

Opportunities for pharmacists: the Quality and Outcomes Framework

In the second of four consecutive articles, **Sue Carter**, head of prescribing and pharmacy, Adur, Arun and Worthing Teaching Primary Care Trust, gives her view on aspects of the new general medical services contract Quality and Outcomes Framework of relevance to pharmacists

The new general medical services contract is ground-breaking. When it is implemented from 1 April 2004, it will underpin the first health system anywhere in the world that systematically resources primary care doctors on the basis of how well they care for patients rather than simply the number of patients they treat. At the core of the funding stream is the Quality and Outcomes Framework (QOF), which sets out a range of national standards based on the best available research evidence, with targets to reach and a set number of reward points for reaching each standard. A total of 1,050 points are available through the QOF, broken down as in Panel 1. The remuneration pounds per point will be adjusted to take into account the size of the register for each disease area in each practice, thus recognising disease prevalence and workload. These calculations will be made automatically by a new national software system, and practice ability to maximise remuneration will depend heavily on robust and consistent computerised data collection.

Implications for secondary care

The QOF will have major implications for other parties in the NHS, especially secondary care. Care must be taken to ensure that secondary care clinical teams understand the process and aims of each chronic disease area, so that local agreement can be reached on GMS-friendly data management, communication and care pathways, etc. Where monitoring takes place in a hospital (for example, blood testing and blood pressure monitoring) and this information could contribute to QOF achievement, communication of such monitoring will need to be timely, specific, reliable and systematic. This is also essential to avoid patients having to undergo duplicate monitoring in hospital and primary care. Secondary care and interface pharmacists could play a major role in liaising with hospital colleagues and tailoring pharmaceutical care and communication to fit the QOF.

Opportunities for pharmacists

There are obvious opportunities for community pharmacists to be commissioned to contribute similarly to patient care through the QOF, but exactly the same principles and constraints apply as to other sectors. The National Pharmaceutical Association (www.npa.co.uk) has published a reference guide on how community pharmacy can help practices to achieve GMS quality indicators.

Panel 1: Areas and reward points as designated in the Quality and Outcomes Framework

■ Clinical indicators

Total maximum points 550

Asthma 72	Cancer 12
COPD 45	Diabetes 99
Epilepsy 16	Heart disease 121
Hypertension 105	Hypothyroid 8
Mental health 41	Stroke/TIA 31

■ Organisational indicators

Total maximum points 184

Medicines management 42
Records and information 85
Other 57

■ Additional areas

Total maximum points 36

Cervical screening, maternity, contraception, child health surveillance

■ Patient experience

Total maximum points 100

Patient survey 70
Consultation length 30

■ Other

Total maximum points 180

Holistic care, quality practice, access

Maximum points available 1,050

Local delivery plans will also need to account for secondary care capacity to cope with increased demand for blood testing and other diagnostic testing, such as echocardiograms for heart failure management.

The medicines management organisational indicators require a systematic approach to repeat prescribing, medication reviews and meetings with the primary care organisation prescribing adviser. Practice pharmacists and PCO pharmacy teams have a major role in helping practices use good quality protocols and develop enhanced skills in these areas, as well as evolving prescribing analysis and visits to suit the new GMS landscape. Community pharmacists have opportunities to work more closely with their local practice to support and influence these stan-

dards, particularly as repeat dispensing schemes become more widespread.

Prescribing levels of treatments associated with the key QOF clinical areas are likely to increase as practices deliver against the new targets, with consequent implications for local budgets and delivery plans. Most QOF clinical areas are associated with prescribing, and the QOF could provide perverse incentives to prescribe high dose polypharmacy to as many patients as possible, as quickly as possible, in order to reach targets. In addition, the QOF does not provide balancing incentives towards cost-effectiveness of prescribing, reducing waste and remaining in budget, creating enormous challenges for PCO pharmaceutical teams. A recently published paper by the Prescribing Support Unit (www.psu.co.uk) explores prescribing cost implications in more detail.

The QOF only covers 10 clinical areas, and there are gaps where quality of care is equally important, such as use of antibiotics, prescribing of benzodiazepines, gastrointestinal disease, osteoporosis and general cost-effective use of budgets and resources. Influencing GPs to continue to focus on these and other non-QOF clinical areas presents another major challenge for PCO pharmacy teams.

Annual assessment and review

There will be an annual assessment and review visit for each practice, using analysed data from the national system, referral patterns, evidence to support claims, etc. More detailed guidance will be published by the Department of Health in April, but much can be gleaned from the existing BMA documentation. This potentially has major workload implications for PCO pharmacists, whose expertise in prescribing and medicines management will be needed by PCOs in new GMS assessment and review teams.

The concept of exception reporting has been introduced so that practices trying to reach percentage targets are not penalised if, for example, patients do not attend for review, or where a medicine cannot be prescribed due to a contraindication or side effect. Panel 2 lists grounds for practices not to have to count patients.

Community pharmacies that have already developed excellent working relationships with their local practices, have invested in the skills and continuing professional development of the pharmacy team, and have developed their premises to include, for instance,

Panel 2: Exception reporting — grounds for practices not to have to count patients

Patients are not counted if:

- They refuse review or recall three times within 12 months
- A treatment is not clinically appropriate, eg, terminal illness or extreme frailty of patient, contra-indicated, allergy or side effects
- There are sub-optimal outcomes despite the maximum tolerated dosage
- They do not agree to investigation or treatment (informed dissent)
- They are newly diagnosed or new to the practice — these patients should have measurements made within three months and delivery of clinical standards within nine months
- The secondary care service on which the clinical standard depends is not available, eg, echocardiograms in chronic heart failure

Panel 3: Chronic obstructive pulmonary disease

- **COPD 5** The % of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service has been offered in the past 15 months — **6 points**
- **COPD 7** The % of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months — **6 points**
- **COPD 8** The % of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March — **6 points**

counselling areas, will be in an ideal situation to support practices in achieving targets and be remunerated for doing so.

Taking chronic obstructive pulmonary disease as an example, there are some particular areas that stand out as opportunities as indicated in Panel 3. Community pharmacy led smoking cessation services could be commissioned by practices, either on an individual patient or group counselling basis; community

pharmacy based medicines management services could contribute to inhaler technique checks; community pharmacies could help in influenza vaccination campaigns. It must be noted, however, that in order for the community pharmacy contribution to be recognised, documented and remunerated, systems must be in place for the intervention to be efficiently recorded in the practice computer system under the designated codes.

The new pharmacy contract is on the horizon, and it is likely to be structured to dovetail with the opportunities for pharmaceutical care in the new GMS contract. Those community pharmacists who are prepared could enter a new and golden era of true recognition as equal partners in improving quality and outcomes for patients.

□ Next week's article will look at new GMS enhanced services.

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