

Primary Care IT Consultant



Changes to QoF 2011/12

*Prescribe
yourself
a helping
hand*

InsightSolutions 
Healthcare IT Professionals

Who are Insight Solutions



- Independent Primary Care Training Consultancy
 - In all things IT & HR
- We deliver exceptional training solutions because we understand what you need
 - All of our consultants have worked in a primary care setting for a number of years – we know & understand your business
 - We have more than 100 years primary care experience between us

InsightSolutions 
Healthcare IT Professionals

Who are Insight Solutions



- IT Experts in:
 - All things QoF, clinical system training (experts in all the main systems), general practice workflow (how to apply & manage your IT system), read codes (v2 & CTv3), data quality & data analysis, medical terminology & more
- HR Expert around all personnel issues:
 - Customer service, policies & guidelines, absence management, behavioural styles & personalities
 - Management Packs – maternity & IG, more to come ...
- Flexibility is our key
 - Flexible solutions to meet your needs

Ethical Disclaimer



All information provided is an opinion and is, therefore, optional. It is designed to enhance your abilities around QoF.

The decision to implement any of these changes rests entirely with each practice/clinician and should be used in conjunction with your PCT/LHB policies & procedures.

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Healthca

General



- National Institute of Clinical Excellence (NICE) took over the review & development of QoF in April 2009
- NICE is an independent organisation responsible for providing national guidance on the promotion of good health & the prevention and treatment of ill health
- NICE's role is only concerned with the clinical & health improvement indicators

General



- A new QoF Advisory Committee was formed
 - Made up of healthcare professionals
 - GPs & staff, patients, carers, commissioners, pharmacists to name but a few
 - Responsible for reviewing existing indicators & looking at new areas for consideration
 - Much more transparent, asking for ideas & opinions from anyone via their website
- Changes are based on best evidence to improve patient care & reduce health inequalities
- More information: <http://pathways.nice.org.uk/>

Setting the scene



- 10 years ago we worked in a very different NHS
- Annual NHS budget in England has more than doubled in the last decade
 - > £102 billion
 - Today £1 of every £13 produced by the UK economy is spent on healthcare
- Recession & the need to cut national debt means we have to focus on improvements

Setting the scene



- NHS needs to identify £15-20 billion of efficiency savings by end of 2013/14
- To meet demands of an ageing population & increased costs we need to concentrate on improving productivity and eliminating waste
- Making sure future investment is effective is a key responsibility to us all

Setting the scene



- Plans to meet these aims with focus on 4 core components:

Quality

Innovation

Prevention

Productivity

QIPP

QIPP



- QIPP Programme is all about ensuring that each £ spent is used to bring maximum benefit & quality of care to patients
- QIPP is working at national, regional & local level
 - Regional & local levels, plans to address the quality & productivity challenge
 - National QIPP is producing tools & programmes to assist local change

QIPP



- 12 national work streams
 - 5 deal with how we commission care
 - Cover long-term conditions, right care, safe care, urgent care & end of life care
 - 5 deal with how we run, staff & supply organisations
 - Covers productive care, non-clinical procurement, medicines, efficient back office functions & pathology
 - 2 enabling work streams covering primary care commissioning & contracting and digital technology

Summary of QoF changes



- QoF is still a maximum of 1000 points
- 96.5 points have been taken from existing areas and reinvested in new quality & productivity indicators
- No new clinical disease areas
- Prevalence will still have a massive bearing on the income you achieve
 - Achievement payments are based on the burden of disease at your practice
 - Average point value 2011/12 is approx £132
 - Was £126

Summary of QoF changes



- A number of indicators have been retired
- There are a number of new NICE recommended indicators
 - A number of new organisational indicators around improving quality & productivity
 - Currently approved for 2011/12 only, may be extended for a 2nd year if significant progress made
 - Aimed at more effective use of NHS resources, cost reduction & improved patient care

Software Update



- Business Rule Sets underpin QoF & the way in which software is written
- V19 rule sets released in April
 - Codes included in this session are included in v19.0 rule sets
 - Are many more than we display today, not enough time or room to include them all!
 - All included in our QoF Read Codes Manual
 - V20.0 rule sets will be released any time now
 - These will just tweak & tidy up areas
 - If there are any changes that will affect you, we will notify you of any changes via our newsletters

Software Update



- Some clinical system suppliers will release interim software
 - It will not be accredited but will give you something to work with, a good flavour of your achievement
- Data entry templates may be released soon
 - They may require updates if the business rules identify codes not included
- April Read Codes have been released
 - You should all now have the latest version of read codes installed

Data Entry Templates



- Throughout this session we will make recommendations on updates to your data entry templates
- Even when your suppliers send you updated tools, ensure that they really capture what you want them to
- They only include the obvious things
 - You have the patient in front of you, use it as an opportunity to capture more than just the obvious

Insight Updates



- This seminar is based on our interpretation of the changes
- We do have many products & services available to assist practices with QoF
 - Data Quality Assessment, QoF Read Code Manual, Data Quality Manual, Exception Code Manual, Exception Code Posters, MH & Depression Posters
 - Details available in your packs
 - Please contact us for more information if required

Retired Indicators



CHD5	% patients with CHD whose notes have a record of blood pressure in the previous 15 months	7
CHD7	% patients with CHD whose notes have a record of total cholesterol in the previous 15 months	7
DM5	% patients with diabetes whose notes have a record of HbA1c or equivalent in the previous 15 months	3
DM11	% patients with diabetes whose notes have a record of blood pressure in the previous 15 months	3
DM16	% patients with diabetes whose notes have a record of total cholesterol in the previous 15 months	3
STROKE 5	% patients with stroke/TIA whose notes have a record of blood pressure in the preceding 15 months	2

Retired Indicators



MH7	% patients with schizophrenia, bipolar affective disorder and other psychoses who did not attend the practice for their annual review who are identified and followed-up by the practice team within 14 days of their non-attendance	3
EP7	% patients aged 18 & over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months	4
INFO1	If a patient is removed from a practice list, the practice provides an explanation of the reasons in writing to the patient & info on how to find a new practice unless it is perceived that such an action would result in a violent response by the patient	1
REC21	Ethnic origin is recorded for 100% of new registrations	1

Retired Indicators



PE7	% patients who, in the appropriate national survey, indicated that they were able to obtain a consultation with a GP (England) or appropriate professional (Scotland, Wales & NI) within 2 working days (Wales 24 hours)	23.5
PE8	% patients who, in the appropriate national survey, indicated that they were able to book an appointment with a GP more than 2 days ahead	35
TOTAL POINTS		92.5

These points, plus a few others from indicators with reduced points, make up the 96.5 points to be reallocated to the QP indicators

Indicators reduced points



DEP1	Reduced by 2 points % patients on the diabetes and/or CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using the 2 standard screening questions
DEP4	Reduced by 8 points In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care
DEP5	Reduced by 12 points In those patients with a new diagnosis of depression recorded between the preceding 1 April to 31 March % patients who have had a further assessment 4 -12 weeks (inclusive) after the initial recording
BP4	Reduced by 2 points % patients with hypertension in whom there is a record of the BP in the last 9 months

Changes to existing indicators



- These generally include a subtle wording change
- However this can change your target patients quite dramatically
- It does result in the indicator having a new number label
 - E.g. COPD1 has changed so is now labelled COPD14



Changes to existing indicators



- CHD11 → CHD14
 - % patients with a history of MI (**from 1 April 2011**) currently treated with an ACE inhibitor (or ARB if ACE intolerant, **aspirin or an alternative anti-platelet therapy, beta blocker and statin** (unless a contraindication or side effects are recorded)
 - Points increased by 3 (10)
 - Thresholds (40-80%)



Rationale CHD14



- NICE guidelines state to support all patients who have had an acute MI treatment should include a combination of ACE, aspirin, beta blocker & statin
- These drug interventions are shown to be cost effective
- More information:

www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing CHD14



- You will need to set up a search to identify & track all newly diagnosed MI's from 1/4/11
 - Treatment
 - This indicator is saying that patients in this target should be on all 4 therapy's or have relevant exceptions for each
 - Must have all therapy's recorded or exceptions within applicable timeframe
 - Existing CHD9 is Aspirin, CHD10 is beta blockers, CHD11 used to include ACE so not a major change

Managing CHD14



■ Implementing & managing CHD14

- Check data entry template
 - Ensure this includes all relevant statin codes & statin exception codes
 - Multiple exceptions will apply to this indicator
 - Statins, ACE or ARB, alternative anti-platelet or aspirin
 - If patient is on statin & ACE treatment, an exception code would be required for aspirin/anti-platelet & betablockers
 - If patient is not on ACE or ARB, an exception for both would be required

Read Codes for Statins



Term	V2	CTV3
Statins (HMG COA reductase inhibitor) – BNF 2.12	bxk% - bxk%	x01R1%
Over the counter statin therapy	8B3z.	XaJxs
Statin prophylaxis	8B6A.	XaFsr
[X]Statin causing adverse effect in therapeutic use	U60CA	XaIsC
Adverse Reaction	TJC24 – TJC25	TJC24 – TJC25 XaIro, Xa5bP%,
Statin Allergy		Xa5zs%
Patient on maximal tolerated lipid lowering therapy	8BL1.	XaJ5i
Statin declined	8I3C.	XaII
Statins contraindicated	8I27.	XaIIg
Statin not indicated	8I63.	XaG2V
Statin not tolerated	8I76.	XaJYw

Changes to existing indicators



- CHD2 → CHD13
 - For patients with newly diagnosed angina (**diagnosed after 1st April 2011**) the % who are referred for specialist assessment
 - Points remain the same (7) as do the thresholds (40-90%)
 - Codes for referral for exercise testing or performing exercise test are no longer applicable

Rationale CHD13



- NICE guidelines state that exercise testing to diagnose or exclude stable angina is not appropriate for people without known CAD
 - Based on clinical & cost effectiveness
 - Exercise testing not sufficiently accurate to recommend this for patients with no prior history of CAD
 - www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing CHD13



- You will need to set up a search to identify & track all newly diagnosed angina
- Change existing data entry templates to remove exercise testing codes
- Current referral timeframes – up to 3 months before and 12 months after diagnosis

Codes for CHD13



Term	V2	CTV3
Cardiological referral	8H44.	8H44., XaBTR
Private referral to cardiologist	8HVJ.	8HVJ.
Referral to rapid access chest pain clinic	8HTJ.	XaFs5
Referral to cardiology special interest general practitioner	8H4R.	XaLFu

NOTE: Codes for exercise testing are no longer included

Changes to existing indicators



■ PP1 → PP1

- In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke/TIA) recorded between the preceding 1 April to 31 March: % patients **aged 30 to 74 years** who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months) using an agreed risk assessment tool
- Points remain the same (8)
- Thresholds (40-70%)

Rationale PP1



- In February 2010 NICE withdrew the guidance relating to a particular method of cardiovascular risk estimation so that the decision could be left to the NHS locally to use the method best suited to their requirements
- Four risk tools should be used: Framingham 1991 (35-74), JBS-2 (40+), ASSIGN (Scotland only) (30-74) and QRISK2 (30-84)
- PP1 use 30-74 age range but PP2 applies to all ages

Codes for PP1



Risk Assessment Terms	V2	CTV3
Framingham 1991 CVD Risk Assessment	38DR../38DF.	XaQaG
JBS CVD Risk	662k. – 662n.	XaKCr - XaKCu
QRISK2	38DP.	XaQVY
CVD Risk by 3 rd Party	38B10	XaX25
ASSIGN (Scottish Practices only)	38D6.	XaOdJ
CVD Risk Assessment Declined	9Oh9.	XaN8t
CVD High Risk Review Declined	8IAK.	XaQ9Y

Lifestyle Term	V2	CTV3
Lifestyle Counselling	67H..	XaEFY
Lifestyle Advice regarding Hypertension	67H8.	XaQaV
Must include Alcohol, Diet, Healthy Eating & Lipid Modification		

Exception codes for patient unsuitable & informed dissent are applicable where appropriate

Changes to existing indicators



- DM23 → DM26, DM24 → DM27 & DM25 → DM28
 - All of these related to HbA1c
- The main change is the target for DM26 which is now **7.5%**
 - This was previously 7%
- DM27 remains at 8% and DM28 remains at 9%
- Points & thresholds remain the same

Changes to existing indicators



- DM26, DM27 & DM28
 - The other change to all of these indicators is the inclusion of the **IFCC** result
 - The wording for these indicators now reads:
 - % patients with diabetes in whom the last **IFCC**-HbA1c is 59/64/75 mmol/mol (equivalent to HbA1c of 7.5% / 8% / 9% in DCCT values) or less (or equivalent test/reference range depending on local lab) in the preceding 15 months

Rationale DM26, 27 & 28



- NICE QoF advisory committee altered HbA1c level from 7% (53) to 7.5% (59) due to unintended consequences in terms of patient care
 - Considered dangerous due to achieving an average of 7 (53) would require values below 7 (53) in individual patients
 - www.nice.org.uk/aboutnice/qof/indicators.jsp

HbA1c dual reporting



- Currently HbA1c are dual reported
 - DCCT aligned & IFCC standardised
 - Get 2 results e.g. 7.5% (DCCT) & 59 (IFCC)
- Later this year dual reporting will stop
 - You will only get one result e.g. 59 (IFCC)
- May have an effect on reporting in short term
 - Check coding, ensure IFCC is recognised and has appropriate code assigned

Managing DM26, 27 & 28



- Ensure that your clinicians are aware of the 3 levels
 - 7.5 (59) / 8 (64) / 9 (75)
- Discuss dual reporting stopping and what this will look like
 - Ensure everyone knows what the results will look like in patient medical records

Codes & value converter



Term	V2	CTV3
Haemoglobin A1c level - IFCC standardised	42W5.	XaPbt

DCCT values for HbA1c(%)	IFCC values for HbA1c (mmol/mol)
4.0	20
5.0	31
6.0	42
6.5	48
7.0	53
7.5	59
8.0	64
9.0	75
10.0	86
11.0	97
12.0	108

Changes to existing indicators



- DM9 → DM29 (was peripheral pulses)
 - % patients with diabetes with a **record of a foot examination AND risk classification:**
 1. **Low risk (normal sensation, palpable pulses)**
 2. **Increased risk (neuropathy or absent pulses)**
 3. **High risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer)**
 4. **Ulcerated foot within the preceding 15 months**
 - Previously 3 points **(4)**,
 - Thresholds remain the same (40-90%)

Rationale DM29



- Patients with diabetes are at high risk of foot complications
- Evaluation of skin, soft tissue, musculoskeletal, vascular & neurological condition on an annual basis is essential
 - To detect feet at increased risk of ulceration
- Foot inspection should include:
 - Sensory neuropathy, foot pulses, deformities & other factors

Rationale DM29



- Foot risk classified
 - Low – normal sensation, palpable pulse
 - Increased – neuropathy or absent pulses or other risk factor
 - High – neuropathy or absent pulses + deformity or skin changes or previous ulcer
 - Ulcerated
- Risk classification now needs to be recorded
 - No requirement to record peripheral pulses, however, as this is likely to be done in order to assess risk, good practice to record this as well

Managing DM29



- The business rules allow you to record risk on either left or right foot for achievement
 - Good practice to include both!
- Foot amputation codes also act as exception codes
 - Only if amputation codes are entered for both feet (if appropriate) or if entered for say the left foot only, risk codes would also need to be present in order to achieve

Codes for DM29



Foot Screen Codes Term	V2	CTV3
Diabetic foot screen	66Aq.	XaPQH
Under care of diabetic foot screener	9NND.	XaJO9
Refer to diabetic foot screener	8H7r.	XaIQS
Peripheral pulses R.-leg	24E1.-24EF.	XE1hO%
Peripheral pulses L.-leg	24F1.-24FF.	XE1hP%
Foot exam exception code	8I6G.	XaJOE
Patient unsuitable for foot pulse check	8IB6.	XaWR7
Diabetic foot examination declined	8I3W.	XaJix

Foot Risk Codes Term	V2	CTV3
Diabetic foot at low risk (Right & Left)	2G5E., 2G5I.	XaIeH, XaIeL
Diabetic foot at Moderate risk (Right & Left)	2G5F., 2G5J.	XaIeR, XaIeS
Diabetic foot at High risk (Right & Left)	2G5G., 2G5K.	XaIeI, XaIeM
Diabetic foot – Ulcerated (Right & Left)	2G5H., 2G5L.	XaIeJ, XaIeK

Codes for DM29



Foot amputation codes	V2	CTV3
Right foot amputation codes	2G42.	XaBLT
	2G44.	XaBLV
	2G46.	XaBLX
Left foot amputation codes	2G43.	XaBLU
	2G45.	XaBLW
	2G47.	XaBLY

Changes to existing indicators



- DM12 → DM30
 - % patients with diabetes in whom the last BP is **150/90** or less in the preceding 15 months
 - Points split over the 2 indicators (8)
 - Slight increase in upper threshold (40-**71**%)
- DM12 has now been split into 2 with different BP ranges (was 145/85)
- Threshold increased due to increased range

Changes to existing indicators



- DM12 → DM31
 - % patients with diabetes in whom the last BP is 140/80 or less in the preceding 15 months
 - Points split over the 2 indicators (10)
 - Threshold (40-60%)

Rationale DM30 & 31



- BP lowering reduces risk of macrovascular (CHD, CVD & PVD) & microvascular (retinopathy, nephropathy & neuropathy) disease
- The target of 140/80 is recommended by NICE while the target of 150/90 has been set for others who cannot manage this (retinopathy, microalbuminuria or cerebrovascular disease)

Rationale DM30 & 31



- Setting a BP target at a higher level is intended to encourage clinicians to address the needs of the minority whose BP is hard to control
 - Expected that most patients will have BP below this target
 - www.nice.org.uk/aboutnice/qof/indicators.jsp

BP maximum tolerated



Term	V2	CTV3
Patient on maximal tolerated antihypertensive therapy	8BL0.	XaJ5h

- For reasons out of the doctors control the targets set within the register cannot be met and there is no benefit to the patient to increase medication
- e.g. Blood Pressure is 200/90 and Dr does not wish to add any more medication to the regime or increase dosage levels for valid reasons
- Patient's medication is being monitored by hospital and not the surgery
- Code should be added as part of Medication Review

Term	V2	CTV3
Medication Review	8B3%	8B314%

Changes to existing indicators



■ Mental Health

- The changes to MH indicators reflect what practices have been doing within a previous MH review
- This review focuses on the physical health needs of patients with MH
- QoF now requires you to record and code the specifics rather than just coding that a MH physical health review has been done
- The following 6 indicators have replaced MH9

Changes to existing indicators



MH11	Record of alcohol consumption in the preceding 15 months	4	40-90%
MH12	Record of BMI in the preceding 15 months	4	40-90%
MH13	Record of BP in the preceding 15 months	4	40-90%
MH14	Aged 40 years & over, record of total cholesterol:hdl ratio in the preceding 15 mths	5	40-80%
MH15	Aged 40 years & over, record of blood glucose level in the preceding 15 months	5	40-80%
MH16	Aged 25-64 England & NI, 20-60 Scotland, 20-64 Wales, record that a cervical screening test performed in the preceding 5 years	5	40-80%

All of the above apply to patients with schizophrenia, bipolar affective disorder & other psychoses

Rationale



- It was felt that the MH physical review needed to be defined
 - Many practices were only recording MH review and it was difficult to see what this comprised of – this ensures that the annual physical review is standardised for all patients
 - www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing MH10-16



- Need to make changes to data entry template
 - Recommend that you still record MH review code (6A6../ XalyU)
 - Need to ensure that your data entry template allows you to record individual data as required
 - We have also included advice codes where applicable – if patient is drinking over recommended limits, you would automatically offer advice to the patient so you need to record that this has been done
 - Not specifically for QoF but for patient history

Codes for MH10-16



Term	V2	CTV3
Mental Health Review	6A6..	XaIyU
Alcohol	136%	136%, Ub0IJ%, 1361%
Alcohol Advice	8CAM.	XaFvp
BMI	22K%	22K%
Exercise Advice	8CA5.	8CA5.
Diet Advice	8CA4.	8CA4.
BP (does not include all of the 246.. Codes)	246%	246%, X773t%
Total Cholesterol : HDL Ratio, Cholesterol/HDL ratio, Serum Cholesterol HDL ratio, Plasma Cholesterol/HDL ratio	* 44PF., 44I2., 44IF., 44IG.	* 44PF., XaERR, XaEUq, XaEUR
Blood Glucose Level	44TJ., 44TK.	X772z%
Cervical Smear	685%, 4K2%	X74Wk%, XE278%, Xa97C%
Smoking Cessation Advice	8CAL.	Ua1Nz

*Error in V19 rules new codes to be introduced in V20



Exceptions for MH10-16



Term	V2	CTV3
Top level exception codes apply (patient unsuitable/informed dissent)		
BP refused	8I3Y.	XaJkR
Hysterectomy & equivalent codes	685H., 685I., 685K., 908Y., 7E05.%, 7E040, 7E042-3, 7E046, 7E049, 7E04B, 7E04G, 7L0A.%, ZV6GB	XE1TV, 685I., 685K., XaKbV, XE06Z%, XaC3i%, XE06b%, 7E046%, X403D% (ex X403F), 7L0A.%, XaRAa
Smear	6853., 685L., 8I6K., 908Q.	6853., XaFs3, XaK29, 908Q.
Alcohol consumption refused	8IA7., 8IAt.	XaNOA, XaX4S
Serum Lithium Therapeutic	44W80, 44vE.	44W80



Changes to existing indicators



- MH4 → MH17
 - % patients on lithium therapy with a record of serum creatinine and TSH in the preceding **9 months**
 - This has changed from 15 months
 - Points remain the same (1)
 - Threshold (40-90%)

Rationale MH17



- Patients on lithium have a greater risk of hypothyroidism, hypercalcaemia & abnormal renal function
- NICE guidelines on bipolar recommend checking patients thyroid function every 6 months together with thyroid antibodies
- Also recommends renal function tests every 6 months
- www.nice.org.uk/aboutnice/qof/indicators.jsp

Changes to existing indicators



- MH5 → MH18
 - % patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding **4 months**
 - Previously 6 months
 - Points remain the same (2)
 - Threshold (40-90%)

Rationale MH18



- Wrong, unclear dose or strength & monitoring are key for lithium therapy
- NICE recommendations are:
 - Monitor serum lithium levels normally every 3 months
 - Monitor older adults carefully for symptoms of lithium toxicity
 - Aim to maintain levels between 0.6 – 0.8
 - Current QOF levels 0.4 – 1.0
 - www.nice.org.uk/aboutnice/qof/indicators.jsp

Changes to existing indicators



■ Depression

- Both indicators relating to the assessment of severity have had a reduction in points (DEP4 now 17 from 25 & DEP5 now 8 from 20)

■ DEP2 → DEP4

- In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity **at the time of diagnosis** using an assessment tool validated for use in primary care
 - Was 'at the outset of treatment'

Rationale DEP4



- Assessment to determine severity is essential for appropriate interventions and improve quality of care
 - Assessment as close as possible to time of diagnosis enables discussion with patient about relevant treatment options using stepped care model of depression
 - Thresholds for considering intervention revised: PHQ-9 to 12, HAD-D to 10 and BDI-II to 20
- www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing DEP4



- Outset of treatment has now been changed to at the time of diagnosis
 - Timeframe was within 28 days of diagnosis
- **The timeframe is still 28 days**, despite the wording change
 - However, note that the rationale suggests that the assessment as close to the time of diagnosis is recommended
 - This could mean that this will change in the future

Changes to existing indicators



- DEP3 → DEP5
 - In those patients with a new diagnosis of depression recorded between the preceding 1 April to 31 March % patients who have had a further assessment **4** -12 weeks (inclusive) after the initial recording
 - Was 5-12 weeks
 - Was worth 20 points, now worth 8 – loss of 12 points

Rationale DEP5



- Depression is a Chronic Disease
 - Treatment is often episodic and short-lived
 - Recognises that in clinical practice most prescriptions or follow-up appointments are given for 1, 2 or 4 weeks at this stage in the illness
 - If treated with anti-depressants patients should be followed up regularly for several months

www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing DEP5



- In terms of coding, nothing will change
 - You will still use the appropriate assessment tool code but check the thresholds for Intervention
- As the 2nd assessment is now 4 weeks, may be easier to target patients with follow-up scripts
- Clinicians need to emphasize to patients how critical it is that they come back for a follow-up in a month's time
 - To check on their condition and compliance of medication
 - NICE recommends on anti-depressants with no suicide risk checks every 2-4 weeks for 3 months then longer intervals if response good

Managing DEP5



- The guidance does not state this has to be face-to-face, although some assessment tools are designed for face-to-face (PHQ-9)
 - Many practices (clinicians) follow-up patients over the telephone
 - Feel that this is better than nothing, better than just keep giving medication and can really assess the patients state of mind
 - Can determine if they really are feeling better or if they just think that the doctor has done all they can
- Check local protocol with PCT

Replacement Indicators



- The following indicators are replacements
- When you look at these indicators it is unclear as to what has changed
 - The wording will be exactly the same
- These next few indicators have significant coding or business logic changes
 - Logic is around how the indicator is managed by your software

Replacement Indicators



■ COPD1 → COPD14

- The practice can produce a register of patients with COPD
 - NICE Guidelines indicate the severity of the airflow obstruction should be recorded so possibly require coding accordingly

Term	V2	CTV3
Mild chronic obstructive pulmonary disease	H36..	XaEIV
Moderate chronic obstructive pulmonary disease	H37..	XaEIW
Severe chronic obstructive pulmonary disease	H38..	XaEII
Very severe chronic obstructive pulmonary disease	H39..	XaN4a

NICE COPD - <http://guidance.nice.org.uk/CG101>

COPD14



- All existing patients with COPD will have a diagnosis code already entered – this code still includes them on the register
- When seen for their review, test & record the severity
 - This will effectively enter a 2nd diagnosis code
 - Leave the original code as this was their original diagnosis – this will be a supporting diagnosis
- For new diagnoses, may choose to use the specific severity code to include them on the register

Determining Disease Severity

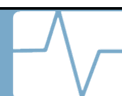


Table 1. Severity of airflow obstruction

		NICE clinical guideline 12 (2004)	ATS/ERS 2004 ³	GOLD 2008 ⁴	NICE clinical guideline 101 (2010)
Post-bronchodilator FEV ₁ /FVC	FEV ₁ % predicted		Post-bronchodilator	Post-bronchodilator	Post-bronchodilator
< 0.7	≥ 80%		Mild	Stage 1 – Mild	Stage 1 – Mild*
< 0.7	50–79%	Mild	Moderate	Stage 2 – Moderate	Stage 2 – Moderate
< 0.7	30–49%	Moderate	Severe	Stage 3 – Severe	Stage 3 – Severe
< 0.7	< 30%	Severe	Very severe	Stage 4 – Very severe**	Stage 4 – Very severe**

* Symptoms should be present to diagnose COPD in people with mild airflow obstruction

** Or FEV₁ < 50% with respiratory failure

ATS, American Thoracic Society; ERS, European Respiratory Society; FVC, forced vital capacity; GOLD, Global Initiative for Chronic Obstructive Lung Disease

Replacement Indicators



■ COPD12 → COPD15

- % of all patients with COPD diagnosed after **1 April 2011** in whom the diagnosis had been confirmed by post bronchodilator spirometry
 - Date change to bring it in line with the present
 - The ONLY codes to be used now are:
 - Remove all other spirometry codes from templates

Term	V2	CTV3
Referral for spirometry	8HRC.	XaK02
Post bronchodilator spirometry	745D4	XaXeg
Spirometry test declined	8I3b.	XaK27
Spirometry test not indicated	8I6L.	XaK2A
Spirometry contraindicated	8I2j.	XaWPN

Replacement Indicators



- MH6 → MH10

- % patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate

- Nice Guidance

www.nice.org.uk/aboutnice/qof/indicators.jsp

Rationale MH10



- Patients on MH register should have a documented primary care consultation
 - Plan for care especially in the event of relapse
 - May include views of relatives/carers
- Up to ½ of people with MH are seen only in a primary care setting
 - Important for primary care to take responsibility for discussing & documenting a primary care plan

Rationale MH10



- The care plan should include:
 - Current health status & social care needs, how they can be met & by whom
 - Social support – family, friends, organisations
 - Social support may only be from MH organisations
 - Summary of services being received
 - Occupational services
 - Only 24% people with MH are currently in work
 - Early warning signs – may indicate possible relapse
 - Patients preferred course of action should a relapse occur
 - Discussed when the patient is well

Rationale MH10



- Plan should be accurate, easily understood, reviewed annually & discussed with relevant people (family/carers)
 - If patient treated under care programme approach, should also discuss with key worker
- If patient has a relapse, once in remission care plan should be updated
 - Care plans dated prior to relapse will not be accepted for QoF purposes

MH - Remission



- From April 2011, you may record patients on the MH register as being in remission
 - It has become apparent that it is occasionally necessary to exclude some patients on the register as their illness is in remission
- Patients will remain on the register (in case of relapse) but will be excluded from MH10-16
- Making an accurate diagnosis of remission can be challenging
 - Based on clinical judgement

MH - Remission



- Only appropriate to record if the patient has been in remission for at least 5 years
 - Where there is no record of antipsychotic meds
 - No MH in-patient episodes
 - No secondary or community care MH follow-up for at least 5 years
- Accuracy of coding should be reviewed on an annual basis
- Where a patient has a relapse, this should be recorded
 - Will again be included in the MH indicators

Managing MH10



- MH care plan only needs to be coded once (ever) after diagnosis
 - The care plan needs to be kept up-to-date (will be checked if you have a QoF verification visit) so each time you review/update it, worth coding again
- If a patient in remission has a relapse you will need to re-diagnose them before they are included in MH10-16

MH remission codes



Term	V2	CTV3
Schizophrenia in remission	E1005	E1005
Non organic psychosis in remission	Eu26.	XaX52
Bipolar affective disorder currently in remission	Eu317	Eu317
Paranoid state in remission	Eu223	XaX51
Paranoid schizophrenia in remission	E1035	E1035
Catatonic schizophrenia in remission	E1025	E1025
Hebephrenic schizophrenia in remission	E1015	E1015
Schizoaffective schizophrenia in remission	E1075	E1075
Bipolar affective disorder currently manic in remission	E1146	E1146
Bipolar affective disorder currently depressed in remission	E1156	E1156

Many more remission codes available – check out the rule sets or purchase Insight's QoF Read Code Manual

New Indicators - EP9



- % of women under the age of 55 years who are taking antiepileptic drugs who have a record of information & counselling about contraception, conception & pregnancy in the preceding 15 months
 - 3 points, 40-90% threshold
 - The timeframe for this indicator will run from 1st January 2011 – 31st March 2012 (15 mths)

Rationale – EP9



- 131,000 women of childbearing age (12-50) have epilepsy (25% of epilepsy patients) and 1 in 200 attending Ante-natal on antiepileptic drugs (AED) - 2500 epilepsy patients a year have a baby
- antiepileptic drugs taken in pregnancy increase chance of major congenital malformations (MCMs)
 - Average MCM is 1-2% with those on 1 AED over 3.5% and on 2 or more AED 6%
 - Identified importance to give patients information on risks
 - For more information:
www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing EP9



- Age range is 18 – 55 years & only applies to patients on the epilepsy register
- Patients with hysterectomy, menopause & sterilisation will automatically be excluded
 - Providing they are coded appropriately
- In order to qualify for achievement, must record all 3 areas within the 15 months
 - Appropriate code or exception
 - Do not have to be all at the same time

Managing EP9



- Set up a report to identify all women 18 - 55 yrs taking antiepileptic medication since 1st January 2011
 - Likely that the rule will look at those taking medication in the last 6 months of the year
- Need to ensure that all patients have a record of INFORMATION & COUNSELLING about 1. contraception, 2. conception, 3. pregnancy
 - Advice must be given in the context of a face-to-face consultation

Managing EP9



- Data entry templates
 - Edit your existing epilepsy template to include appropriate information & counselling codes
 - Ensure your clinicians are aware of this new indicator so that they can offer appropriate information & counselling at point of care

Read Codes – EP9



Term	V2	CTV3
Anti-epilepsy Drugs – BNF 4.8	dn%, d26%	x000i%, d26..%
Pre-conception advice for patients with epilepsy	67IJ0	XaRfW
Contraceptive advice for patients with epilepsy	6110.	XaRFV
Pregnancy advice for patients with epilepsy	67AF.	XaRFX
Pregnancy advice for patients with epilepsy declined	8IAi.	XaRFg
Contraceptive advice for patients with epilepsy declined	8IAg.	XaRFe
Pre-conception advice for patients with epilepsy declined	8IAh.	XaRff
Pregnancy advice for patients with epilepsy not indicated	8IB4.	XaRFc
Contraceptive advice for patients with epilepsy not indicated	8IB2.	XaRFa
Pre-conception advice for patients with epilepsy not indicated	8IB3.	XaRFb

New Indicators – LD2



- % patients on the LD register with Down's Syndrome aged 18 yrs & over who have a record of blood TSH in the preceding 15 mths (excluding those who are on the thyroid disease register)
 - 3 points
 - 40-70% threshold
 - Timeframe for this will run from 1st January 2011 to 31st March 2012

Rationale – LD2



- Poor thyroid function can impair the quality of life
 - Children and Adults with Down's syndrome are at increased risk of thyroid dysfunction, particularly hypothyroidism, compared with the general population
 - Incidence of thyroid dysfunction increases with age
 - For more information:
www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing LD2



- Ensure patients with Down's syndrome are coded correctly, not just coded for LD register
- Identify all patient with Down's syndrome over 18 years old who are not included on the hypothyroidism register
 - Ensure these patients have annual recall for Blood test
- Update existing guideline to include TSH bloods

Read Codes – LD2



Laboratory Tests - Term	V2	CTV3
Thyroid function tests	442A.%	X77Wg%, XE2wy&, XE25G, X7729%, X772A%, X772B, X772C, XaDte%, XaDtF%, 442C., 4422., 4423

Downs Syndrome - Term	V2	CTV3
Downs Syndrome -	PJ0%	XE1MZ%

New indicators – DEM3



- % of patients with a new diagnosis of dementia from April 2011 to have FBC, calcium, glucose, renal & liver function, TFT, serum vitamin B12 & folate levels recorded 6 months before or after entering onto the register
- As well as recording the blood tests ensure you record the health review done
 - 6AB.. / XaMGF

Rationale DEM3



- No universal consensus on appropriate diagnostic tests
 - Reviewing existing guidelines found similarities
 - Main reason for investigations is to rule out potentially reversible or modifying cause
- NICE Guideline states that basic Dementia test should be performed at time of presentation usually within Primary Care to include:
 - routine haematology, biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function), thyroid function tests, serum vitamin B12 and folate levels

www.nice.org.uk/aboutnice/qof/indicators.jsp

Managing DEM3



- Only applies to diagnosis made after 1st April 2011
- Ensure all New Dementia Patients after 1st April 2011 have appropriate bloods taken or arranged within 6 months of diagnosis
 - Update care arrangements and carers details to ensure this is carried out
- Update existing guideline to include relevant blood tests

Read Codes DEM3



Term	V2	CTV3
Full Blood Count	423.., 426.., 42A.., 42H..	Xa96v, 426.., 42A.., XaIdY
Serum Glucose *	44T1.-44T3., 44TE.-44TK., 44U..%	44f%, XM0ly%
Liver Function Test	44FA., 44FD., 44G7., 44G9., 44GB.	XaERY, XaERx, XaES4, XaES3, XaLJx
Renal Function	44J9., 44JA., 44J3., 44JF., 44JC., 44JD.	XM0lt, XaDvl, XE2q5, XaETQ, XaERX, XaERc
Thyroid Function Test	442W., 442X.	XaELV, XaELW
Vitamin B12 Level	42T., 44Le.	XE2pf, XaJ27
Folate Level	42U5., 42UE.	42U5., X76tC

*** More codes available than listed here**

New indicators



- The following new indicators are all related to Quality & productivity (QP)
 - 3 distinct areas, 11 indicators, 96.5 points
- Each section is made up of a number of indicators, set points for each but thresholds will be determined locally
 - Where thresholds apply, marked with a *
 - There should be 20% points between upper & lower threshold

QP1-5 Prescribing



QP1	Practice conducts an internal review of their prescribing to assess whether it is clinically appropriate & cost effective, agrees with the PCO 3 areas for improvement & produces a draft plan for each area – completed by 30 th June 2011	6
QP2	Practice participates in an external peer review of prescribing with a group of practices & agrees plans for 3 prescribing areas for improvement firstly with the group & then with the PCO – completed by 30 th September 2011	7
QP3*	% scripts complying with the agreed plan for the 1 st improvement area as a % of all scripts in that area during the period 1 Jan 2012 – 31 March 2012	5
QP4*	% scripts complying with the agreed plan for the 2 nd improvement area as a % of all scripts in that area during the period 1 Jan 2012 – 31 March 2012	5
QP5*	% scripts complying with the agreed plan for the 3 rd improvement area as a % of all scripts in that area during the period 1 Jan 2012 – 31 March 2012	5

QP1-5



- PCT/LHB will provide the practice with data on their prescribing & comparisons with others
 - May include generic prescribing
 - Information about costs & clinically suitable lower cost alternatives
- Areas agreed must not be the same as those for MED6 & MED10
- It is your practice choice where you focus, you need to demonstrate improvements
 - Likely to be areas of significant expenditure throughout the year
 - Areas which offer improved clinical effectiveness or productivity savings or both (compared to similar practices)

Prescribing habits



Practice Population	9975
Antibiotics issued last 6 months (almost 25% of the total number of patients)	2167
Scripts issued in March 2011 (almost a third of the total number of patients in 1 month)	3147
Practice Population	15250
Antibiotics issued last 6 months (only 16% of the total number of patients)	2462
Scripts issued in March 2011 (almost 40% of the total number of patients in 1 month)	6001

Prescribing habits



Practice Population	4133
Antibiotics issued last 6 months (30% of the total number of patients)	1339
Scripts issued in March 2011 (35% of the total number of patients in 1 month)	1452
Practice Population	2463
Antibiotics issued last 6 months (75% of the total number of patients)	1853
Scripts issued in March 2011 (More than double the total practice population)	5842

QP6-8 Outpatient Referrals



QP6	Practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5
QP7	Practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area & proposes areas for commissioning of service design improvements to the PCO	5
QP8*	Practice engages with the development of & follows 3 agreed 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 outpatient referrals & produces a report of the action taken to the PCO no later than 31 st March 2012	11

QP6-8



- PCT/LHB will provide data on secondary care referrals
- You may wish to verify this against your data
- Clinicians will then meet up to discuss
 - Identify any referrals anomalies in ref patterns
 - Compare patterns to existing care pathways to identify areas of improvement
 - The output of the review should be made available to others in the external review
 - Groups should be a minimum of 6 similar practices

Referral statistics



Practice Population	9975
Referrals last 12 months – 24%	2385
Practice Population	15250
Referrals last 12 months – 18%	2784
Practice Population	4133
Referrals last 12 months – 43%	1795
Practice Population	2463
Referrals last 12 months – 30%	738

QP9-11 Emergency Admissions



QP9	Practice meets internally to review the data on emergency admissions provided by the PCO	5
QP10	Practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or with practices in the PCO area & proposes areas for commissioning of service design improvements to the PCO	15
QP11*	Practice engages with the development of & follows 3 agreed pathways (unless in individual cases they justify clinical reasons for not doing this) in the management & treatment of patients in aiming to avoid emergency admissions & produces a report of the action taken to the PCO no later than 31 st March 2012	27. 5

QP9-11



- PCT/LHB will provide data on emergency admissions
 - Can you compare this against your data?
- Practices should meet to explore the reasons for emergency admissions to identify areas of improvement
 - This report should be made available to other practices within the group
- Once identified, the practice will follow 3 agreed care pathways in the management & treatment of patients to avoid emergency admissions

Emergency Admissions - stats



Practice Population	9975
Coded emergency admissions last 12 months	13
Emergency admissions with QoF exception (top level)	2
Practice Population	15250
Coded emergency admissions last 12 months	10
Emergency admissions with QoF exception (top level)	3
Practice Population	4133
Coded emergency admissions last 12 months	4
Emergency admissions with QoF exception (top level)	0
Practice Population	2463
Coded emergency admissions last 12 months	4
Emergency admissions with QoF exception (top level)	1

Reporting on QP indicators



- Practices must produce reports
 - Detailing the internal review, when & who attended
- Achievement will be measured in the final ¼ of 2011/12
- Thresholds will be set locally
- As with most other organisation indicators, exceptions will not apply

Increased Thresholds



- The following indicators all have a 1% threshold increase
- This is due to increasing the measurement/target to achieve

Increased Thresholds



CHD6	% patients with CHD in whom the last BP reading (measured in the preceding 15 months) is 150/90 or less	17	40-71%
STROKE 6	% patients with a history of stroke/TIA in whom the last BP reading (measured in the preceding 15 months) is 150/90 or less	5	40-71%
DM30	% patients with diabetes in whom the last BP reading (measured in the preceding 15 months) is 150/90 or less	8	40-71%

Direct Enhanced Services (DES)



- Extended hours DES
 - Extended by 1 year to 31st March 2012
 - Payment reduced from £3.01 - £1.90 per patient
- Clinical DESs
 - Ethnicity & 1st language DES no longer available
 - You are expected to record this information as a matter of routine – you need to understand the 'make-up' of your population to meet their health needs
 - Alcohol reduction, learning disabilities & health checks and osteoporosis DESs extended for a further 12 months (31st March 2012)
 - All requirements & payments will remain the same

Direct Enhanced Services (DES)



- Patient Participation DES (NEW)
 - Funded by the reduction in the extended hours DES
 - Seeks to improve patient participation & make practices more responsive to the needs & wishes of patients
 - Key requirements are:
 - Patient reference group; agree priority areas; collate patient views through a patient survey; agree action plan with group; publicise the survey results; publicise actions taken & achievements
 - £1.10 per registered patient

Patient Participation DES – Validation & Payment



DES Component	Weighting of payment – year 1	Weighting of payment – year 2
1. Establish a PRG comprising only registered patients, use best endeavours to ensure PRG is representative	20%	0%
2. Agree with PRG priority issues, include these in a local practice survey	20%	10%
3. Collate patient views through survey, inform PRG of the findings	20%	20%
4. Provide PRG chance to comment & discuss findings of survey. Reach agreement with PRG of changes in provision & manner of services – if no significant agreement, agree with PCT	20%	30%
5. Agree with PRG plan of action, including priorities arising from survey. Seek PRG approval to implement changes	20%	30%
6. Publicise local patient participation report on practice website & update report on subsequent achievements	0%	10%

Patient Participation DES – Validation & Payment



- Payment will be made no later than May 2012 (year 1) & May 2013 (year 2)
 - Based on the content of the report on the practice website
 - Report must be completed & publicised no later than 31 March each year
 - Failure to publish its report to the website by 31 March each year will result in no payment being made to the practice for that year

Exception Codes



- The use of exception codes remains the same
- Always use as appropriate – QoF verification visits will look closely at exceptions
- Never use high level exceptions for single indicators
 - Where there is no option available, max thresholds have been set at 90% for this reason
- Never use as a replacement to high quality, accurate data

Prevalence



- Major feature of QoF is accurate registers
- Whilst it is recognised that they may not always be 100% accurate, it is up to the practice to demonstrate systems in place to maintain high quality registers
- If your registers are not accurate, this will affect the care you offer to patients (or not) and your income
- It is not unusual for an average practice to be losing around £10,000 per year due to inaccurate registers

Summary



- Whilst the changes do not appear too significant, they are detailed & complex
- You need to ensure that everyone in your practice is aware of them
 - Especially the clinicians
 - Especially whilst you do not have up-to-date data entry templates & prompts
- QoF is a team effort – you coming here today will not be enough on it's own
- Happy to come along to the practice & deliver a tailored session for your entire team

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