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### Disclaimer:

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*Based on v20 QoF business rule sets, April 2011.*

## **Quality and Outcomes Framework (QoF) Introduction**

The National Quality & Outcomes Framework was introduced to general practice on 1<sup>st</sup> April 2004. The objective of QoF is to improve the quality of care patients are given who suffer from chronic illness and diseases – improved quality to improve patient outcomes. The QoF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.

QoF is a Primary Care Service tool, and is a major source of funding to practices throughout the country. One of the four areas (Clinical) makes up nearly 70% of the QoF payment on its own.

When QOF was first introduced as part of the GMS (General Medical Services) contract in 2004, the following principles were agreed on where QOF standards should apply:

- Indicators should, where possible, be based on the best available evidence.
- The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.
- Data should never be collected purely for audit purposes.
- Only data which is useful in patient care should be collected. The basis of the consultation should not be distorted by an over emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.
- Data should never be collected twice e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

## Structure of QoF

There are a maximum of 1,000 points available to practices across QoF, which in turn determine payments. The key payment dates each year are:

- By 31 March - practices are paid retrospectively for points achieved in the previous year. Practices will be paid on average (dependent on average prevalence rates), £130.51 (in England), £130.47 (Wales), £130.47 (Scotland), £127.26, (Northern Ireland), for each point they achieved (2011/12 payment figures).
- Payments should be completed by the end of June, although they can be made earlier when they have been agreed by the practice and the primary care organisation.

Payments are subject to certain thresholds (targets) and take account of the national prevalence of diseases, by applying a standard calculation to all practices (Adjusted Disease Prevalence Factor – ADPF). Payments are also increased or reduced based on your patient list size. The average patient list size in England is 5891, in Wales it is also 5891, Scotland is 5095 and Northern Ireland is 4937.

With the average practice having several thousand patients, the accuracy of your QoF recording should be as high quality as possible - if Data Quality is poor, this will in turn not only affect your patient care, but also the payment your surgery will receive (see data quality section at end).

## Domains and indicators within QoF

QoF has a range of national quality standards, based on the best available, research-based evidence. These fall into four domains (see below). Each domain has measures of achievement, known as indicators, against which practices score points according to their level of achievement. Practice payments are calculated on the points achieved and prevalence (register list sizes).

The four domains are:

- **Clinical** - this domain has indicators across different clinical areas e.g. coronary heart disease, heart failure, hypertension etc.
- **Organisational** - this has indicators across the five areas of records and information, information for patients, education and training, practice management, medicines management and quality and productivity. It requires practices to hold policy information and have processes in place, which actively demonstrate sound practice and understanding amongst their practice team.
- **Patient experience** - this has an indicator on the length of patient consultations.
- **Additional services** - this has indicators across the four service areas of cervical screening, child health surveillance, maternity services and contraceptive services.

## Clinical Domains

The Clinical Domain consists of 20 different areas of chronic disease and illness. These 20 areas are then broken down into 88 areas, also known as Indicators, where we need to achieve targets. These have a structure that is split into 3 sections:

- **Structure** – E.g. A disease register in place
- **Process** – E.g. Is the indicator being measured, and an appropriate intervention being made for what % of the population
- **Outcome** – E.g. How well is the condition being controlled across the % of that population.

The maximum points available for the clinical disease areas are 664. This makes up nearly 70% of all QoF payments for the year.

**20 Clinical domains are:**

- **CHD – 8** Indicators (targets to achieve) worth maximum **76** points
- **Heart Failure - 4** Indicators (targets to achieve) worth maximum **29** points
- **Stroke - 7** Indicators (targets to achieve) worth maximum **22** points
- **Hypertension - 3** Indicators (targets to achieve) worth maximum **79** points
- **Diabetes - 15** Indicators (targets to achieve) worth maximum **92** points
- **COPD - 5** Indicators (targets to achieve) worth maximum **30** points
- **Epilepsy - 4** Indicators (targets to achieve) worth maximum **14** points
- **Hypothyroid - 2** Indicators (targets to achieve) worth maximum **7** points
- **Cancer - 2** Indicators (targets to achieve) worth maximum **11** points
- **Palliative Care - 2** Indicators (targets to achieve) worth maximum **3** points
- **Asthma - 4** Indicators (targets to achieve) worth maximum **45** points
- **Dementia - 3** Indicators (targets to achieve) worth maximum **26** points
- **Depression - 2** Indicators (targets to achieve) worth maximum **31** points
- **Smoking - 2** Indicators (targets to achieve) worth maximum **60** points
- **Atrial Fibrillation - 3** Indicators (targets to achieve) worth maximum **27** points
- **Learning Disabilities - 2** Indicators (targets to achieve) worth maximum **2** points
- **Mental Health - 10** Indicators (targets to achieve) worth maximum **40** points
- **CVD PP - 2** Indicators (targets to achieve) worth maximum **13** points
- **Obesity - 1** Indicators (targets to achieve) worth maximum **8** points
- **Chronic Kidney Disease - 5** Indicators (targets to achieve) worth maximum **38** points

**Disease Registers**

An important feature of the QoF is the establishment of disease registers. Registers relate to each of the disease areas within the clinical domains. If you have one or more patients with an appropriate diagnosis code in each of these areas, you have a practice register. **While it is recognised that these may not always be 100% accurate, it is the responsibility of the practice to demonstrate it has systems in place to maintain a high quality register. (Data Quality)**

Register totals, as a percentage of your total practice list size, are used to measure your raw disease prevalence which is what determines the value of each of your points.

## **Prevalence**

Prevalence is a measure of practices disease registers at a particular point in time and only incorporates the Clinical domain areas. All patients included in any of the disease registers will count towards prevalence.

Condition resolved codes removes patient from some of the registers and will no longer count towards your payments. Prevalence ignores exception coding so the patients with an exception code still count towards your payments. £'s per point is adjusted dependent on the practice register size compared with the national average for that register. So it is of the utmost importance that your registers are accurate to ensure you get the maximum £'s per point for your patients and surgery (Data Quality - see end pages)

## **What could affect Prevalence?**

- High Asian population will affect your figures - Increased MI/Angina/diabetes
- An Elderly population will also affect figures - Increased Diabetes register (10% males, 8.9% females)
- Particularly young practice list – university practice - Low CHD, Stroke COPD, but High Asthma, smoking, and depression.
- 25% population obese - Males registered at the practice from minority ethnic groups much lower prevalence (Obesity)
- 4 patients in every 1000 have a learning disability - Specialist unit in catchment area could increase figures