2013/14 Quality and outcomes framework

Frequently asked questions

November 2013
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Section 1. Introduction

NHS Employers and the General Practitioners Committee (GPC) of the British Medical Association (BMA) have agreed a set of Quality and Outcomes Framework (QOF) Frequently Asked Questions (FAQs) in conjunction with NHS England, the National Institute of Health and Care Excellence (NICE) and the Health and Social Care Information Centre (HSCIC). These FAQs 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 described in the queries process outlined in ‘Section 5’. 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:
1. Clinical indicators
2. Public health indicators
3. Quality and productivity indicators
4. Additional services indicators
5. General questions
   o Financial questions
   o Technical questions
   o Miscellaneous questions

We have also provided a list of the questions at the back of the document as a 'quick guide' to help you find what you are looking for.

This document was first published in June 2011, then updated again in June 2012 and both versions were applicable across the UK. The most recent version relates to England only.

The previous versions of the FAQs are available on the NHS Employers website under the relevant contract year.

http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx
Section 2. QOF guidance and process questions

1. Is new guidance available for QOF for 2013/14?

The details of the QOF changes for 2013/14 and the supporting guidance are available to download from the NHS Employers and BMA websites:

http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF201314.aspx
http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/qof-guidance

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. There were a lot of changes in 2013/14, is there a summary of the changes to download?

Yes, there is a summary of changes document available to download from the NHS Employers and BMA websites via the links in Q1.

4. Why is the QOF no longer a UK agreement?

On 18 March 2013, the Department of Health (DH) in England announced the changes to the GMS contract for 2013/14. This announcement followed the consultation on proposed changes to the contract that ran from 6 December 2012 to 26 February 2013. Scotland, Northern Ireland and Wales did not feel that some of the changes being made in England would be appropriate for their local populations and instead reached agreement with their respective GPCs. As such, individual changes were made in each of the four countries.

The GPC did not agree to, or support all of these changes – details can be found in its consultation response. Following the consultation, the Government decided to defer the introduction of two of the indicators recommended by NICE for one year, to phase in thresholds for two new indicators and to increase points for three new indicators.

5. Why are thresholds increasing year on year?

The QOF was introduced in 2004, but thresholds have not been raised above average achievement levels since its introduction. Following on from the DH consultation, there will be an increase in thresholds for all existing indicators, in line with the 75th centile of achievement phased in over two years. For 2013/14, this applies to 20 indicators and
the remaining indicators from 2014/15. From 2015/16, thresholds will change on an annual basis in relation to practice achievement. This aims to encourage the continual improvement in patient care.

6. Why have some indicators been transferred to the new public health domain from 1 April 2013?

The public health domain was introduced to QOF to recognise the commitment made in the November 2010 Government White Paper ‘Healthy Lives, Healthy People: our strategy for Public Health England’. It was felt that in line with this strategy a section of the QOF should be dedicated to evidence-based public health and primary prevention indicators.

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

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.

8. 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 NICE QOF Advisory Committee. The recommendations of the Committee will then be fed into negotiations between NHS Employers and the GPC.

The focus for new indicators will be provided by NICE Quality Standards. It is important that interested individuals register as a stakeholder in the development of individual quality standards. By doing so, stakeholders will be able to comment on their content.

The comments facility and full details of quality standards in development are available on the NICE website.

1 NICE. http://www.nice.org.uk/aboutnice/qof/qof.jsp
9. 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 website:

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

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www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/gmscontract200304/Pages/NewGMSContract200304.aspx
Section 3. QOF indicator questions

Clinical domain questions

General clinical questions

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

Yes. Patients with co-morbidities will be included in the registers for any disease areas which apply to them if they meet the relevant criteria for the disease register. For example, a patient could be on the Asthma disease register and also the COPD register as they could meet the criteria for both conditions.

However, whilst patients with co-morbidities can be on more than one register, it is not possible to extract data from the clinical systems outlining how many patients are on multiple registers.

11. Where patients with co-morbidities are receiving treatment or have had particular testing for one of their conditions (and the relative indicators), this may supersede the requirements of another indicator associated with their other condition(s). In these circumstances, is there a way to code the patient so that no unnecessary tests are carried out?

During the development of indicators, consideration is given to co-morbidities and the need to address situations where a patient's treatment or tests for one of their conditions could supersede treatment or tests required by their other condition. However, NHS Employers and GPC have identified a small number of indicators where issues with co-morbidities have not yet been addressed. This has been raised with NICE for further consideration. There will be no changes to any relevant indicators before 1 April 2013.

Atrial fibrillation (AF)

12. If a patient has been diagnosed with atrial fibrillation (AF) and successfully treated, will that patient remain on the AF register?

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 patient history.
Diabetes (DM)

13. DM013 requires that practices refer patients for a dietary review to a 'suitably competent professional', what is the definition of a suitably competent?

The QOF guidance states on page 84 that the dietary review should be delivered by a healthcare practitioner who meets the start of the level one competencies of the Diabetes UK framework.

"The NICE quality statement on nutrition and physical activity advice in the NICE quality standard for diabetes in adults is based on recommendations from the NICE clinical guidelines CG15 and CG87. It states that ‘People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme’.

The NICE quality standard defines an appropriately trained healthcare professional as one with specific expertise and competencies in nutrition. This may include, but is not limited to, a registered dietician who delivers nutritional advice on an individual basis or as part of a structured educational programme. The Diabetes UK competency framework for dieticians sets out level one competencies that are the minimum standard for any staff involved in the healthcare of people with diabetes. Therefore, if non-dieticians are employed to deliver dietary advice, they should conform to the level one competencies described in the Diabetes UK framework as a minimum.

The provision of good dietary advice and nutritional information may also be included as part of diabetes education and self-management programmes."

Page 4 of the Diabetes UK competency framework outlines who the framework is aimed at as follows:

"Who is the Competency Framework for?

The competency framework is essentially for registered dieticians. However, all frontline staff that have direct or non-direct patient contact do require basic competences in diabetes-specific medical nutrition therapy to answer general queries and reduce the potential for people with diabetes receiving conflicting messages. Thus, Level 1 competences have been developed for all frontline staff. The category has been divided into two sections, non-direct patient contact such as porters and receptionists and direct patient contact, for all non-dietitian frontline staff from assistants to consultants. Level 2 to 5 competences have been developed for registered dieticians (bands 5 to 8) however, diabetes specialist staff from other disciplines such as nursing, podiatry and medicine, may choose to work towards meeting certain competences, especially if they deliver structured education to people with diabetes”.

From page 14 of this framework, the competencies are broken down in to the following categories and for each category, the competencies for level one are outlined in terms of direct and non-direct patient care:

1. Section 1: Pathophysiology, Epidemiology and Clinical Diabetes Guidelines
2. Section 2: Teaching and Learning Skills
3. Section 3: Individualised Self-Management Education
4. Section 4: Psychosocial and Behavioural Approaches
5. Section 5: Group-based Structured Education
6. Section 6: Principles of Medical Nutrition Therapy
7. Section 7: Short-term complications
8. Section 8: Specific Nutrition-Related Needs of Children and Adolescents with Type 1 and Type 2 Diabetes
9. Section 9: Co-morbidities
10. Section 10: Specific Nutrition-Related Needs Pre-Conception, in Gestational Diabetes, and during and after Pregnancy
11. Section 11: Specific Nutrition-Related Needs of Older Adults, Including those Living in Care Facilities
12. Section 12: Specific Nutrition-Related Needs of People from Ethnic Groups
13. Section 13: Eating Disorders
14. Section 14: Coeliac Disease
15. Section 15: Prescribable diabetes medication
16. Section 16: Evaluation and Audit and Research

14. Will a practice meet the criteria by referring their patient(s) to a dietician?

The dietary advice delivered by a dietician to whom the patient has been referred would meet the criteria for a 'suitably competent profession'. However, it is the completion of the subsequent advice that meets the criteria for the indicator and not the act of referring the patient.

In the event that a patient does not attend the appointment with the dietician whom they have been referred to, this would not mean that the practice could exception report the patient as DNA as it does not meet the criteria for that code. A patient must have failed to attend an appointment on three separate occasions in order to be exception reported. Please see the exception reporting guidance in the QOF guidance for further information around exception reporting criteria.

15. For DM014, what should practices do if there isn't a local 'structured education programme'?

Where services are no available locally, practices would be expected to discuss this with the CCG, with a view to encouraging the commissioning of the relevant services. In some areas this may take some time so practice may wish to consider whether it would be appropriate to offer the service in-house (as per the guidance on page 84) or look elsewhere where the required service is available - different CCG, neighbouring practice etc.
Where all possible avenues for referral have been exhausted, practices can use the specific ‘Diabetes structured education programme not available code for this indicator which was available in the October 2013 Read code release.

Practices should keep in mind, that if all eligible patients are exception reported using this code, then this would result in a zero denominator and numerator which would therefore mean that the practice had not achieved the indicator and no payment would be due.

16. What happens if there is a long waiting list post 31 March 2014?

The indicator is for all patients on the diabetes register therefore, in most cases practices would have time to achieve this indicator. Where a patient is registered or diagnosed between January and March 2014 they will be excluded from the denominator for this indicator due to the automatic exception for this cohort.

In the event that there are long waiting lists or the service is not available the practice would be expected to explore fully with their CCG whether or not a suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the services was unavailable. Alternatively, practices can offer the service in-house providing it meets the required standard.

Asthma (AST)

17. AST002 (2012/13 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.

18. Why did the code clusters for AST002 changed after the start of the 2013/14 QOF year?

During the 2013/14 business rules review amendments were proposed to the relevant codes for Asthma8 (now AST002) in order to refine the code clusters. During the four
country review of the business rules - a process through which a number of identified experts including GPs, system suppliers, lay people and representatives from the four countries review the rules sets - no comments were received to suggest that the revised codes would be problematic. The usual process when introducing changes to the code clusters for cumulative indicators such as AST002 is to reset the indicator so that historical diagnoses do not need to be revisited. On this occasion, this process did not take place.

NHS Employers agreed with the NICE, the HSCIC and GPC to revert to the previous code clusters for AST002 (i.e. version 24 of the Business Rules). The changes to the business rules have been applied to v26 therefore meaning it is not necessary for practices to recode patients this year.

Please note that until the code clusters are updated in clinical systems, any extracts being run will likely show an under achievement which will correct itself once the code clusters are updated.

19. AST003 (2012/13 Asthma 9) – Can a review of inhaler technique be carried out over the telephone?

An assessment of inhaler technique is an important element of the structured review and as such should be performed in a face-to-face consultation.

Depression (DEP)

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

There is no register indicator for the depression indicators. The disease register for the depression indicators (DEP001 and DEP002) is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

21. Do DEP001 and DEP002 need to be delivered in a face-to-face consultation or can they be done via the telephone?

Due to the nature of DEP001 the bio-psychosocial assessment should, by default, be given as part of a face-to-face consultation. However, the assessment can be carried out over more than one consultation and can relate to information already contained within the patient record as clinically appropriate.

Postal questionnaires are not acceptable for the purpose of the depression indicators.

22. What is involved in the bio-psychosocial assessment (BPA)?

A BPA is defined as a qualitative assessment of a patient with suspected depression. This assessment should considers physical, psychological and social aspects of the condition. The guidance breaks up the components of this assessment in to two groups. Group one addresses eleven components that constitute good clinical practice
although not all may be carried out as part of the initial BPA, the BPA would generally include:

1. an assessment of current symptoms and their duration and severity
2. suicidal intent
3. discussion of treatment options
4. any previous episodes requiring treatment previously
5. initial exploration of reasons behind current episode of depression; and
6. immediate social support available to patient:

Group two is made up of a further five components which practice may wish to address, but do not have to deliver for the purposes of achieving this indicator and they are as follows:

7. co-morbid mental health or physical disorders
8. any past history of mood elevation, to determine if the depression may be part of a bipolar disorder
9. awareness of sources of help
10. patient’s views of the cause of their symptoms
11. discussion of the need for follow-up.

The details of the BPA in their component parts that are carried out, should be recorded in the free text of a patient record and the code for BPA recorded.

Clinicians may optionally wish to use formal assessment questionnaires such as PHQ9, HADS and BDI-II to assess the duration and severity of the current episode. This is in addition to the group one bulleted list, rather than instead of.

23. Are practices expected to consider all of the items contained in the group one bulleted list in one consultation?

The guidance states that the components of the BPA do not have to be delivered during one consultation, however it is the code for the BPA and date of diagnosis that needs to be recorded on the same date so the indicator doesn’t request that all eleven components are delivered within a standard consultation.

24. When patients are diagnosed with depression by the private sector or in secondary care (i.e. when sectioned), can practices still achieve the indicators?

DEP001 indicator requires that the contractor records the BPA as complete at the same time that diagnosis is recorded. When the BPA and diagnosis of depression are made in secondary care by specialist mental health services and the contractor doesn’t know whether the BPA has been completed, the contractor can exception report the patient. This is because once a patient has been diagnosed with depression, it is not clinically appropriate to deliver a further BPA to support the diagnosis of depression, although elements may be returned to during the management of depression.
It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should try to find out the diagnosis date in order to record this and invite the patient for a review within the timeframe for DEP002. If the date of diagnosis is unknown or the letter arrives too late then the contractor records the date of diagnosis as the date the letter arrives and invites the patient for review within the timeframe for DEP002 from that date.

Suspected depression seen in secondary care may not always be referred to specialist mental health services for further assessment and management. It may be in the form of a discharge letter from an acute medical or surgical ward, A&E or from an outpatient appointment. It may be reasonable in these circumstances for a contractor to contact the patient to ask them to attend for an assessment to assess if they have a clinical diagnosis of depression. In such cases, the BPA can be carried out at that time. Where the ongoing care for patients is being provided by specialist mental health services the patients should be exception reported from DEP002. Where a patient has been excepted from DEP001 using a domain level exception code because they are being managed in secondary care, they will also be excepted from DEP002.

**Mental health (MH)**

**25. 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.

For MH010 (2012/13 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.

**26. 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 have been able to 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 MH002 - MH008 (2012/13 MH10 - MH13, MH19, MH20 and MH16).

For full details see the mental health section of the 2013/14 QOF guidance.

**Cancer (CAN)**

**27. For CAN002, is the three month period for the review from the date of diagnosis or from the date the practice is informed of the diagnosis?**

The business rules for this indicator are in line with the previous Cancer 3 indicator which looked for the new or first episode (i.e. the diagnosis date) and the intention is that the review occurs within the required timeframe from this date and not the date that the letter is received.

**28. What is the evidence to support the reduction in the timeframe for this indicator (CAN001)?**

The evidence to support the reduced timeframe is based on the period around diagnosis being critical and that people newly diagnosed have a lower quality of life than those with longer term cancer. This was supported both through the piloting of the new indicator and the subsequent consultation. For further details around the NICE recommendation, see the NICE menu of indicators.

It is recognised that the indicator wording may be slightly misleading, however the business rules are correct and the diagnosis date is the trigger for the three month review period. In line with good practice the diagnosis date should be used. Consideration will be given by NICE as to whether an update to the indicator wording is required for 2014/15.

**Chronic kidney disease (CKD)**

**29. When performing a urine dip test on a patient diagnosed with CKD and the result shows no proteinuria, is it necessary to send the specimen to the lab? Will performing the dip test still qualify achievement of CKD004?**

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) is available on our respective websites via the links in Q1.

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3 The CKD FAQs were published prior to the QOF ID’s being changed from April 2013. A comparison of the QOF ID’s is included in the summary of changes spreadsheet referred to in section one.
Osteoporosis (OST)

30. The osteoporosis register requires that a patient has had a diagnosis of osteoporosis confirmed by a DXA scan. What happens if the patient is not diagnosed within the same QOF year as the fragility fracture occurs?

If a practice meets the criteria outlined in the indicator (copied below) but spanning two QOF years, that will not affect the practices ability to achieve the indicator. However, achievement and therefore payment is only applicable for the QOF year in which the diagnosis was made.

To be eligible for inclusion on the osteoporosis register, patients aged 50-74 years must:

1. fall within the age range defined in the indicator
2. have had a fragility fracture on, or after 1 April 2012 (implementation date for the disease area)
3. have had a DXA scan with a positive result
4. have had a diagnosis of osteoporosis

To be eligible for inclusion on the osteoporosis register, patients aged 75 years and over must:

1. fall within the age range defined in the indicator
2. have had a fragility fracture on, or after 1 April 2012 (implementation date for the disease area)

31. Will DXA scan waiting lists be prioritised so that practices can make diagnoses quicker?

No. It would be inappropriate to prioritise a service purely for the purposes of achieving QOF indicators. According to the statistics published by the HSCIC in February 2012, the average waiting time in England is six weeks and only a small number of patients on the waiting list wait longer.

Further details on waiting times for DXA scanning and other diagnostics and procedures are available via the link below under ‘Commissioner Based Monthly Data’:


32. Are men included in the register for this indicator?

Yes. As the indicator wording refers to ‘patients’ this means the indicator applies to male and female patients.
Public health domain questions

Cardiovascular disease – primary prevention (CVD-PP)

33. CVD-PP001 (2012/13 PP1) asks for CVD risk to be calculated for patients with hypertension using a risk calculator. The age range for the indicator is given as 30 - 74 years, but the tool in use by the practice’s clinical system does not cover patients aged 34 years and under. What should happen in these circumstances?

In order to allow for all four risk assessment tools to be used (each have different individual age thresholds), the upper and lower age ranges for this indicator have 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 2013/14 QOF guidance via the link in Q1.

34. The wording for CVD-PP001 (2012/13 PP1) excludes patients with specific pre-existing conditions, do these exclusions also apply to CVD-PP002?

Yes, the patient register for both indicators is the same. The register covers all patients with Hypertension (unless resolved) who are eligible for the care described by the two indicators excluding those with existing CHD, Stroke and TIA, PVD, TIA, diabetes and CKD.

Obesity (OB)

35. Why are exception codes not acceptable for the Obesity indicator?

There is currently only one indicator in the obesity clinical area and this is a register. Therefore, exception codes do not apply.

Smoking (SMOK)

36. The criteria for SMOK004 (2012/13 Smoking 8) and SMOK005 (2012/13 Smoking 6) states that an offer of support and treatment must be given. Does this mean that the patient must be offered both support and treatment in order to achieve the indicator?

The business rules for indicators SMOK004 and SMOK005 will look for a record of support or treatment i.e. a suitable code from either the REFERSSSA_COD OR the PHARM_COD clusters. The intent of the indicator is for patients to be offered ‘support and treatment’ whether this means a referral to a smoking cessation service, drug treatment or follow-up appointments with the practice (GP/nurse etc) and not for a
patient to accept ‘support and treatment’. If a patient declines support and/or treatment, then suitable codes have been included in the relevant clusters to accommodate this.

Public health additional services sub domain questions

Cervical screening (CS)

37. 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'.
Quality and productivity (QP) domain questions

Secondary care outpatient referral indicators QP001 to QP003

38. Will there be any national templates available?
No, templates will not be made available in England

39. 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.

40. 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 i.e. will it increase quality or productivity in services for patients?

41. Do the care pathways for QP001 to QP003 have to be newly developed or can they be ones that were in development at the time the indicators were published?
Practices will be required to undertake an internal and external review. In doing this, practices will need to consider the data afresh to determine whether improvements that need to be made can be delivered through following the existing pathways more closely, whether the existing pathways require amending or whether alternative pathways should be developed.

42. 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.

43. Do practices within the peer review group have to be in the same NHS England area team locality?
No, there is no requirement in the QOF guidance/SFE for practices in the external peer review group to be from within the same NHS England area team locality area, however, the guidance states that "contractors participate in an external peer review with other contractors who are members of the same CCG". As such, the external peer review
groups should include practices with similar characteristics, or with similar referral routes or care pathways. Practices may also choose to work within their clinical commissioning groups (CCGs).

44. Can practices be represented at the external peer review meeting by another practice’s GP or by a practice manager?

For indicators QP002, QP004 and QP007, each practice participating in the external peer review meeting should be represented by at least one GP from their own practice. It would be inappropriate for practice managers to represent the practice or for another practice’s GP to represent more than their own practice (including single-handed practices). External peer review meetings are expected to be arranged at a time that is convenient for all the practices and should not disrupt patient services.

Where a single-handed practice is unable to represent themselves at an external peer review meeting this should be discussed with NHS England or their CCG as appropriate. If it requires that the practice manager attends then this would be under extraordinary circumstances and with the agreement of NHS England or the CCG.

45. What period of data should be provided to practices to conduct the review meetings?

The guidance is not prescriptive about the period of data required to conduct the review meetings and this has been left to local agreement. However, the data supplied should cover a sufficient period to allow for a suitable comparison and it would therefore seem sensible for this to not be less than six months. That said, if the indicators for which this data is required would be related to something that would benefit from a full year’s data review, then this should be considered. For example, conditions that could be affected by seasons and therefore result in increased prescribing, referrals or admissions in winter months.

46. What would happen if a practice engages in the development of three agreed care pathways and then, for whatever reason, one or more of the pathways is withdrawn by NHS England or the CCG?

In such circumstances, it would be considered outside the practice’s control if a pathway was withdrawn by NHS England or the CCG. Providing the practice can demonstrate that they ‘actively responded to the care pathway development process’ (see QP 8.1 of the 2012/13 QOF guidance) then the practice would still be eligible for all the points. Where the local arrangements for payment and verification require that a report be submitted, then the practice would be expected to submit the report by the deadline agreed and in the report explain that they were unable to deliver care along the pathway as it was withdrawn.
47. What would happen if a practice engages in the development of three agreed care pathways and then either while following the pathways, the eligible patient(s) leave the practice or the practice has no eligible patients because the pathway chosen was one across the locality?

If a practice engaged in the development of the pathway and had been delivering care to patient(s) along those lines, but the patient(s) left the practice before the 31 March 2013, then the practice would still be eligible for all the points. The practice would need to inform NHS England or the CCG to explain the reasons why they were unable to deliver care along the pathway.

In the second example, it is expected that the three pathways chosen would reflect the needs of a practice’s patient population. Should a situation arise were one or more of the pathway(s) chosen was locality wide and the practice has no suitable patients, then the practice would still be eligible for all the points. Where the local arrangements for payment and verification require that a report be submitted, then the practice would be expected to submit the report by the deadline agreed and include details of why the chosen pathway(s) was not relevant for the practice population i.e. no eligible patients to deliver the care to.

**Accident and emergency indicators QP004 to QP006**

48. Will there be any national templates available?

No, templates will not be made available in England.

49. In some areas, local GPs run the Minor Injury Units (MIU) and A&E departments. Should patients who attend these types of departments in order to see their own GP for a planned appointment, be included in the data analysis?

No, attendances at MIUs or A&E departments that are planned should not be included in the data that is reviewed. This includes patients who are directed to attend A&E as part of local emergency admission procedures. The A&E indicators are regarding those attendances that could be considered ‘avoidable’ because the patient could have been dealt with in primary care.

50. Many practices near A&E departments have service level agreements (SLA) or locally agreed services to provide medical support, treatment and/or assessments. Should this be included in the data analysis?

Where services at an A&E department are provided by a practice under a SLA they may choose to use this service to provide routine care for their patients more flexibly. Where this service is provided through a SLA and not a care based contract, then these attendances should not be included in the data analysis. The practice and NHS England or the CCG should take into account local arrangements that mean patients choose to go to A&E because their own practice GP is working there.
51. What would happen if a SLA or existing local agreement already covers the three areas practices are required to focus on for the A&E indicators?

If there is an existing SLA or local agreement in place that overlaps with these indicators then NHS England or the CCG may wish to review this and propose alternative pathways to what is currently in place within the existing contract.

52. In the guidance and the SFE there is a definition of what constitutes an accident and emergency attendance. It states "A&E attendances are defined as those patients seen for both first and follow-up attendances for the same condition with the exception of planned follow-ups". What does this mean?

The intention of this indicator is to encourage practices to consider the reasons for unavoidable A&E attendances and practices are therefore required to review all attendances at A&E whether it be the first attendance or a unplanned follow-up attendance. Planned follow up attendances are not included in the definition. For example:

1. If a patient attends A&E with a sprained wrist and is sent away and subsequently returns, unannounced, with the same sprained wrist, then both attendances would constitute an A&E attendance for the purposes of QP007, 008 and 009. The practices would be required to consider each attendance against their agreed definition of ‘unavoidable’.

2. If a patient attends A&E with a sprained wrist and is sent away and has a planned follow-up at that A&E department which they attend, then only the first attendance would constitute an A&E attendance for the purposes of QP007, 008 and 009.

3. If a patient attends A&E with a sprained wrist and is sent away and attends two days later with a knee injury, then both of these attendances would count for the purpose of QP007, 008 and 009.
Section 4. General questions

Financial questions

53. How much is a QOF point worth?

From 1 April 2013, the value of a QOF point in England is £156.92. This figure is subject to change in subsequent years dependant upon any uplifts being applied.

54. How many points are available in QOF?

From 1 April 2013, there are 900 points in the QOF across four domains – clinical, public health (include public health additional services), quality and productivity and patient experience. For full details of the different domains, please see the current QOF guidance.

55. Why did the value of a QOF point rise by £23.16 for 2013/14 but the total number of points reduced by 100 to 900 points?

The value of a QOF point increased by £23.16 for 2013/14 to become £156.92 due to the way in which CPI is calculated (now using the 1 January figure each year rather than the fixed 5,891). This increased to the value of a QOF point, does not represent an increase in real terms.

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

The PMS points deduction (or offset) is value based, fixed figure of £13,050 regardless of practice size. 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. From April 2013, the PMS deduction is done only to the pounds total not the points total as in previous years.

When the PMS practices total QOF achievement has been calculated, CQRS will check the type of contract the practice holds. If the practice has a PMS contract, then CQRS will deduct £13,050 from the practices achieved pounds. This calculation is done before the total QOF achievement is adjust for the proportion of the year the practice is open.

57. Are payments adjusted by practice list size?

Yes. All QOF payments are weighted by list size (the Contractor Population Index (CPI)) and in the clinical domain by disease prevalence.
58. How is achievement calculated for the clinical domain?

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

\[
\text{actual achievement} \times \frac{\text{number of points available for indicator}}{\text{maximum potential achievement}} \times \£x (\text{value of a QOF point})
\]

59. Does this adjustment formula apply to any other domains in the QOF?

No. The target population factor adjustment only applies to those indicators within the additional services domain entitled to under the SFE.

60. 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.

61. 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.

62. If a practice exception reports all eligible patients within a disease area i.e. secondary care service not available, can the practice still claim the points?

If all eligible patients are exception reported then this will result in non-achievement of the indicator(s) and no payment will be due.
Technical questions

63. What system is used to calculate achievement and payment for QOF?

In England the system used to calculate QOF payments is the Calculating Quality Reporting System (CQRS) which will be able to calculate payments for a range of quality services. Further information on CQRS is available on the HSCIC website.

64. Will practice achievement information be made public?

Yes. QOF achievement for all practices in England is published by the HSCIC each year.

65. When does the QOF achievement period end?

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

66. How will the 2012/13 QOF data be published as there is now a new NHS structures for primary care?

Although 2012/13 data will relate to a period when the PCT/SHA structure was still in place, NHS England, the HSCIC, NHS Employers and GPC agreed the data should be presented under the new structure i.e. CCG/area team/region. The reasons for this are:

1. By the time the data are published the new structures will have been in place for around six months.
2. Presenting the data under the new structures will provide a useful benchmark for future comparison.
3. The data will be immediately relevant and useful to the new organisations.
4. There is already a demand for data presented under the new structures.

67. Would it be possible to access the data under both the old and the new structures?

No, it would be impractical to present the data under both structures. However, should any users require the data under the old structure, the HSCIC will provide a mapping table alongside the published data to allow users to map the practices to their former parent PCT/SHA organisations to enable them to aggregate the data to these levels.

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

Exception reporting criteria and guidance 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

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4 HSCIC website. www.hscic.gov.uk/qof
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 DM003. Achievement will always overrule an exception.

69. Do exception codes apply to registers?

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

70. 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 reason 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.

71. If an indicator requires that a patient is invited for a review but is exception reported i.e. patient unsuitable or patient did not attend, should they be invited to attend for a review the following QOF year?

If the indicator requires that the ‘activity’ is delivered every X months, then the ‘exception’ would only be valid for the same timeframe as specified in the indicator wording. Therefore, the three invites would need to be sent out each year and only when the patients has refused to attend all three appointments can the practice exception report that patient.

For further information on exception reporting, please see the NHS Employers and GPC exception reporting guidance.

72. Will practice exception reporting data be published?

Yes. Exception reporting data for all practices in England is published by the HSCIC each year.
Miscellaneous questions

73. 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 Q70 'Can patients newly registered with a practice who have not had assessments undertaken within the required time from initial diagnosis be exception reported?'.

74. 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.

75. What is the process if a practice and NHS England are in dispute?

In England when a QOF related contractual dispute arises, NHS England by way of the area team 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).

76. Historically an 'offer of appointment' has been in writing to the patient. Taking into account the changes in methods of communication and technology, is it acceptable for the invitation to be sent via email or text?

Practices may make use of methods other than written letters to offer patient’s appointments. However, this must be with the explicit consent of the patient concerned and their acceptance to be contacted via another media. The invitation must also be specific to individual patient.

For example:

‘appointment for patient x, at 00.00, on DD/MM/YYYY, at practice Y’
77. What happens if a practice has no patients eligible for a disease area or for specific indicators?

QOF rewards practices for providing the care to eligible patients, as outlined in the indicator wording or 'criteria' for the relevant disease area(s). If a practice has no patients that fall in the 'denominator' of a particular indicator or indicator set, then unfortunately they have no patients who require the care described by the indicator and therefore no means to achieve the points associated with that indicator(s). QOF works on a positive payment mechanism basis, which means that a practice starts at zero and works upwards to the maximum number of points available (for 2013/14 this is 900 points).
Section 5. Queries process

England

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. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

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.

QOF queries should be directed as follows:

In England queries should be directed as follows:

1. All queries relating to QOF, in particular clinical and business rules/coding queries should be sent to the HSCIC via enquiries@hscic.gov.uk Where required, the HSCIC will work with other key stakeholders (e.g. NICE) to respond.
   - Queries relating specifically to payment through CQRS can be sent to the HSCIC via cqrsfeedback@hscic.gov.uk
2. Miscellaneous, non-clinical organisational (inc quality and productivity) and patient experience domains queries should be sent to:
   - NHS Primary Care Commissioning for PCOs 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

Further information on GPES and CQRS can be found on the HSCIC website via the links below:

http://www.hscic.gov.uk/gpes
http://systems.hscic.gov.uk/cqrs
Scotland, Wales and Northern Ireland

Queries relating to the 2013/14 QOF indications in Scotland, Wales and Northern Ireland should be directed follows:

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 and Scottish General Practitioners’ Committee in consultation.

The QOF guidance for Scotland can be found at http://www.sehd.scot.nhs.uk/pca/PCA2013(M)02guide.pdf

Wales

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

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

The QOF guidance for Wales can be found at http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=65378

Northern Ireland

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

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

The QOF guidance for Northern Ireland can be found at http://www.dhsspsni.gov.uk/quality_and_outcomes_guidance_2013_14_v2.pdf
Section 6. Summary of questions

Below is a list of the questions included in this document. Please see the contents page for page numbers.

QOF guidance and process questions

1. Is new guidance available for QOF for 2013/14?
2. Can I buy copies of guidance/books, or can you send me copies?
3. There were a lot of changes in 2013/14, is there a summary of the changes to download?
4. Why is the QOF no longer a UK agreement?
5. Why are thresholds increasing year on year?
6. Why have some indicators been transferred to the new public health domain from 1 April 2013?
7. What is the process for making changes to the QOF?
8. How can I influence changes to indicators or suggest new indicators for consideration?
9. How can I get a copy of the blue book?

Clinical domain questions

General clinical questions

10. Can a patient be on more than one register?
11. Where patients with co-morbidities are receiving treatment or have had particular testing for one of their conditions (and the relative indicators), this may supersede the requirements of another indicator associated with their other condition(s). In these circumstances, is there a way to code the patient so that no unnecessary tests are carried out?

Atrial fibrillation (AF)

12. If a patient has been diagnosed with atrial fibrillation (AF) and successfully treated, will that patient remain on the AF register?

Diabetes (DM)

13. DM013 requires that practices refer patients for a dietary review to a ‘suitably competent professional’, what is the definition of a suitably competent professional?
14. Will a practice meet the criteria by referring their patient(s) to a dietician?
15. For DM014, what should practices do if there isn’t a local ‘structured education programme’?

16. What happens if there is a long waiting list post 31 March 2014?

**Asthma (AST)**

17. AST002 (2012/13 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)?

18. Why did the code clusters for AST002 changed after the start of the 2013/14 QOF year?

19. AST003 (2012/13 Asthma 9) – Can a review of inhaler technique be carried out over the telephone?

**Depression (DEP)**

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

21. Do DEP001 and DEP002 need to be delivered in a face-to-face consultation or can they be done via the telephone?

22. What is involved in the bio-psychosocial assessment (BPA)?

23. Are practices expected to consider all of the items contained in the group one bulleted list in one consultation?

24. When patients are diagnosed with depression by the private sector or in secondary care (i.e. when sectioned), can practices still achieve the indicators?

**Mental health (MH)**

25. 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?

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

**Cancer (CAN)**

27. For CAN002, is the three month period for the review from the date of diagnosis or from the date the practice is informed of the diagnosis?

28. What is the evidence to support the reduction in the timeframe for this indicator (CAN001)?
Chronic kidney disease (CKD)

29. When performing a urine dip test on a patient diagnosed with CKD and the result shows no proteinuria, is it necessary to send the specimen to the lab? Will performing the dip test still qualify achievement of CKD004?

Osteoporosis (OST)

30. The osteoporosis register requires that a patient has had a diagnosis of osteoporosis confirmed by a DXA scan. What happens if the patient is not diagnosed within the same QOF year as the fragility fracture occurs?

31. Will DXA scan waiting lists be prioritised so that practices can make diagnoses quicker?

32. Are men included in the register for this indicator?

Public health domain questions

Cardiovascular disease – primary prevention (CVD-PP)

33. CVD-PP001 (2012/13 PP1) asks for CVD risk to be calculated for patients with hypertension using a risk calculator. The age range for the indicator is given as 30 - 74 years, but the tool in use by the practice’s clinical system does not cover patients aged 34 years and under. What should happen in these circumstances?

34. The wording for CVD-PP001 (2012/13 PP1) excludes patients with specific pre-existing conditions, do these exclusions also apply to CVD-PP002?

Obesity (OB)

35. Why are exception codes not acceptable for the Obesity indicator?

Smoking (SMOK)

36. The criteria for SMOK004 (2012/13 Smoking 8) and SMOK005 (2012/13 Smoking 6) states that an offer of support and treatment must be given. Does this mean that the patient must be offered both support and treatment in order to achieve the indicator?

Public health additional services sub domain questions

Cervical screening (CS)

37. 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?
Quality and productivity (QP) domain questions

Secondary care outpatient referral indicators QP001 to QP003

38. Will there be any national templates available?
39. What is the definition of a care pathway?
40. How is the actual delivery of a care pathway to be funded?
41. Do the care pathways for QP001 to QP003 have to be newly developed or can they be ones that were in development at the time the indicators were published?
42. Do practices always have to follow care pathways in the treatment of patients if it is not clinically appropriate to do so?
43. Do practices within the peer review group have to be in the same NHS England area team locality?
44. Can practices be represented at the external peer review meeting by another practice’s GP or by a practice manager?
45. What period of data should be provided to practices to conduct the review meetings?
46. What would happen if a practice engages in the development of three agreed care pathways and then, for whatever reason, one or more of the pathways is withdrawn by NHS England or the CCG?
47. What would happen if a practice engages in the development of three agreed care pathways and then either while following the pathways, the eligible patient(s) leave the practice or the practice has no eligible patients because the pathway chosen was one across the locality?

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64. Will practice achievement information be made public?
65. When does the QOF achievement period end?
66. How will the 2012/13 QOF data be published as there is now a new NHS structures for primary care?
67. Would it be possible to access the data under both the old and the new structures?
68. Is exception reporting done on an indicator by indicator basis?
69. Do exception codes apply to registers?
70. Can patients newly registered with a practice who have not had assessments undertaken within the required time from initial diagnosis be exception reported?
71. If an indicator requires that a patient is invited for a review but is exception reported i.e. patient unsuitable or patient did not attend, should they be invited to attend for a review the following QOF year?
72. Will practice exception reporting data be published?

Miscellaneous questions

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74. Is there an age limit for patients in the QOF?
75. What is the process if a practice and NHS England are in dispute?
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