QOF
frequently asked questions

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BMA

NHS Employers

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Introduction

NHS Employers and the General Practitioners Committee (GPC) of the British Medical Association (BMA) have agreed a set of UK QOF FAQs which cover a number of historical issues and commonly asked questions.

This document should be consulted before queries are raised with any of the parties as outlined in the QOF Queries section of the 2011/12 QOF guidance document. The document is available on the NHS Employers and BMA websites via the links in question one.

This document contains questions in the following areas:

- General questions
- Clinical indicators
- Organisational, quality and productivity and patient experience indicators
- Additional services indicators
- Financial and technical questions
    - Financial
    - Technical
        - Business rules and exception reporting
        - Prevalence
        - QMAS
- Miscellaneous questions
- QOF Queries

General questions

1. Is there new guidance available for QOF for 2011/12?

The details of the QOF changes for 2011/12 and the supporting guidance are available to download from the NHS Employers and BMA websites:

www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF2011-12.aspx

www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qofguidance2011.jsp

2. Can I buy copies of guidance/books, or can you send me copies?

All of the publications relating to QOF are only available to download and print from the QOF section of our respective websites (see links in **Q1**). It is not possible to purchase hard copies.

3. Why were there no changes to the QOF in 2010/11?

No changes were made to the QOF for 2010/11 as agreed as part of the 2009 H1N1 (swine flu) vaccination programme agreement. Details of this agreement are available on the pandemic flu pages of our respective websites via the links below. As such, the 2009/10 version of the QOF guidance still applied for 2010/11.

www.nhsemployers.org/FluPrimaryCare

www.bma.org.uk/health_promotion_ethics/influenza/panflugp/gpcnhsestatementfluvaccines.jsp

4. What is the process for making changes to the QOF?

The National Institute for Health and Clinical Excellence (NICE) became responsible for managing the QOF clinical and health improvement indicators from April 2009. As part of this process, NICE prioritises areas for new indicator development, develops and selects indicators for inclusion on the NICE menu of indicators, makes recommendations for the retirement of indicators and consults with individuals and stakeholder groups.

The NICE menu of indicators is published in August each year and the recommendations are used to inform national contract negotiations between NHS Employers and the GPC on changes to the QOF.

5. How can I influence changes to indicators or suggest new indicators for consideration?

NICE operates an online facility which allows stakeholders to comment on current QOF indicators. Comments will be used to review existing QOF indicators against set criteria which include:

- evidence of unintended consequences
- significant changes to the evidence base
- changes in current practice.

Comments are fed into a rolling programme of reviews and considered by the Advisory Committee. The recommendations of the Committee will then be fed into negotiations between NHS Employers and the GPC. The online facility is available on the NICE website:

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

6. How can I get a copy of the blue book?

The 'blue book' is only available from 'The New GMS Contract 2003' section of the NHS Employers website. As there is no consolidated version of this document, each section needs to be printed individually. The individual documents are available via the link below:

www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/gmscontract200304/Pages/NewGMSContract200304.aspx

Clinical area questions

General questions

7. Can a patient be on more than one register?

Yes. For example, a patient could be on the Asthma disease register and also the COPD register as they could meet the criteria for both disease areas as they are both respiratory diseases. This would also be the case for those indicators relating to other conditions, such as heart disease.

Secondary prevention of coronary heart disease

8. For CHD13, where a patient is diagnosed through clinical assessment alone, how should this be recorded in the patient notes?

Where a patient has been diagnosed with chronic heart disease (CHD) on clinical assessment, then an explanation should be included in the patient notes as to how the diagnosis has been made. These patients will need to be exception reported against this indicator as referral for specialist assessment only applies to those patients in whom it was not possible to make a diagnosis of angina on clinical grounds alone.

Where a generic exception code is used for this indicator, the patient will then be exception reported from all other indicators within this disease area and the clinical system reminders will be removed. Practices are reminded, however, that achievement always overrules exceptions and therefore even if a patient has been exception reported from an indicator and the practice then delivers the activity described (i.e. not with the particular indicator in mind but by default) then this would count towards achievement.

For further information, please see **Q62** 'Is exception reporting done on an indicator by indicator basis?'

Cardiovascular disease – primary prevention

10. Many patients who develop hypertension take a number of other medications which may affect the ability to calculate cardiovascular disease (CVD) risk. Is there an intention to expand the exceptions in PP1 to take this into consideration?

This is currently with NICE for consideration when reviewing the guidance for 2012/13 QOF.

11. CVD PP1 asks for CVD risk to be calculated for people with hypertension using a risk calculator. These calculators have specific age ranges, is there an age range for this indicator?

In February 2010, NICE withdrew its guidance recommending a particular method of CVD risk estimation (Framingham) so that the decision could be left to local NHS organisations to use the method best suited to their requirements. It should be noted that all four risk equations allow for a structured risk assessment to be undertaken.

In order to allow for all four risk assessment tools to be used (they each have different individual age thresholds), an upper and lower age range for this indicator has been set at 30 to 74 years. Practices will be expected to use one of the four age appropriate tools to risk assess their patients even if it is not a tool normally available on the practices clinical system.

For the list and full details of the risk assessment tools available, see the CVD primary prevention section of the 2011/12 QOF guidance.

12. CVD PP2 asks to give lifestyle advice about increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet. However, there is no READ code for advice about diet and several codes for lifestyle advice which are not appropriate i.e. 'harm minimisation' and 'relapse prevention'.

The read codes chosen are a direct match to what the indicator is looking for in terms of lifestyle advice. New codes were included in the October 2009 release as follows:

- Lifestyle counselling
- Lifestyle advice regarding hypertension.

13. The wording of indicator CVD PP2 includes patients with pre-existing CHD, diabetes etc. CVD PP1 doesn't include these patients, however when looking at the cohort of patients in the QOF indicators section of SystmOne both cohorts are the same. Does PP2 therefore include or exclude those patients with pre-existing CHD, diabetes etc?

The patient registers for both CVD PP1 and CVD PP2 are the same and therefore are for all patients with Hypertension (unless resolved) excluding those with existing CHD, Stroke and TIA, peripheral vascular disease (PVD), TIA, diabetes and chronic kidney disease (CKD).

Hypertension

14. In version 16 of the Business rules, 67H (lifestyle counselling) and 67H8 (lifestyle advice regarding hypertension) are the only codes which count as meeting CVD PP2. However, some of the other 'daughter' codes of 67H (which cover advice for smoking, diet, alcohol and exercise) are relevant to this target. Can all daughter codes be included as meeting CVD PP2?

Consideration has been given to the inclusion of the daughter codes of 67H but it was decided not to progress this for version 16 of the rule sets. The reason for this is that it would require a complete rewrite of the rule set with a separate cluster for each daughter code as all would need to be entered in order for the indicator to be met. This would also require additional clusters to check whether or not a patient was recorded as being a smoker or not as obviously those who have never smoked do not require smoking cessation advice.

Further consideration may be given to the inclusion of these codes in the future (as at v20, no changes have been made). In the meantime, practices are advised to record the detail of their advice either with additional coding using the daughter codes or in free text as with the other 'basket codes' to enable verification.

Diabetes

15. Will automated computer search engines recognise the new units for HbA1c-IFCC?

The QOF Business Rules were updated to include both the new codes and units for the HbA1c-IFCC measurement of mmol/mol. The existing HbA1c DCCT measurement of '%' also remains, so that practices using either or will qualify. These changes were made in version 15.0 of the QOF rulesets published in August 2009.

All practices using a GPSoC clinical system will have access to the relevant 5 byte and CTv3 IFCC codes.

Chronic obstructive pulmonary disease

16. Why has COPD12 been renumbered to COPD15 and why has the date changed from April 2008 to April 2011?

The chronic obstructive pulmonary disease indicator (COPD12) was introduced in April 2008 and required that diagnosis was confirmed by post bronchodilator spirometry. New READ codes should have been introduced to replace the temporary codes being used for this indicator. Unfortunately, the new codes

were not requested as intended. This has now been rectified and the new post bronchodilator codes will be included from April 2011 as follows:

- 745D4 | Post bronchodilator spirometry
- 8HRC. | Referral for spirometry
- XaXeg | Post bronchodilator spirometry
- XaK02 | Referral for spirometry.

The previous codes for reversibility test have now been removed.

It is due to these coding changes, that the indicator has been renumbered and the date changed to April 2011.

Mental health

17. Patients whose lithium was stopped are still showing up in population manager as requiring their lithium levels to be within the correct range. Is there another READ code that can be used to rectify this?

NHS Employers and the GPC do not provide direct support for practice clinical system such as Population Manager, however we do have experience in understanding the business rules. The following explanation is in relation to QMAS.

For MH18, the indicator is worded as follows "The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months". There is no mention that the patient must be receiving 'ongoing' lithium, therefore the rules do not consider if the lithium has stopped or not. If the patient has been on lithium treatment in the "preceding 6 months", the indicator is attempting to ensure that the patient is/was within a "therapeutic range".

It is important to note, that for the following QOF year the patient would disappear from the indicator completely assuming the patient does not restart lithium treatment.

18. Is there a READ code available which would enable a practice to remove a patient from the mental health register following resolved episode?

See question and answer in the exception reporting section of these FAQs.

Asthma

19. Asthma 8 – Patients who turn eight years old in the current QOF year, but who were diagnosed with asthma in the previous QOF year and before they were eight, are registered as not having their diagnosis confirmed by serial peak flow or spirometry reversibility. Once the patient turns eight should the diagnosis be made again (especially as the diagnostic tests would be invalid on patients on regular asthma treatment)?

It is acceptable to re-examine the diagnosis using tests of variability or reversibility for patients diagnosed with asthma below the aged of eight years, who have subsequently turned eight and are receiving long-term anti-inflammatory therapy. In those patients who are not receiving long-term anti-inflammatory therapy they should be treated as a new presenting case and the diagnosis re-evaluated. Therefore, in terms of rules:

Asthma diagnosed below eight years turning eight years:

1. Check if receiving inhaled steroids (ICS) (on own or in combination with a long-acting beta agonists)/leukotriene antagonist (LTRA) if so look for codes for reversibility / variability from five years onwards
2. If not receiving ICS or LTRA treat as a new patient.

20. Asthma 6 – Can a review of inhaler technique be carried out over the telephone?

An assessment of inhaler technique is an important element of this review and as outlined in the QOF guidance, should be performed in a face-to-face consultation.

Depression

21. Who is included in the registers for the depression indicators?

For DEP1, the register includes all patients on the diabetes register (aged 17 years and over) and/or all patients on the CHD (no minimum age) register.

For DEP4 and DEP5 all patients over 18 years with a current diagnosis of depression regardless of whether they are currently receiving treatment for depression.

22. The wording of DEP4 states that the depression indicators relate to patients with a new diagnosis of depression within the preceding year, whereas the business rules use 'total prevalence' of all patients with an 'active' diagnosis of depression. Does this mean that patients with an episode of depression many years ago but who have had no symptoms or treatment since their initial diagnosis are included in this prevalence calculation?

Yes, all patients with an active diagnosis of depression in the records would be included in the prevalence calculation for these indicators even if these patients no longer have symptoms or are no longer receiving treatment.

GPC have queried this calculation as they believe that QMAS should only count the patients diagnosed in the previous QOF year (1 April – 31 March) and as such this has been raised with NICE for consideration. Should NICE recommend any changes to this process, these changes would not be implemented before the 2012/13 QOF year.

Depression – timeframe

A number of questions have been raised around the timeframes for the depression indicators. As such, we thought it would be helpful to provide an explanation for the rationale behind the structure of these indicators.

23. Depression 2 (DEP4 from 2011/12)

The original DEP2 indicator was introduced to QOF in April 2006. From April 2009 the associated business rules were revised to deal with a cross-year indicator where workload spans more than one QOF year, to:

ensure fair and consistent payments to all practices ensure that patients who were diagnosed in the last three months of the QOF year are identified.

The QOF is set up to support annual activity that is completed in one QOF calendar year, which runs from 1 April to 31 March. Prior to the business rule change in April 2009, any patient newly diagnosed with depression between January and February would have been removed from the denominator, due to the new diagnosis exception criteria. Furthermore, because the indicator specifically relates to a new diagnosis, the same patient would not be picked up in the following QOF year.

The depression indicator business rules were therefore revised, from 1 April 2009, to cover 15 months so as to address this issue.

DEP2 was reviewed and updated through the NICE process and replaced by DEP4 in April 2011. The above explanation for the timeframe and the business rules still applies.

24. Depression 3 (DEP5 from 2011/12)

The DEP3 indicator was a new indicator introduced in April 2009. At the time, given it was a new indicator, the first line of the supporting rules excludes any newly diagnosed patients before April 2009 (see page 16 of business rules v.17) as we do not expect practices to have done the work before April 2009. The business rules for DEP3, like DEP2, are structured to take account of the cross year issue given the activity described by the indicator can span more than one QOF year. This supports the spirit of the indicator and also ensures fair and consistent payment to practices.

DEP3 was reviewed and updated through the NICE process and replaced by DEP5 in April 2011. The above explanation for the timeframe and the business rules still applies.

25. Where a practice has failed to meet the criteria of DEP4, is the practice still eligible to achieve DEP5?

As the business rules for DEP5 are currently written, they do not take account of patients who have not had an assessment under DEP4, but does include patients who have been assessed under DEP4, but does include any who have been assessed even if this assessment was outside the 28 days required by DEP4.

The consequence of this is that those patients who have not been assessed under DEP4 are counted as a failure against DEP4 and are excluded from DEP5 (i.e. not included in the numerator or denominator for DEP5). While for those patients who have been assessed under DEP4, but outside the 28 day timeframe, are counted as a failure for both DEP4 and DEP5 (i.e. included in the denominator but not the numerator for each indicator.

The difference in the way the business rules treat patients who have been a failure against DEP4 when determining the denominator and numerator for DEP5 is inconsistent. For this reason NHS Employers and GPC have asked NICE to review this difference.

Should NICE recommend any changes to this link between the indicators, these changes would not be implemented before the 2012/13 QOF year.

26. QMAS depression 1 register issue (England only)

In England, QMAS has been incorrectly using the depression register size for the two other depression indicators (DEP2 and DEP3, changed to DEP4 and DEP5 in 2011/12) rather than using the DEP1 register size, which is different. This means that practices whose register for DEP2/4 and DEP3/5 is zero, but a register for DEP1 of greater than zero, QMAS has reduced the achievement for DEP1 to zero.

This issue is expected to have affected a very small number of practices (only three in 2010/11) and the system requires a simple manual fix. Connecting for

Health (CfH) will contact each of the practices concerned and BT will be correcting the issue for 2011/12 onwards, the change is expected to go live in October 2011.

Chronic kidney disease

27. When performing a urine dip test on a patient diagnosed with chronic kidney disease (CKD) where the result shows no proteinuria, is it necessary to send the specimen to the lab? Will performing the dip test still qualify achievement of CKD6?

In order to achieve this indicator a precise result which is only achievable through a laboratory test must be recorded. Therefore, a urine dip stick test would not qualify towards the indicator.

A set of QOF CKD FAQs (updated in July 2011) are available on our respective websites via the links in **Q1**.

28. If a patient has been diagnosed with atrial fibrillation (AF) and successfully treated – does that person remain on the AF register at a practice?

Patients are removed if there is an 'AF resolved' code present in their records after the patient's latest AF recording. However, this should not be done for paroxysmal AF (PAF), diagnosis of which is clinical and based on the patient history.

Organisational domain questions

Education

29. Education 1 requires that there is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months. Does this include partners?

For the purpose of achievement for this indicator, partners are not currently counted. However, it is expected that all clinicians working within a practice would have up to date basic life support skills and this includes partners.

30. Is there a set timeframe for the three significant event reviews for Education 10?

It is expected that the three significant events being reviewed should have occurred in the current QOF year e.g. if the review takes place in March 2011, the events should have occurred between 1 April 2010 and 31 March 2011. In addition, the reviews should be carried out as soon as reasonably practical after the event.

Quality and productivity

In Wales, guidance has been issued jointly by the National Medicines Management Programme and GPC Wales in relation to the quality and productivity indicators and this can be found at: www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=53858

Prescribing indicators QP1 to QP5

31. 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 PCO), choose and agree with the PCO 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 PCO.

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

In such circumstances, the PCO 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 PCO. For the purposes of achievement, the PCO 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.

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

In England and Northern Ireland the guidance/SFE clearly states that the measurements must be number of prescription items.

In Scotland, agreement has been made with SGPC to allow the use of number of items dispensed or defined daily dose – whichever measure is most clinically appropriate.

For Wales, please see the local guidance linked above.

34. 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.

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

PCOs are 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 national data for a chosen area, and should avoid frequent short-term changes to prescriptions that could leave patients confused about their medication.

36. 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 PCO 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.

37. Are community based prescribing staff included in the internal peer review meetings?

Where community based staff prescribe on behalf of and within a practice's prescribing budget, then the practice should invite them to the internal review meeting. It is expected that PCOs will allow the relevant staff the time to attend the internal review as it is in the interests of all parties. However, should community staff be unable to or do not wish to participate in the review, then it is expected that the practice will at least inform the community staff 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.

38. ePACT data is England only, where can practices in Northern Ireland, Scotland and Wales get the relevant achievement data?

In Wales, the Medicines Management National Programme are responsible for the data to support the prescribing indicators, this will be provided using CASPAR.net.

In Scotland, PRISMS data will be made available to practices in through local Health Board Pharmacy Support Teams or by direct access to PRISMS by practices.

In Northern Ireland, the Business Services Organisation is responsible for this data and this will be provided using the Electronic Prescribing Eligibility System (EPES).

39. Will the costs associated with the holding of an external peer review be covered by my PCO?

No. The number of QOF points allocated to these indicators is expected to cover any overheads incurred, for example locum costs.

Care pathway indicators QP6 to QP11

40. 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.

41. 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 PCO needs to decide first of all whether it should commission the care pathway – will it increase quality or productivity in services for patients?

42. 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 PCO and practice, this would be acceptable.

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

Practices 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.

44. When should PCOs enter the number of points achieved into QMAS or equivalent?

In England, - ePACT data to measure achievement should be available by mid-May 2012. PCOs should use the ready reckoner (or formula on page 166 of the 2011/12 QOF guidance) to calculate the points achieved for each of their practices. The points should be entered into QMAS no later than the end of May 2012. If this is not possible, then PCOs should make local arrangements with their respective payment agency.

In Scotland, the last quarter performance data will be available through PRISMS in late May/early June. Therefore, PSD will do a month 13 reconciliation on aspirational payment at end of July.

Practices in Wales and Northern Ireland will be informed of the local arrangements to calculate their achievement.

Additional services questions

Cervical screening

45. From April 2011 both the 9NiT (did not attend cervical smear) and the 9O8S (cervical smear defaulter) codes will be withdrawn from the cytology business rules.

The above codes were removed as they do not meet the criteria for exception coding a patient as 'did not attend' (DNAs). The criteria for exception coding DNAs require a practice to send out three notifications to a patient requesting they make an appointment/attend for a cervical smear test to be performed. Only after three notifications have been sent, may a practice code a patient as a DNA for exception reporting purposes.

A practice may use one of these codes to indicate that a patient has not attended a specific appointment, rather than for the purpose of exception coding. However, the business rules do not currently differentiate between the two scenarios for using these codes and therefore it would not be possible to confirm that the code was actually used to exception code.

NHS Employers, the GPC and other key stakeholders agreed to removing these codes.

46. Will the structure of the business rules be reconsidered to allow for the use of these codes?

The NHS IC, NICE and NHS Employers will consider how the CS1 business rules could be updated to take into consideration the exception reporting policy for patients who do not attend cervical smears.

47. If a practice has a patient that fails to attend for a cervical smear following three invitations by letter and the patient has not signed a disclaimer, how should that patient be exception reported?

In reference to the question, the codes 9NiT and the 9O8S codes were removed. As such, in circumstances as described in this question, the most appropriate code to use is '6853. CA cervix screen - not wanted'.

Financial and technical Questions

Financial

48. How much is a QOF point worth?

From 1 April 2011, the value of a QOF point in England is £130.51 (in Wales this is £130.47, in NI this is £127.26 and in Scotland this is expected to be confirmed in August 2011).

This figure is subject to change in subsequent years dependant upon any uplifts being applied.

49. How many points are available in QOF?

From 1 April 2011, there are 1,000 points in the QOF across four domains – clinical, patient experience, organisational and additional services. For full details of the different domains, please see the current QOF guidance.

50. How is the PMS points deduction calculated for England?

The PMS points deduction (or offset) is value based, fixed (regardless of practice size) at the value of a QOF point and not points based. The intention is to recover £13,050 from the average PMS practice, a figure which is then translated into points.

This is because many PMS practices already receive a number of allowances in their baseline payments set out in the 2004 PMS guidance ("Sustaining innovation through new PMS arrangements"). GMS practices do not receive these payments, but receive similar payments through the QOF. So the deduction for PMS practices ensures that they do not receive the same payments twice.

Where a PMS practice takes part in the QOF, their annual achievement will be subject to a deduction of a set number of points before the achievement is translated in actual QOF payments. The calculation used is the division of the fixed sum of £13,050 by the current pounds per point. For example, for 2011/12 this would be as follows:

£13,050 divided by £130.51 = 100.00 points

In terms of publication of QOF achievement in England, all scores published by the NHS IC are before PMS point deductions because the IC are concerned with data on achievement and not the actual payments.

In Scotland there is no standardised deduction from PMS payment – at an NHS Board level if the PMS contract includes QOF performance at local negotiation

within the PMS contract takes place. This question doesn't not apply in Wales as there are no PMS practices in Wales.

This question doesn't not apply in Northern Ireland as there are no PMS practices in Northern Ireland.

51. Are payments adjusted by practice list size?

Yes. All QOF payments are weighted by list size (the Contractor Population Index) and in the clinical domain by disease prevalence.

52. How is achievement calculated for the clinical domain?

The formula used to calculate the achievement of indicators in the clinical domain is:

$$\frac{\text{actual achievement}}{\text{maximum potential achievement}} \times \text{number of points available for indicator} \times \text{£xx (value of a QOF point}$$

53. If a practice delivers the care outlined in an indicator but then the patient moves practice, will that patient still count towards the practices achievement?

No. A practice is only rewarded for the care delivered to patients registered within the practice at the 31 March each year (REF_DAT in the business rules).

However, when a patient moves to a new practice after having care outlined in QOF delivered in their previous practice, the new practice would be rewarded for this as long as the electronic patient record is up to date and accurate.

54. What happens if a patient's old practice only delivered part of the care as outlined in the indicator and then the patient moved to a new practice? Will this patient count towards the achievement in the new practice?

In such circumstances, the new practice will need to ensure that the care outlined in the indicator is delivered accordingly in order for the patient to be included in the numerator. However, should the indicator require that certain activity is done within a particular timeframe and the old practice has not done this, then the patient may not be included in the numerator.

See the technical business rules and exception reporting section for further information relevant to this question.

Technical – prevalence

55. What changes were made to the formula for the prevalence calculations in 2009/10?

In 2009/10 the square root component was removed and in 2010/11 the five per cent 'cut off' was removed. This change resulted in a much fairer system where practices that have high prevalence will be rewarded based on patient need and for the work that they do.

56. What were the agreed prevalence changes?

As part of the agreed changes to QOF in the 2009/10 GMS contract negotiations NHS Employers agreed with the GPC that the current prevalence arrangements (Adjusted Practice Disease Factor – APDF) used to determine QOF payments would be amended over the next two financial years in the following way:

on 1 April 2009, the square rooting component of the current arrangements would be discontinued

on 1 April 2010, true prevalence will be used to determine QOF payments, i.e. the current cut-off arrangements will be discontinued.

57. Did this change impact prevalence results?

In England and Scotland, the national adjusted prevalence was higher than the national raw prevalence for diabetes, COPD and heart failure in 2009/10. The reason for this is that the changes to the prevalence formula were staggered over two years as per **Q56** 'What were the agreed prevalence changes?'.

In 2009/10 the five per cent cut off remained in place. QMAS calculated this by taking the range of practice prevalence (top and bottom) working out five per cent of that range and raising the prevalence of all those practices below that to the cut-off. The prevalence rates were then rebased around the new national mean. Because the top and bottom practices can be outliers this can mean that the adjusted national prevalence is skewed.

In Scotland the effect of the prevalence changes was magnified in practices with predominantly young populations such as University/College practices.

In Wales local health boards (LHBs) were provided with modelling data of the impact on their practices for both the removal of the square rooting and the removal of the five per cent cut off. LHBs were asked to share the data with practices and to discuss with those forecast to be most affected.

In Northern Ireland only one practice was affected by the cut off and therefore its removal has had no impact.

58. Do patients who have been exception reported for a particular disease area still count towards the disease prevalence?

Yes. Disease prevalence is calculated based on the number of patients with that condition compared with the national average. If a patient is exception reported for a particular factor e.g. diabetes it will only affect achievement not prevalence.

Technical – QMAS

In England the system used to calculate QOF payments is the Quality Management Analysis System (QMAS). Further information on QMAS is available on the NHS Connecting for Health Website via the link below:

www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/qmas

In Scotland the system used to calculate QOF payments is the QOF calculator accessible through the Practitioner Services Division website via the link below:

www.isdscotland.org/health-topics/general-practice/quality-and-outcomes-framework/

In Wales the system used to calculate QOF payments for 2010/11 is CMWeb (accessible only in Wales). A procurement exercise is currently underway for a web based software solution for future years.

In Northern Ireland the system used to calculate QOF payments is the Payment Calculation Analysis System (PCAS).

59. When will QMAS be switched back on after the changes are made for the 2011/12 QOF?

In England, it is estimated that new QMAS functionality for the changes to QOF in 2011/12 will not be available until October 2011. This is because the agreement on the GMS contract for 2011/12 was not concluded until March 2011 and is not due to any changes in the process for developing business rules. Normally we would expect negotiations to be concluded by the turn of the calendar year, which would allow QMAS to be updated by the second quarter of the financial year to which the changes apply.

A new systems is currently being procured to replace QMAS – the GP Payments Calculation Service. One of the key requirements for the new system will be to ensure faster turnaround of changes to the system.

In Scotland the QOF Calculator is currently available, based on ruleset v18. Scotland propose to upgrade the system for the 2011/2012 new indicators in October 2011 in line with when the GP Clinical Systems data extracts will be available. The QOF Calculator will be available on v18 of the ruleset until October at which time it will be upgraded to v20. There will be no switch off

period.

In Wales, like QMAS in England, new CM Web functionality for the changes to QOF in 2011/12 will not be available until October 2011 when the GP Clinical Systems QOF v20 submissions will be available. However, from July 2011 onwards, once the 2010/11 QOF payment is completed, the system will be re-activated to accept QOF v18 submissions that are being submitted by GP Clinical System Suppliers. At this point all v18 submissions received from May 2011 onwards will be processed. It is estimated that the contract for a replacement web-based QOF management system will be awarded by October 2011. Implementation will take place during October 2011 based on QOF v20 submissions. CM Web will run in parallel during this implementation until February 2012 to ensure that practices and LHBs have access to a QOF management system during the transition period.

In Northern Ireland PCAS is currently available, based on ruleset v18. Files are uploaded that are sitting on the server so that practices can monitor their progress against the previous years targets, however some of which will have changed due to wider QOF changes. It is proposed to upgrade the system for the 2011/2012 revisions when the GP Clinical Systems data extracts will be available. There will be no switch off period.

60. Why is there a delay in updating the QOF Codes on some practice systems? (England only)

The business rules were sent to system suppliers (SS) on 6 June (v20.0 sent as part of the GPSoC-CCN-105 (Annual QOF Review 2010)). However, the changes need to be assured by the SS and this assurance requires a test pack to be provided by the NHAIS team and current estimates the test pack to be created are mid to end of August.

Once SS have confirmed their changes are correct then they can deploy these changes to a local system e.g. Population Manager. If a supplier deploys the changes without this assurance then the reporting of achievement could be incorrect.

As per the previous question, QMAS will be go live with the latest QOF changes on the 24 October 2011 and after this date SS will be able to roll out the changes to QMAS. Therefore, the delay to system changes is not due to specific suppliers and CfH are looking in to whether some SS have deployed changes to the business rules without assurance.

61. When does the QOF achievement period end?

QOF achievement is calculated from midnight on 1 April to midnight 31 March each year.

Technical – business rules and exception reporting

Exception reporting guidance is available to download from our respective websites via the links below:

www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/Rewarding-QOF.aspx

www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/exceptreportingoct06.jsp

62. Is exception reporting done on an indicator by indicator basis?

Exception reporting criteria are set out in the QOF guidance. Codes for criteria A (patient refused to attend), B (patient unsuitable), G (informed dissent) except the patient from all the indicators in the indicator set. Other exception criteria must be applied on an indicator by indicator basis such as those indicators which have disease specific codes to record contraindications and intolerances (D, E and F) or where a patient has a supervening condition (H) or where a secondary care service is unavailable (I).

However, achievement always overrules exceptions and therefore even if a patient has been exception reported from an indicator and the practice then delivers the activity described (i.e. not with the particular indicator in mind but by default) then this would count towards achievement.

For example, if a patient is exception reported from the diabetes indicator set in July, but the practice checks the patient's blood pressure in December for an unrelated reason and it is 140/80 or less, then that patient would count towards the achievement for DM31. Achievement will always overrule an exception.

63. Is there a code available which would enable a practice to remove a patient from the mental health register following a resolved episode?

Historically, patients who have been added to the QOF mental health register for schizophrenia, bipolar affective disorder and other psychoses have not been able to be removed via a resolved code. This is due to the lack of professional consensus as to what mental health resolved means. However, over time it has become apparent that it may be appropriate to exclude some patients from the care in the associated indicators because their illness is in remission (or they had a single episode of psychosis sometime ago).

From 1 April 2011 practices may record patients as being in remission. Where a patient is recorded as being 'in remission' they remain on the register (in case their condition relapses at a later date) but they are excluded from the activity described by the indicators MH10 – MH16 inclusive.

For full details and background see the mental health section of the 2011/12 QOF guidance.

64. From April 2011, new codes have been added that relate to the MH11 alcohol consumption indicator. What are the definitions for these codes?

The terms are taken from NICE public health guideline 24: Alcohol-use disorders: preventing harmful drinking Page 51 of 100 and the definitions are:

Higher-risk drinking – Regularly consuming over 50 alcohol units per week (adult men) or over 35 units per week (adult women).

Increasing-risk drinking – Regularly consuming between 22 and 50 units per week (adult men) or between 15 and 35 units per week (adult women).

Lower-risk drinking – Regularly consuming 21 units per week or less (adult men) or 14 units per week or less (adult women). It is also known as 'sensible' or 'responsible' drinking.

65. Do exception codes apply to registers?

Patients can only be 'excepted' from indicators and not registers within QOF.

66. Why are there no exception codes allowable for the Obesity indicator?

There is currently only one indicator in the Obesity Clinical Area and this is a register. Therefore, as per **Q65** (above) no exception codes apply.

67. Can patients newly registered with a practice who have not had assessments undertaken within the required time from initial diagnosis be exception reported?

Patients who are not seen within the allotted time cannot be exception reported. The reasoning behind this is that if this was allowed then practices could simply exception report any patient who had not met the target, thereby meeting the requirement whether reviews were taking place or not. However, if a patient newly registers or is newly diagnosed in the last three months of the year (1 January – 31 March) they are automatically excepted from measurement indicators. Similarly, for target indicators they are automatically excepted for the last nine months of the year (1 July – 31 March). These patients will however, go in to the denominator for relevant indicators in subsequent years therefore practices should make every effort to deliver the care required in line with good clinical practice.

Miscellaneous questions

68. Will practice achievement information be made public?

Yes. QOF achievement for all practices in England is published by the NHS IC each year and can be found at: www.ic.nhs.uk/qof

69. Where can I find QOF achievement data for Scotland, Wales and Northern Ireland?

In Scotland the QOF results are published on the ISD website:

www.isdscotland.org/health-topics/general-practice/quality-and-outcomes-framework/

In Wales the QOF achievement data is available via the HOWIS GMS contract website:
www.wales.nhs.uk/gms

In Northern Ireland. QOF achievement data is available via the Department of Health, Social Services and Public Safety website at:
www.dhsspsni.gov.uk/index/stats_research/stats-resource/stats-gp-allocation/gp_contract_qof.htm

70. Will practice exception reporting data be published?

Yes. Exception reporting data for all practices in England is published by the NHS Information Centre each year. Please see question above for links to view the devolved administrations exception reporting data.

71. When does a new patient first qualify for inclusion in the QOF?

Patients are eligible for the care outlined in the QOF indicators as soon as they are fully registered with the practice and treatment commences. However, any patient registered during the last three months of the year will be automatically excepted from all qualifying indicators as per **Q67 '**Can patients newly registered with a practice who have not had assessments undertaken within the required time from initial diagnosis be exception reported?'.

72. Is there an age limit for patients in the QOF?

No. Some individual indicators have age ranges associated with them, for example due to the age ranges of the risk assessment tools recommended or the suitability to perform certain tests on particularly young or old patients. Some QOF disease registers have age ranges associated with them which exclude younger patients whose care is mainly managed by specialists. In addition some

of the individual indicators have age ranges in line with the care expected to be delivered.

There are times when a patient may qualify for the care outlined in the indicator, however a GP should always treat a patient appropriately using clinical judgement relevant to that individual. QOF includes exception rules which allow practices to except a patient for clinical reasons, for example where there are contraindications, intolerance of medicine or extreme frailty.

73. What is the process if a practice and PCO are in dispute?

In England when a QOF related contractual dispute arises, the PCT and the contractor must make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute without the need to refer it for formal determination by the NHS Litigation Authority Appeals Unit (or in certain cases the courts). Further information is available in the Statement of Financial Entitlements (General Medical Services Contract Regulations 2004).

Contract disputes for Scottish practices are dealt with in accordance with the procedure set out in The National Health Service (General Medical Services Contract)(Scotland) Regulations 2004.

Contract disputes for Welsh practices are dealt with in accordance with the procedure set out in The National Health Service (General Medical Services Contract)(Wales) Regulations 2004.

Contract disputes for Northern Ireland practices are dealt with in accordance with procedures set out in The Health and Personal Social Services (Contracts) Regulations (Northern Ireland) 2004.

Queries process

Queries can be divided into three main categories:

1. those which can be resolved by referring to the guidance and/or FAQs
2. those which require interpretation of the guidance or business rules
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, business rules, payment, QMAS, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. Alternatively, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

England

In England queries should be directed as follows:

- All queries relating to QOF, in particular clinical and business rules/coding queries should be sent to the NHS IC via enquiries@ic.nhs.uk Where required, the IC will work with other key stakeholders (e.g. NICE) to respond.
- Miscellaneous, non-clinical organisational (inc quality and productivity) and patient experience domains queries should be sent to:
  - NHS Primary Care Commissioning for PCTs only via the helpdesk http://helpdesk.pcc.nhs.uk/
  - NHS Employers for PCO's via QOF@nhsemployers.org
  - GPC for general practice via info.gpc@bma.org.uk

Scotland

In Scotland queries should be directed as follows:

Level one (NHS Boards):

Practices should send queries to their Board Lead contact for resolution from agreed guidelines/ existing FAQs. Where there is uncertainty or it is not possible to resolve the query, it is escalated to level two.

Level two (Scotland):

The Board (or national body) escalates queries as necessary to the Scottish QOF queries portal at nationalamsDroa@nhslothian.scot.nhs.uk

Responses will be agreed between the Scottish Government (SG) and Scottish General Practitioners' Committee (SGPC) in consultation.

Wales

Queries in Wales should be directed to the NHS Wales Informatics Service's Primary Care Service Desk as follows:

- Telephone 08450 267 297
- E-mail primarycare.servicedesk@wales.nhs.uk

Northern Ireland

There is no formal helpdesk facility in Northern Ireland therefore queries should be directed as follows:

- queries relating to the content of the QOF tables should be sent to qofdataenquiries@dhsspsni.gov.uk
- queries relating to GMS policy should be sent to gmsenquiries@dhsspsni.gov.uk

Where an issue relating to clinical indicators has arisen mid-year that cannot be resolved with simple clarification of the guidance, this will fall in to the NICE process of reviewing QOF indicators.

NHS Employers
www.nhsemployers.org
QOF@nhsemployers.org
29 BressendenPlace
London SW1E 5DD

2 Brewery Wharf
Kendell Street
Leeds LS10 1JR

British Medical Association
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This document is available in pdf format at www.nhsemployers.org

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