpcpd.nes.scot.nhs.uk/media/1021425/medicine standard audit report format - mar 11.doc

8. Delays in Elements of QOF QP

Where, in QOF QI, there have been unexpected delays in the provision of data, pathways, internal reporting template or access to KIS for practices, practices will be expected to have up until 8 weeks after the provision of whichever is the later of these elements, to submit their internal reports to Boards.
Whilst this agreement may extend the deadline for submission of internal reports beyond the date noted in the Scottish QOF Guidance (31st August 2013), it would not preclude practices, should they so choose, from submitting their internal report before that extended deadline, or from submitting a partial report before the extended deadline and submitting any 'delayed elements' in time for that extended deadline.

During any period of delay (of access to SPARRA, an internal reporting template or KIS), practices need not create a paper version of ACP-PP, but there is no reason why MDT meetings could not be held to discuss patients who would be suitable for ACP-PP, or to consider how teams could work in MDTs once these elements become available.

9. In addition to these queries, the following amendments to the guidance are highlighted:

- p 178 CS002(S) should read “the percentage of women aged 20 or over and who have not attained the age of 60” rather than “the percentage of women aged 25 or over and who have not attained the age of 65”.

- p 51 The register of patients with heart failure is not used to calculate APDF for HF003(S). It is used only to calculate APDF for HF001 and HF002.

- P 175 SMOK 005.1(S) Rationale
  'An offer of support and treatment' therefore means offering a referral or self-

referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team or local pharmacies that provide smoking cessation services/NRT) plus appropriate pharmacotherapy i.e. only if the offer of pharmacotherapy at this point fits with local Board policy. Where such support is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

- P 84 DM 013.1 Rationale
  If there is no one in the practice competent to provide this level of dietetic advice to patients then the contractor should refer the patients to a local dietetic service for that advice. If it is agreed that a local service does not exist for this purpose, then a mechanism to ensure no detriment to the practice should be agreed locally and may involve manual adjustment.

Annex B

Changes to Scottish QOF Framework 2013/2014

Scottish QOF
Changes for 2013-14

Annex C

GMS QUALITY & OUTCOMES FRAMEWORK 2013-14
QUALITY & PRODUCTIVITY (QP) INDICATORS

PRACTICE INTERNAL REVIEW REPORT
(All yellow shaded boxes expand to fit text)

Practice Name -	
Practice Number -	
Name of GP/PM Lead -	
Date submitted -	

	Out Patient Referrals	**Emergency Admissions**	**Learning from Anticipatory Care Plans (ACP-PPs)**
Date of internal review meetings			
Names / designation of those attending			

QP001(S)	1. Outpatient Referrals; our practice response

1.1. What our practice does

The internal factors that we think contribute to variation in our practice overall and individual GP referral patterns include;

The following are specific ways of working in our own practice (*internal to the practice)* which are aimed at supporting independent management in the community and reducing avoidable referrals:

Three useful elements of what we do which we think could be rolled out to other practices are:

1.2 What other people/services do

External factors that the practice feels contribute to the outpatient referral rates in the three pathway areas are (e.g. lack of access to local services; clarity around referral guidelines etc) are:

i) ***Pathway A***

ii) ***Pathway B***

iii) ***Pathway C***

One thing which other people/services do (or could do) which, if addressed or more widely implemented, we think would reduce avoidable referrals in each of the three areas are:

iv) ***Pathway A***

v) ***Pathway B***

vi) ***Pathway C***

Our identified learning points (*for the practice as a whole or individual GPs)*, which we think, could potentially reduce outpatient referrals in the future. (one for each pathway, and each to include a learning point, action to be taken and by whom)

vii) ***Pathway A***

viii) ***Pathway B***

ix) ***Pathway C***

QP004(S)	2. Emergency admissions; our practice response

2.1 What our practice does

Our comments on our emergency admissions data in general are:

Our comments on whether some of these admissions could have been avoided (especially whether we could have made better use of currently available services to help with this) are:

The following are specific ways of working in our own practice (*internal to the practice)* which are aimed at supporting independent management in the community and reducing avoidable admissions:

Three useful things we do which we think could be rolled out to other practices to reduce unnecessary admissions are:

2.2 What other people/services do

Our practice response about emergency admissions: [yellow shaded boxes expand to fit entered text]

Our comments on whether there have been external changes (ie what other people or services have started doing) which might have reduced avoidable admissions in the past year are:

Our comments on how we think some of these admissions could have been avoided by what people/services outwith the practice could do are:

The following are specific ways of working in our own practice (*internal to the practice)* which are aimed at supporting independent management in the community and avoiding potentially unnecessary admissions:

Useful things we do which we think could be done by other people/services to reduce avoidable admissions are:

Our identified learning points (*for the practice as a whole or individual GPs)* which we think could potentially reduce emergency admissions in the future. (each to include a learning point, action to be taken and by whom)

1)

2)

3)

QP004(S)	3. Learning from Anticipatory Care Plans/Poly-Pharmacy Reviews (ACP-PPs); our practice response

Brief summary of practice general discussion points:

Specific issues in relation to:

1. **What is working well in relation to the creation and use of ACP-PPs?**

2. **What could be improved in relation to the creation and use of ACP-PPs?**

3. What can you do as a practice to make the creation and use of ACP-PPs more effective and/or efficient?
4. What can your Board do to make the creation and use of ACP-PPs more efficient and/or effective?
Highlight any positive or adverse access issues within the practice in relation to undertaking ACP-PPs e.g. understanding the contract requirements/guidance, accessing and using the data available (e.g. SPARRA), working with others in the primary care team, IT issues, sharing and updating ACPs etc
Highlight any correlation between the ACP-PP workload and particular practice factors e.g. levels of deprivation, multi-morbidity etc