GUIDE TO CODING AND DISEASE REGISTERS FOR THE CONTRACT

Updated October 2012

The following guidance discusses the effect of recent changes to the Quality and Outcomes Framework (QOF) on disease populations and indicators. It takes account of recent changes to the specifications for 2012-13 and includes both the recent upgrade to V22 of the code and search specifications issued to software systems in January 2012 and V23 issued May 2012. V23 contains changes relating to the April 2012 Read code release and may not be included in software system upgrades until later in the year. Changes are highlighted in red. There is advice on issues that may need consideration in respect of practice coding and recording of data. The SCIMP website also lists the complete Contract v23 Read codes:-
http://www.scimp.scot.nhs.uk/clinical-coding/contract-codes

For the full official guidance for the QOF 2012-13 click here:-
http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_2012-13.pdf

For details of the latest published Department of Health technical dataset and business rules documents click here:- http://www.pcc-cic.org.uk/article/qof-business-rules-v230These define in detail which Read codes are valid, the relevant timescales and the searches used by QMAS

Specific advice on exception coding can be found at:-
http://www.sehd.scot.nhs.uk/pca/PCA2006(M)15.pdf

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ASTHMA

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Population (Asthma1) – *The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months*
Points 4

- Patients require an appropriate Read Code and an asthma medication prescription within the last year.
- V23 has added omalizumab (xolair) injections to the list of appropriate codes.
- It is possible to remove patients from the population by using one of the Asthma resolved codes. This is required to be dated after the most recent Asthma Read code.

It is now accepted that patients can have co-existing Asthma and COPD and therefore may be on both registers.

Indicators

ASTHMA 8 – *'The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility..*
Range 45-80%
Points 15

- This indicator now specifies that the diagnosis tests should include measures of variability or reversibility. This applies particularly to spirometry and it should be noted that there is now a much smaller group of acceptable spirometry codes in Asthma compared with COPD. Care will be needed in patients who have both conditions. The register starts from 1.4.06 therefore there is no need to review the coding of patients diagnosed before this.
- V22 – codes added to ruleset that allow exception coding for spirometry
  - 8I3b. Spirometry test declined
  - 8I6L. Spirometry not indicated
  - 8I2j. Spirometry contraindicated
  - 33720 Unable to perform spirometry

  These require entry within the last 15 months

ASTHMA 10 – *'The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months.'*
(Indicator re-numbered, previously ASTHMA3)
Range 45-80%
Points 6

- This indicator is the same as in 2007 – 08. Patients with Asthma are included in the indicators Smoking 3 and 4. The Asthma exception codes do not apply for the Smoking 3 and 4 indicators. There are separate 'Smoking' exception codes that can be used.
- V22 New code added to allow exception coding from this indicator
  - 137k. Refusal to give smoking status

~~**ASTHMA6** – *'The percentage of patients with asthma who have had an asthma review in the preceding 15 months.'*~~Replaced by Asthma9

ASTHMA9 – *'The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions.'*

Range 45-70%

Points 20

- 3 RCP questions are:- In the last month:
    1. Have you had difficulty sleeping because of your symptoms (including cough)?
    2. Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
    3. Has your asthma interfered with you usual activities (for example, housework, work/school etc)?
- There are separate codes for each of these questions. To meet the indicator requires a codes for an asthma review AND a code for each of the questions, all entered with the same date.
- V23 had expanded the codes that can be used for these questions, see SCIMP code list.

ATRIAL FIBRILLATION

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Population (AF1) - *The Practice can produce a register of patients with atrial fibrillation.*
Points 5

- Codes for both Atrial Fibrillation and Paroxysmal AF are included. Patients can be coded as AF resolved and will be excluded from the population if this is dated after the most recent 'AF' code.
- There are overall exception codes available for patient unsuitable and informed dissent.

Indicators

AF5. *The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1)*
Range 40-90%
Points 10

The revised $CHADS_2$ system scores 1 point, up to a maximum of 6, for each of the following risk factors (except previous stroke or TIA, which scores double, hence the '2'). A score of 0 is classified as low risk, 1 moderate risk, and 2 or more high risk.

☐ C - congestive heart failure (1 point)

☐ H - hypertension (1 point)

☐ A - age 75 years or over (1 point)

☐ D - diabetes mellitus (1 point)

☐ S_2 - previous stroke or TIA (2 points).

- Patients are excluded from this indicator if they have had a CHAD2 score of >1 in the past (ie, more than 15 months ago). These patients have previously been assessed as at high risk of future Stroke and do not need the risk reassessed each year.
- Patients are also excluded if they have been diagnosed with AF or have registered with the practice in the previous 3 months, or have a valid exception code in the last 15 months..

AF6. *In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1(latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy*
Range 50-90%
Points 6

- The CHADS2 read code requires entry within the previous 15 months AND with a value of '1' added for patients to qualify for the denominator of this indicator.
- Prescriptions should be recorded in the previous 6 months. Codes for OTC salicylates can be used but require entry within the last 6 months.

- QOF Guidance states ‘For the purposes of the QOF, acceptable anti-coagulants are warfarin, phenindione and dabigatran. In Scotland, Healthcare Improvement Scotland (HIS) consensus recommends that warfarin remains the anticoagulation of clinical choice for moderate and high-risk atrial fibrillation patients with good international normalised ratio (INR) control but that dabigatran can be used under certain specific clinical circumstances142. NICE has a technology appraisal in progress (as of January 2012) on the use of dabigatran for the prevention of stroke or systemic embolism in people with atrial fibrillation.’ The search specifications will pick up patients prescribed any of these medications in the previous 6 months. Acceptable anti-platelets are aspirin, dipyridamole and clopidogrel

- To exception code from this indicator an exception code for each of the 4 different drugs needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).

AF6. *In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy*

Range 40-70%

Points 6

- Patients qualify for the denominator of this indicator if they have ever had a CHADS2 Read code with a value of >1 entered in their records (no time limit of ‘last 15 months’ as for AF6).
- QOF Guidance states:- ‘For the purposes of the QOF, acceptable anticoagulants are warfarin and phenindione. In Scotland HIS consensus recommends dabigatran under certain circumstances’. The search specifications will pick up patients prescribed any of these medications in the previous 6 months.

CANCER

Index

Population Cancer1. – *The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1st April 2003'.*
Points 5
This indicator remains unchanged from 2007-08. The register is for all new patients since 1.4.03.

Indicators

Cancer3 *'The percentage of patients with cancer, diagnosed within the preceding 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis'*
Range 50-90%
Points 6

- This indicator only applies for new diagnosis in the last 18 months.
- The review code requires entry within the previous 12 months and also within 6 months of the first occurence of the Cancer code. It is possible that some patients diagnosed 12-18 months ago may have a review code more than 12 months ago. These reviews will not count for the year 2010-11 but will have been included in 2009-10
- A new diagnosis in the last 6 months will be excluded if no review has been done. This allows the full 6 months in which to do a review. These patients will count for the following year so a review is still required within the 6 month period.

CORONARY HEART DISEASE

Index

Population CHD1 – *The practice can produce a register of patients with Coronary Heart Disease.*
Points 4

- V23 removed codes G310. (post myocardial infarction syndrome), Gyu31 [X](Other current complications following acute myocardial infarction)and G36% (Certain current complications following acute myocardial infarction) from codeset. G39.. (Coronary microvascular disease) has been added to the dataset in V23

Indicators

- Patients with CHD are included in the indicators Smoking 5 and 6. The CHD exception codes do not apply and there are separate 'Smoking' exception codes that can be used.
- Although not an indicator within CHD , patients with CHD are required to be assessed for possible depression using the 2 standard questions (see Depression). For assessment of depression the CHD exception codes do not apply and there are separate 'Depression' exception codes that can be used.
- CHD14 applies to patient who have had an MI since 1.4.11. The overall exception codes for IHD (9h0.., 9h01.., 9h02..) will not count for this indicator. There are separate codes for patients with an MI -
  - 9hM.. Exception reporting: myocardial infarction quality indicators
  - 9hM0. Excepted from myocardial infarction quality indicators: informed dissent
  - 9hM1. Excepted from myocardial infarction quality indicators: patient unsuitable

CHD6 - *The percentage of patients with Coronary Heart Disease, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.*
Range 40-75%
Points 17

- Exception codes exist for blood pressure procedure refused and on maximal tolerated hypertensive treatment.

CHD8 - *The percentage of patients with Coronary Heart Disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less.*
Range 45-70%
Points 17

- V22 – Removed codes 44P1. – 44P4 (serum cholesterol normal, borderline, raised, very high) removed from the dataset.
  V23 has added code 44PK. (Serum fasting total cholesterol).

CHD9 - *The percentage of patients with Coronary Heart Disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.*
Range 50-90%
Points 7.

- The time period for prescriptions is 'in the last 15 months'.

CHD10 - *The percentage of patients with Coronary Heart Disease who are currently treated with a beta-blocker.*
Range 40-65%
Points 7

- The time period for prescriptions is 'in the last 6 months'.

CHD 14 - *The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin*
Range 45-80%
Points 10

- To meet this indicator patients need to have received all 4 types on medication in the last 6 months (or OTC code for aspirin in last 15 months), or have a combination of these plus exception codes for any they are not taking. The different time periods for OTC aspirin and statin have been raised as an issue.
- Code for OTC Statin is no longer included in the codeset
- V23 added further medications to the ARB group to include Olmesartan contained in compound medications

- NOTE – overall exception codes for IHD (9h0.., 9h01.., 9h02..) will not count for this indicator. There are separate codes for patients with an MI -
  - 9hM.. Exception reporting: myocardial infarction quality indicators
  - 9hM0. Excepted from myocardial infarction quality indicators: informed dissent
  - 9hM1. Excepted from myocardial infarction quality indicators: patient unsuitable

CHD12 - *The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March.*
Range 50-90%
Points 7

- New Read codes created for 2012-13 season both for vaccinations given and for exception coding. Care needed as codes used in previous years are not in theV22 specification.

  For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted, the only acceptable codes are:-
  - 65ED. Seasonal influenza vaccination
  - 65E20 Seasonal influenza vaccination given by other healthcare provider

  For exception codes, the persisting allergy codes, 14LJ., U60K4, ZV14F remain the same. For expiring exceptions the previous codes 8I2F., 8I6D., 9OX5. are no longer accepted. Codes that should now be used are:-
  - 68NE. No consent - influenza imm. (previously in specification)
  - 8I2F0 Seasonal influenza vaccination contraindicated (new)
  - 8I6D0 Seasonal influenza vaccination not indicated (new)
  - 9OX51 Seasonal influenza vaccination declined (new)

  Some of the 'old' codes will be detected for the 'at risk' flu surveillance searches as the codeset definitions for the QOF and PRIMIS at risk differ.

CHRONIC KIDNEY DISEASE

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Population CKD1 *The practice can produce a register of patients aged 18 years and over with CKD. (US National Kidney Foundation: Stage 3-5 CKD)*
Points 6

- For patients age 18 or over.
- **NOTE** the Contract guidance states that 'This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m^2 for over 3 months).' This implies that a patient should not be diagnosed with a specific stage of renal disease without at least 2 eGFR results over a 3 month period.

Laboratories in Scotland calculate estimated Glomerular filtration rate (eGFR) and add this to their standard results. From this practices will need to add the correct coding for the stage of renal disease where appropriate. The coding is based on the International classification developed by the US National Kidney Foundation which describes 5 stages of chronic kidney disease.

Classification of CRD - From US National Kidney Foundation

	GFR	Read Code
Stage 1 - Kidney Damage with normal or raised GFR	>=90	1Z10.
Stage 2 - Kidney Damage with mild decrease GFR	60 - 89	1Z11.
Stage 3 - Moderate decrease in GFR	30 - 59	1Z12.
Stage 4 - Severe decrease in GFR	15 - 29	1Z13.
Stage 5 - Kidney Failure	< 15 (or dialysis)	1Z14.

- The Consensus statement on management of early CKD, February 2007 by the Renal Organisation states:-

We recommend sub-classifying CKD stage 3 into 2 groups, 3A and 3B:

- 3A defines a lower risk group with eGFR of 45-59.
- 3B defines a higher risk group with eGFR of 30-44.

In addition for each of the CKD Stages there are now codes defining 'CKD without Proteinuria' and 'CKD with Proteinuria'. These have been added to the codes that count as 'Proteinuria If patient also has hypertension they will count for CKD5.

V23 added codes K053. (Chronic kidney disease stage 3), K054. (Chronic kidney disease stage 4)and K055. (Chronic kidney disease stage 5) to codeset for CKD. In addition codes K051. (Chronic kidney disease stage 1) and K052. (Chronic kidney disease stage 2) if dated after a CKD stage 3-5 code have been added to the codeset to remove patients from the CKD register.

For Read codes click on link to SCIMP list of V23 Contract Read codes
http://www.scimp.scot.nhs.uk/clinical-coding/contract-codes

- Codes for Stages 1 and 2, if they are the most recent of any of the codes, will remove the patient from the register.
- There are overall exception codes available for patient unsuitable and informed dissent.
- CKD is included as a disease area in the Smoking 3 and 4 Indicators. CKD exception codes will not count for this. There are separate Smoking exception codes.

Indicators

CKD2 *'The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months.'*
Range 50-90%
Points 6
CKD3 *'The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less.'*
Range 45-70%
Points 11

- these indicators are unchanged from 2010-11. The same exception codes exist for blood pressure procedure refused (applies to Indicators CKD2 and 3) and on maximal tolerated hypertensive treatment (applies to Indicator CKD3).

CKD5 *'The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB)*
Range 45-80%
Points 9

The population for this = patients on the CKD register AND on the Hypertension register AND with a code for 'Proteinuria'. The codes for Proteinuria differ from those specified in the Diabetes indicators – see SCIMP Contract Read codes for listing of codes.

- V22 code G24z1 (Hypertension secondary to drug) removed from hypertension diagnosis codes.
- V23 codes G2400 (Secondary malignant renovascular hypertension) and G2410 (Secondary benign renovascular hypertension) removed
- Prescriptions should have been prescribed within the last 6 months.
- To exception code from this indicator an exception code for BOTH an ACE Inhibitor AND an A II receptor blocker needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).
- V23 added to the ARB medications to include Olmesartan compounds

CKD 6 – *The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months*.
Range 45-80%
Points 6

- Acceptable codes are:
  44lD. Urine protein/creatinine ratio
  46TC. Urine albumin:creatinine ratio

COPD

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Population– COPD14 *The practice can produce a register of patients with COPD.*
Points 3
NICE clinical guideline 101 has recommended a change to the diagnostic threshold for COPD. See http://guidance.nice.org.uk/CG101 for further details. As this may lead to an increase in the recorded prevalence of COPD, this indicator has been renumbered from April 2011 in recognition of this.

It is now accepted that patients can have co-existing Asthma and COPD and therefore may be on both registers.

- V23 removed codes H3y0. (Chronic obstructive pulmonary disease with acute lower respiratory infection) and H3y1. (Chronic obstructive pulmonary disease with acute exacerbation, unspecified) and added code H3A.. (End stage chronic obstructive airways disease). This is a newly released Read code.

Indicators

- Patients with COPD are included in the indicators Smoking 3 and 4. The COPD exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

COPD15 – *The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry*
Range 45-80%
Points 5

- NICE clinical guideline 101 recommends changes to the diagnostic thresholds for COPD. See page 70 of QOF guidance document :- http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_2012-13.pdf
  or NICE website for full guidance http://guidance.nice.org.uk/CG101
- The spirometry code requires entry within the time period of 3 months before to 12 months after the earliest COPD code.
- It is possible to exception code people from this specific indicator if spirometry is contra-indicated, not indicated or declined. These require re-entry every 15 months.
- Click on link for SCIMP Contract Read codes http://www.scimp.scot.nhs.uk/clinical-coding/contract-codes . Note that they are different from the spirometry codes used for the asthma population. Care will be needed in patients who have both conditions.

COPD10 – *The percentage of patients with COPD with a record of FEV1 in the preceding 15 months.*
Range 40-75%
Points 7

COPD 13 – *The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.*
Range 50-90%
Points 9

- Patients require both a COPD review code AND an MRC dyspnoea score code entered in the last 15 months to meet this indicator

MRC dyspnoea scale

Grade	Degree of breathlessness related to activities
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up a slight hill
3	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking about 100 m or after a few minutes on level ground
5	Too breathless to leave the house, or breathless when dressing or undressing

Adapted from Fletcher CM, Elmes PC, Fairbairn MB et al. (1959) The significance of respiratory symptoms and the diagnosis of chronic bronchitis in a working population. *British Medical Journal* 2:257–66.

COPD8 – *The percentage of patients with COPD who have had influenza immunisation in the preceding 1st September to 31st March.*
Range 45-85%
Points 6

- New Read codes created for 2012-13 season both for vaccinations given and for exception coding. Care needed as codes used in previous years are not in theV22 specification.

  For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted, the only acceptable codes are:-

  65ED. Seasonal influenza vaccination
  65E20 Seasonal influenza vaccination given by other healthcare provider

  For exception codes, the persisting allergy codes, 14LJ., U60K4, ZV14F remain the same. For expiring exceptions the previous codes 8I2F., 8I6D., 9OX5. are no longer accepted. Codes that should now be used are:-

  68NE. No consent - influenza imm. (previously in specification)
  8I2F0 Seasonal influenza vaccination contraindicated (new)
  8I6D0 Seasonal influenza vaccination not indicated (new)
  9OX51 Seasonal influenza vaccination declined (new)

  Some of the 'old' codes will be detected for the 'at risk' flu surveillance searches as the codeset definitions for the QOF and PRIMIS at risk differ.

CARDIOVASCULAR DISEASE – PRIMARY PREVENTION

Index

PP1 – *In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment treatment tool.*
Range 40-75%
Points 8

- Patients with codes for IHD, Diabetes, Stroke, TIA, CKD PVD or Familial hypercholesterolaemia are excluded from this population requiring CHD Risk assessment. See http://www.scimp.scot.nhs.uk/clinical-coding/contract-codes for list of codes for these disease areas.
- Patients are also excluded if they have a 'hypertension resolved' code dated after the latest 'hypertension' code.
- Care needed with Risk Assessment tools and codes. Acceptable tools are Joint British society (JBS) CVD risk assessment, QRISK and ASSIGN (Scotland only). See http://assign-score.com/ for details of ASSIGN risk assessment.
- Patients newly diagnosed with hypertension age <30 or >=75 do not require CVD Risk assessment but do still require lifestyle advice.
- Risk assessment codes require entry within the time scale of 3 months before to 3 months after the new Hypertension diagnosis date.
- There are overall exception codes available for patient unsuitable and informed dissent. For Indicator PP2 these will require re-entry every 15 months.
- V23 added codes 38G6. (Joint British Societies cardiovascular disease risk score) and 38G8. (Dundee CVS risk score)
- There are now 3 codes that exception code patients specifically from requiring risk assessment (V23 added 8IEL.)

  8IAK. (Cardiovascular disease high risk review declined)
  9Oh9. (Cardiovascular disease risk assessment declined)
  8IEL. (QRISK cardiovascular disease risk assessment declined).

PP2 – *The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.*
Range 40-75%
Points 5

- There are two Read codes, 67H.. (Lifestyle counselling) or 67H8. (Lifestyle advice regarding hypertension) that counts for this indicator. However the BMA QOF Guidance states:-

  'Verification – PCOs may randomly select a number of case records of patients in which this advice has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.'

  It may therefore be sensible to add addition information either as text or specific Read codes to show types of counselling given.
- code for hypertension needs to be after 1.4.09 AND be recorded as a latest first or new episode

DEMENTIA

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Population DEM1 *'The practice can produce a register of patients diagnosed with dementia.'*
Points 5

- There are overall exception codes available for patient unsuitable and informed dissent.

Indicators

DEM2 – *'The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months.'*
Range 35-70% (previously 25-60%)
Points 15

- Details of what should be included in a review are listed in the QOF guidance (see links to BMA and NHS Employers websites on page 1). A review of carers needs is included within this.
- The only acceptable code for review is 6AB.. (Dementia annual review).

DEM 4 *The percentage of patients with a new diagnosis of dementia recorded between the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register. (*Indicator renumbered, previously Dem3)
Range 45-80%
Points 6

- Codes specified as on SCIMP spreadsheet. Care will be needed to ensure that imported lab results are coded with appropriate codes to meet this dataset.
- Codes for blood tests require entry within time period 6 months before to 6 months after the first diagnosis date
- V22 Code for HbA1c now acceptable as an alternative to glucose test
- V22 - Patients can be excluded from this indicator using 8IEG. (Blood glucose test declined). Required entry within the last 15 months.
- Patients are excluded if they have been diagnosed within the last 6 months AND not had all the required tests. This is to allow the required time for tests to be done. Note that, if excluded in this QOF year, these patients will be included in the next year. Although the indicator states 'recorded between the preceding 1 April to 31 March' the ruleset searches for diagnosed within the last 18 months but then excludes those diagnosed 12-18 months ago who met the criteria and were included in the previous years figures. This ensures all patients will be included, but only once, in the yearly figures.
- Specific codes for Liver function tests, that qualified in 2011-12, have been removed in V22. You may need to ensure your coding of these results meets the specification - see SCIMP code guidance http://www.scimp.scot.nhs.uk/clinical-coding/contract-codes

DEPRESSION

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Population

- V22 Indicators 3 and 4 have been renumbered to DEP6 and DEP7. This is because of a change in the calculation of Depression prevalence figures. Previously the prevalence figures were based on patients with a diagnosis of depression ever in their history. Now it is patients diagnosed with depression since 1.4.2006.
- These are different populations for the 3 indicators – see below.
- There are overall exception codes available for patient unsuitable and informed dissent, these apply to all indicators. It should be noted that Diabetes or CHD exception codes do not apply to DEP1.

Indicators

DEP1 – *'The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions.'*
Range 50-90%
Points 6

- The population is all patients who are currently on either the Diabetes register or the Coronary Heart Disease register. From this group patients who have been diagnosed with depression in the last 15 months and have not been screened for depression with the 2 questions, will be excluded from the population. Patients who do have the screening questions and are then subsequently diagnosed with depression will remain in the population.
- Diabetes or CHD exception codes do not count. There are separate 'Depression' exception codes that can be used.
- The two standard screening questions are:-

1. During the last month, have you been bothered by feeling down, depressed or hopeless?
2. During the last month, have you often been bothered by having little interest or pleasure in doing things?

These two questions may be best integrated as part of the CHD or Diabetes annual review and then coded accordingly. A 'yes' to either question is considered a positive test and they should then be assessed for further symptoms of depression. For 2008-09 the guidance has been modified to specify that these questions should be asked as part of a consultation and should not be posted to patients.

DEP 6 – *In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care.* (Indicator renumbered, previously DEP4)
Range 50-90%
Points 17

- The search looks for the latest, first or new entry of a Depression code within the time period. Care may be needed in the dating of codes if you commonly

record diagnosis read codes at each patient encounter. Your software system will advise on the correct way to indicate a new diagnosis.

- A Depression resolved code is available which will remove the patient from the population if dated after the most recent depression code. At present this code should be used with caution as it will have the effect of reducing your Depression population and possibly your payments.
- Any entry of one of the Depression codes will put the patient into the population. **Entry of the assessment score needs to be entered within 28 days after the latest depression code date**
- **The search looks back 15 months from the reference date, therefore although the indicator states 'the previous 1st April to 31st March, patients diagnosed from the previous 1st January may be included. If they had a 1st assessment prior to 1st April they will be excluded.**
- Applies only to patients age 18 or over and does not include post-natal depression. Care should be taken as code E204. (Neurotic depression reactive type) which is a commonly used code, is not included for the Contract as it has a synonym term for post-natal depression.
- Care is also needed with codes for depression that indicate psychosis as they will also include the patient in the Mental Health register.

The three assessment tools to choose from are:-

1. Patient Health Questionnaire (PHQ9) – can be downloaded free of charge from www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/
2. The Beck Depression Inventory 2nd edition (BDI-II) - can be ordered from http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=112&page_id=9707008&query=beck%2A&hiword=besk%2A+
3. The Hospital Anxiety and Depression Scale(HADS) – can be ordered from www.nfer-nelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1125

DEP 7 – *In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. ((*Indicator renumbered, previously DEP5).
Range 45-80%
Points 8

- Second assessment requires entry within 2 – 12 weeks after the first assessment. Note this is not after the diagnosis date. Previously was 4 – 12 weeks.
- The same Assessment Read codes are used for the first and second assessments
- Patients will only meet this indicator if they have both the first assessment within 28 days of diagnosis AND the second assessment 2-12 weeks after the first.
- **The search looks back 68 weeks from the reference date, therefore although the indicator states 'the previous 1st April to 31st March, patients diagnosed before 1st April may be included. If they had a 2nd assessment prior to 1st April they will be excluded.**

DIABETES

Index

Population DM19. – *The practice can produce a register of all patients age 17 years and over with Diabetes Mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.* (new wording)
Points 6

- The range of codes that qualify for the Diabetes population has been significantly expanded from the previous restriction of C10E% and C10F%. See SCIMP website for details.
- It is possible to remove patients from the population by using one of the Diabetes resolved codes. This is required to be dated after the most recent Diabetes Read code.

Indicators

- Patients with Diabetes are included in the indicators Smoking 3 and 4. The Diabetes exception codes do not apply and there are separate 'Smoking' exception codes that can be used.
- Although not an indicator within Diabetes , patients with diabetes are required to be assessed for possible depression using the 2 standard questions (see Depression). For assessment of depression the Diabetes exception codes do not apply and there are separate 'Depression' exception codes that can be used.

DM2. *The percentage of patients with diabetes whose notes record BMI in the preceding 15 months.*
Range 50-90%
Points 1 (previously 3)

DM 26: (Replacing previous DM23 – HbA1c <7) *The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.*
Range 40-50%
Points 17

DM 27: (Replacing previous DM24 – HbA1c <8) *The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months*
Range 45-70%
Points 8

DM 28- (Replaced previous DM25) *The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.*
Range 50-90%
Points 10

- Old results / codes for HbA1c as a percentage are no longer accepted to meet these indicators. Must now be an IFCC-HbA1c result.
- It is possible to specifically exception code for these indicators, for patients on maximum tolerated diabetes treatment.

DM21. *The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months.*
Range 50-90%
Points 5

- Patients can be specifically exception coded from this indicator if retinal screening is not indicated, unsuitable or refused. These exclusion codes require review and re-entry if appropriate, every 15 months.

DM 29: The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.
Range 50-90%
Points 4

- Exception codes available for amputations of leg. Note specific codes required and need to have two codes, one each for right and left amputations to except from this indicator

DM10. *The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months..*
Range 50-90%
Points 3

- Patients can be specifically exception coded from these indicators if foot examination or neuropathy testing is not indicated or declined. These codes require review and re-entry if appropriate, every 15 months.
- Care is needed in the exception codes used as need to be specific for Diabetic foot examination or neuropathy testing not indicated or refused.
- Exception codes available for amputations of leg. Note specific codes required and need to have two codes, one each for right and left amputations to except from this indicator
    - V23 removed codes 29B1. (O/E - tactile sensation normal), 29B2. (O/E - anaesthesia present), 29B20 (O/E - anaesthesia in legs), 29B21 (O/E - anaesthesia of extremities), 29B3. (O/E - hypoaesthesia present)

DM 30. *The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less.*
Range 45-71%
Points 8

DM 31. *The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less.*
Range 40-65%
Points 10

DM 13: *The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria).*
Range 50-90%
Points 3

DM 22: *The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months.*
Range 50-90%
Points 1

- estimated Glomerular filtration rate (codes 451E. or 451F.) was added in 2006-07, as an alternative to creatinine testing. Creatinine testing on its own is still sufficient to meet this indicator.
- Codes remain unchanged from previous years

DM15. *The percentage of patients with diabetes with a diagnosis of proteinuria or micro-proteinuria who are treated with ACE inhibitors (or A2 antagonists).*
Range 45-80%
Points 3

- The time period for prescriptions is 'in the last 6 months'.
- To exception code from this indicator an exception code for BOTH an ACE Inhibitor AND an A II receptor blocker needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).
- V23 added further medications to the ARB group to include Olmesartan contained in compound medications

DM 17: *The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5 mmol/l or less.*
Range 40-75%
Points 6

- V22 – Removed codes 44P1. – 44P4 (serum cholesterol normal, borderline, raised, very high) from the dataset.
  V23 has added code 44PK. (Serum fasting total cholesterol).

DM18. *The percentage of patients with diabetes who have had influenza immunisation in the preceding 1st September to 31st March.*
Range 45-85%
Points 3

- New Read codes created for 2012-13 season both for vaccinations given and for exception coding. Care needed as codes used in previous years are not in theV22 specification.
  For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted, the only acceptable codes are:-
  65ED. Seasonal influenza vaccination
  65E20 Seasonal influenza vaccination given by other healthcare provider
  For exception codes, the persisting allergy codes, 14LJ., U60K4, ZV14F remain the same. For expiring exceptions the previous codes 8I2F., 8I6D., 9OX5. are no longer accepted. Codes that should now be used are:-
  68NE. No consent - influenza imm. (previously in specification)
  8I2F0 Seasonal influenza vaccination contraindicated (new)
  8I6D0 Seasonal influenza vaccination not indicated (new)
  9OX51 Seasonal influenza vaccination declined (new)
  Some of the 'old' codes will be detected for the 'at risk' flu surveillance searches as the codeset definitions for the QOF and PRIMIS at risk differ.

EPILEPSY

Index

Population – EPILEPSY 5 *The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy.*
Points 1

- Patients require an appropriate Read Code and an epilepsy medication prescription within the last 6 months.
- It is possible to remove patients from the population by using one of the Epilepsy resolved codes. This is required to be dated after the most recent Epilepsy Read code.
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months.

Indicators

EPILEPSY 6: *The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months***.**
Range 50-90%
Points 4

EPILEPSY 8*:* *The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months***.**
Range 45-70%
Points 6

- this indicator is the same as 2007-08 apart from the qualifying age range.
- Patients can be specifically excluded from this indicator if they are considered to be on maximum anticonvulsant therapy.

EPILEPSY 9: *The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months.*
Range 50-90%
Points 3

- Applies to women age under 55
- Patients require a separate code for each of the 3 types of counselling, entered within the last 15 months, to meet the new Epilespy9 indicator. It is not necessary for these all to be entered on the same date.
- Patients with a code for sterilisation or hysterectomy are permanently excluded from this indicator..
- There are separate codes to exclude from each of the 3 types of counselling. To exclude a patient as refused or not appropriate the patient requires either an exclusion codes or a code to meet the criteria, for each of the 3 types of counselling.

HEART FAILURE

Index

Population HF1 *The practice can produce a register of patients with Heart Failure*
Points 4

- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months. It is important to ensure that it is the Heart Failure exception codes (9hH%) that are used rather than the LVD exception codes. The latter were removed from the specifications in Version 10.
- V23 added new code G584.(Right ventricular failure) to Heart failure diagnosis codeset.

Indicators

- Patients with Heart Failure are included in the indicators Smoking 3 and 4. The Heart Failure exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

HF 2: *The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment*
Range 50-90%
Points 6

- The code for echocardiogram or referral needs to be recorded within the timescale of 3 months before to 12 months after the earliest Heart Failure code (if after 1.4.06).
- There are specific codes to exclude patients from this indicator (Echo declined or Angiocardiography declined)
- V22 new code added for ECHO - 8H7o0 (Fast track heart failure referral for transthoracic two dimensional echocardiogram).

HF3: *The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication*
Range 45-80%
Points 10

- The population for this indicator is a subgroup of the Heart Failure population. They require a specific code for Left Ventricular dysfunction.
- V22 has removed codes 662f. – 662i. (New York Heart Failure classifications) from qualifying for this population.
- Prescriptions need to have been prescribed within the last 6 months.
- To exclude a patient they require individual exclusion codes for both ACE inhibitor AND Angiotensin Receptor Blocker.
- V23 added further medications t the ARB group to include Olmesartan contained in compound medications

HF4: *The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.*
Range 40-65%
Points 9

- Patients not on an ACE or A11 Receptor blocker are not included in this population.
- Prescriptions need to have been prescribed within the last 6 months.
- Licensed beta-blockers are carvedilol, bisoprolol and nebivolol. However patients who are on an unlicensed beta blocker prescribed anytime after 6 months before the Heart Failure diagnosis date are excluded from the population as it may not be appropriate to change them to a licensed preparation.

HYPERTENSION

Index

Population BP1 – *The practice can produce a register of patients with established hypertension.*
Points 6

- It is possible to remove patients from the population by using one of the Hypertension resolved codes. This is required to be dated after the most recent Hypertension diagnosis Read code.
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months.

Indicators

- Patients with hypertension are included in the indicators Smoking 3 and 4. The hypertension exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

BP 4: *The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months.*
Range 50-90%
Points 8
BP 5: *The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less.*
Range 45-80% (previously 40-70%)
Points 55

HYPOTHYROID

Index

Population Thyroid 1 – *The practice can produce a register of patients with hypothyroidism*
Points 1

Indicators

THYROID 2: *The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months.*
Range 50-90%
Points 6

LEARNING DISABILITIES

Index

Population – LD 1: *The practice can produce a register of patients aged 18 years and over with learning disabilities.*

Points 4

- this applies to patients age 18 years or over.

Indicators

LD 2: *The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)*

Range 45-70%

Points 3

- A previous diagnosis of hypothyroidism + on medication will exclude patient from indicator LD2 unless the hypothyroid diagnosis has been made within the last 15 months. Prescription of levothyroxine requires to be in the previous 6 months
- There are specific exclusion codes for patient not suitable and patient refused.

MENTAL HEALTH

Index

Population- MH8 *The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychosis.*
Points 4
Patients are included in this population if they have either :-

1. one of the defined codes for schizophrenia, bipolar affective disorder or other psychosis.

Or

2. they have received a prescription for Lithium in the last 6 months and have no subsequent 'Stopped Lithium' code.

Note - Patients who qualify only through group 2 above (on lithium) are not included in indicators MH11, MH12, MH13, MH14, MH15, MH16 or MH6.

- The concept that a patient may opt out of review (ie. Say they do not wish to be on the register) has been removed (since 2005-06). They may still be exception coded as for the other QOF disease areas.
- Codes are included to allow coding of Mental Health problems in remission. These will permanently remove the patient from the MH register unless a subsequent MH code is added to their record.

Indicators

- Schizophrenia, Bipolar disorder and other psychosis are now included as disease areas in the Smoking 3 and 4 Indicators. Mental Health exception codes will not count for this. There are separate Smoking exception codes.

MH11: *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months*
Range 50-90%
Points 4

- Patients can be coded as having refused Alcohol consumption screening using codes :-

  8IA7. Alcohol consumption screening test declined
  8IAt. Extended intervention for excessive alcohol consumption declined

  These codes require re-entry every 15 months

MH12: *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months.*
Range 50-90%
Points 4

- This uses the same Read codes for BMI as for the Diabetes indicator.

MH13: *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.*
Range 50-90%
Points 4

- Patient can be codes as refusing blood pressure monitoring using code:-

8I3Y. Blood pressure procedure refused

This code requires re-entry every 15 months

MH19. (renamed, previously MH14)*The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months*
Range 40-80%
Points 5
V22 - MH patients who have existing diagnoses for hypertension, familial hypercholesterolaemia, CKD (Stage 3-5), CVD, Stroke / TIA, PVD, or Diabetes are automatically excluded from this indicator

MH20: *The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months.*
Range 45-80%
Points 5

- Patients with Diabetes diagnosed more that 12 months ago will be excluded from this indicator unless they have a subsequent 'Diabetes resolved' code.
- V22 - HbA1c measurements are an acceptable alternative to Glucose measurements.
- V22 - Patients can be excluded from this indicator using 8IEG. (Blood glucose test declined).

MH16: *The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.*
Range 45-80%
Points 5

- Patients coded as having had a hysterectomy will be permanently excluded from this indicator.
- Patients can also be excluded from this indicator using codes

6853.	Ca cervix screen - not wanted
685L.	Cervical smear refused
8I6K.	Cervical smear not indicated
9O8Q.	Cerv.smear disclaimer received

These codes require re-entry every 5 years

- V23 added new codes for smear codeset, 4K2H. (Cervical smear epithelial cells absent), 4K2F. (Cervical smear pus cells present) and 4K2G. (Cervical smear red blood cells present)

MH17: *The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.*
Range 50-90%
Points 1

MH18: *The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.*
Range 50-90%
Points 2

MH10 – *The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and / or carers as appropriate.*
Range 30-55%
Points 6

- Only patients qualifying under 1 above are included for this indicator.
- The Mental Health care plan codes require to be entered any time after the earliest Mental Health diagnosis code.
- There is guidance information regarding what should be covered in a care plan see page 95 of QOF guidance documentation :- http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_2012-13.pdf

OBESITY

Index

Population - OB1: *The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months*
Points 8

- It is the latest code that counts for the population. The guidance is unclear how a patient may be removed from the population if they lose weight and are coded as BMI below 30
- Applies to patients age 16 years or over.
- Guidance states that this is a prospective register of patients that have had their BMI measured as part of routine care.

New to QOF 2012-13

OSTEOPOROSIS

Index

:Secondary prevention of fragility fractures (OST)

POPULATION - OST1. *The practice can produce a register of patients:*
1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and
2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012
Points 3

- Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has described this as a force equivalent to a fall from a standing height or less.
- The WHO defines osteoporosis as a bone mineral density of 2.5 or more standard deviations below that of a normal young adult (T-score of −2.5 or less) measured by a central dual-energy X-ray absorptiometry (DXA) scan.
- NICE recommends that a diagnosis of osteoporosis may be assumed in women and men aged 75 years and over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible[190]. SIGN recommends that in frail elderly women (aged 80 years and over) a DXA scan would be a prerequisite to establish that BMD is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.
- For section 1, patients age 50-74 require an osteoporosis code (recorded ever) AND a DXA scan code that indicate a positive result of osteoporosis or a T score of <-2.5 (recorded ever) AND a fragility fracture code recorded on or after 1.4.12, to be included in the register.
- For section 2 patients age 75 and over require only a fragility fracture code recorded on or after 1.4.12.
- There are specific exclusion codes for patient not suitable and patient refused.

Indicators

OST2: *The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent*
Range 30-60%
Points 3

- NICE stated Alendronate is the first line treatment for Osteoporosis and gives guidance regarding other treatments for osteoporosis, see:- http://publications.nice.org.uk/alendronate-etidronate-risedronate-raloxifene-strontium-ranelate-and-teriparatide-for-ta161
- Searches will accept, Etidronate, Alendronate, Risedronate, Raloxifene, Teriparatide, Strontium.
- Patients with a fragility fracture in the previous 3 months are excluded unless the meet the indicator
- Prescriptions required in the previous 6 months
- If contra-indicated, patients require an exception codes for each of the 4 classes of medications (Bisphosphonate, Raloxifene, Teriparatide, Strontium) to be fully excepted from this indicator. These are persistant (require entry only once ever if allergy) or expiring (require entry in last month for not tolerated, not indicated, declined or contraindicated).

OST3:*The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent*

Range 30-60%

Points 3

- NICE stated Alendronate is the first line treatment for Osteoporosis and gives guidance regarding other treatments for osteoporosis, see:- http://publications.nice.org.uk/alendronate-etidronate-risedronate-raloxifene-strontium-ranelate-and-teriparatide-for-ta161
- Searches will accept, Etidronate, Alendronate, Risedronate, Raloxifene, Teriparatide, Strontium.
- Patients with a fragility fracture in the previous 3 months are excluded unless the meet the indicator
- Prescriptions required in the previous 6 months
- If contra-indicated, patients require an exception codes for each of the 4 classes of medications (Bisphosphonate, Raloxifene, teriparatide, Strontium) to be fully excepted from this indicator. These are persistant (require entry only once ever if allergy) or expiring (require entry in last month for not tolerated, not indicated, declined or contraindicated).
- V23 added prescriptions for Calcitonin, Ibandronic acid and Denosumab.

PALLIATIVE CARE

Index

Population – PC 3: *The practice has a complete register available of all patients in need of palliative care/support irrespective of age.*
Points 3

- From 2008 this applies to all patients irrespective of age (previously was only those age 18 years or over).
- This indicator applies to patients with an appropriate Palliative Care code dated after 1.4.08 (previously was after 1.4.06).
- V23 added new codes for population codeset, 8CMQ. (On Liverpool care pathway for the dying) and 9NgD. (Under care of palliative care service)

Indicators

PC2 - *The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.*
Points 3

- There is no coding or search for this. Results will be based on 'web-based' reporting. The contract guidance states that ' The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.

New to QOF 2012-13

Peripheral Arterial Disease

Index

Population PAD1: *The practice can produce a register of patients with peripheral arterial disease*
Points 2

- QOF guidance refers to SIGN 89 for guidance on making the diagnosis - http://www.sign.ac.uk/guidelines/fulltext/89/index.html . NICE are producing a clinical guideline for lower limb PAD (publication expected Oct 2012)
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months.

Indicators

- Patients with PVD are included in the indicators Smoking 5 and 6. The PVD exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

PAD2: *The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken*
Range 40-90%
Points 2

- The time period for prescriptions is 'in the last 15 months'.
- Codes for OTC salicylated are included. These also require entry within the last 15 months.
- Salicylate, Clopidogrel or Warfarin prescriptions are acceptable.

PAD3: *The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less*
Range 40-90%
Points 2

- Exception codes exist for blood pressure procedure refused and on maximal tolerated hypertensive treatment.
- QOF guidance document refers to NICE guidance regarding hypertension, see:- http://guidance.nice.org.uk/CG127

PAD4: *The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less*
Range 40-90%
Points 3

- QOF guidance document refers to NICE guidance regarding lipid modification, see http://guidance.nice.org.uk/CG67
- Patients are excluded from this indicator if they were diagnosed or registered within the last 9 months, unless they meet the target.
- V23 has added code 44PK. (Serum fasting total cholesterol).

RECORDS

Index

There are now 2 topics for which computer searches are defined (smoking indicators removed and now part of formal smoking section in QOF). There are for Blood Pressure recording and Clinical Summaries. Ethnicity was removed in 2011-12.

Blood Pressure

Records 11: *The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients***.**
Points 10
Records 17: *The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients*.
Points 5

- The codes and searches are the same as for 2011 – 12

Summaries

Records 15: *The practice has up-to-date clinical summaries in at least 60% of patient records*
Points 25
Records 18: *The practice has up-to-date clinical summaries in at least 80% of patient records*
Points 8
Records 20: *The practice has up-to-date clinical summaries in at least 70% of patient records*
Points 12

- These are new searches introduced from 2006 – 07. Previously an audit of 50 patient notes was required as evidence.
- The introduction of these searches have been recognised as a problem in Scotland as summary codes have not routinely been used. A manual work around has been in place from NHS National Services Scotland, Practitioner Services Division (PSD) to account for this.

SEXUAL HEALTH

Index

Population (SH1) - *The Practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS*
Points 4

- This applies to Contraception after 1.4.09
- Data will be picked up from prescriptions and also Read codes where entered. Click on link for SCIMP Contract Read code guidance and time intervals:- http://www.scimp.scot.nhs.uk/coding_guidance.html.
- There are overall exception codes available for patient unsuitable and informed dissent.

SH 2. *The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months***.**
Range 50-90%
Points 3

- This applies to patients who have a prescription or Read code for oral or patch contraceptive in the last 15 months. If entering only read codes without electronic prescriptions, the Read codes will need re-entering each year.
- Guidance stresses that both verbal and written information is required. If code 679K2 or 8CAw. (Advice about long acting reversible contraception) are used then it is assumed both have been given. If codes 8CAw1 or 8CAw2 are used the BOTH need to be entered to meet this indicator.

SH3 – *The percentage of women prescribed emergency hormonal contraception at least once in the last year by the practice who have received information from the practice about long-acting reversible methods of contraception at the time of, or within one month of the prescription.*
Range 50-90%
Points 3

- If there have been 2 or more issues of Emergency hormonal contraception for a patient, it is the most recent one that will count for this indicator.
- If issued within the last month the patient will be excluded if LARC advice not given. This is to allow for insufficient time being allowed to do this.
- Guidance stresses that both verbal and written information is required. If code 679K2 or 8CAw. (Advice about long acting reversible contraception) are used then it is assumed both have been given. If codes 8CAw1 or 8CAw2 are used the BOTH need to be entered to meet this indicator.

SMOKING

Index

Population (SMOKING 5)- *The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma,schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months*
Range 50-90%
Points 25 (previously30)

- All patients who are in one or more of the Contract populations for Coronary Heart Disease, PAD, Stroke or TIA, Hypertension. Diabetes, COPD' Asthma, CKD or Schizophrenia, Bipolar disorder or other Psychosis. An age limit of 20 is put on the Asthma patients. Those aged under 20 are covered in indicator Asthmas3. PAD is newly added in V22
- Smoking status should be recorded after the first diagnosis date. If a patient has several of the population morbidities the smoking status should be recorded after the earliest recorded date of any of the morbidities. But also note changes below.
    1. If age over 25 never smoked recording is required only once after the age of 25 and after the earliest date of diagnosis of relevant disease areas.
    2. For ex-smokers this can either be recorded in the last 15 months or recorded for 3 years in succession. Subsequent smoking status recording will negate these 3 years of ex-smoker recording.
- There are some age limits for some of the disease areas. Asthma >=20 (age 14-19 covered by Asthma10), CKD >=18, diabetes >=17.

Indicators

Smoking 6 (replaces Smoking 4): *The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months.*
Range 50-90%
Points 25 (previously 30)

- The population is patients whose latest code is for a 'current smoker'. This can have been recorded at any time (ie. not limited to those entered in the last 15 months)
- V22 new wording for indicator to include PAD and also that an offer of support and treatment is required in the last 15 months.
- V22 required two separate codes, one each for support and for treatment. V23 of the search specifications has modified this to require one codes for either support OR treatment. (See Read code list on SCIMP website for details of appropriate codes)

Smoking 7 (previously Records23): *The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months*
Range 50-90%
Points 11

- Smoking status is required in last 27 months. There are 2 specific differences to this:-
    1. If age over 25 never smoked recording is required only once after the age of 25
    2. For ex-smokers this can either be recorded in the last 27 months or recorded for 3 years in succession. Subsequent smoking status recording will negate these 3 years of ex-smoker recording.

New Indicator

Smoking 8: *The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months*
Range 40-90%
Points 12

- V22 required two separate codes, one each for support and for treatment. V23 of the search specifications has modified this to require one codes for either support OR treatment. (See Read code list on SCIMP website for details of appropriate codes)

STROKE / TIA

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Population- Stroke1 *The practice can produce a register of patients with Stroke or TIA.*
Points 2

- V23 removed code ZV125 ([V]Personal history of circulatory system disease) and Gyu62 ([X]Other intracerebral haemorrhage) from Stroke codeset.
- V22 removed code F4236 (Amaurosis fugax) from TIA codseset
- V23 added code to TIA codeset, Fyu55 ([X]Other transient cerebral ischaemic attacks and related syndromes)

Indicators

- Patients with Stroke or TIA are included in the indicators Smoking 3 and 4. The Stroke exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

STROKE13 – *The percentage of new patients with a stroke or TIA who have been referred for further investigation.*
Range 45-80%
Points 2

- For patients who present with a new stroke or TIA code from 1.4.08.
- The code for scan or further referral should be dated within 3 months before to 1 month after the new stroke or TIA date (previously was 12 months after the diagnosis date) .

STROKE 6: *The percentage of patients with a history of TIA or stroke, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.*
Range 40-75%
Points 5
STROKE 7: *The percentage of patients with TIA or stroke, who have a record of total cholesterol in the preceding 15 months.*
Range 50-90%
Points 2
STROKE 8: *The percentage of patients with TIA or stroke, whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.*
Range 40-65%
Points 5

- V22 – Removed codes 44P1. – 44P4 (serum cholesterol normal, borderline, raised, very high) removed from the dataset.
  V23 has added code 44PK. (Serum fasting total cholesterol).

STROKE 12 – *The percentage of patients with a Stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken.*
Range 50-90%
Points 4

- To exception report a patient from this indicator they will require an exception code for each of the 4 types of medication (salicylate, clopidogrel, anticoagulant and dipyridamole) within the required time scales.

STROKE 10: *The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March.*
Range 45-85%
Points 2

- New Read codes created for 2012-13 season both for vaccinations given and for exception coding. Care needed as codes used in previous years are not in theV22 specification.

  For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted, the only acceptable codes are:-

  65ED. Seasonal influenza vaccination
  65E20 Seasonal influenza vaccination given by other healthcare provider

  For exception codes, the persisting allergy codes, 14LJ., U60K4, ZV14F remain the same. For expiring exceptions the previous codes 8I2F., 8I6D., 9OX5. are no longer accepted. Codes that should now be used are:-

  68NE. No consent - influenza imm. (previously in specification)
  8I2F0 Seasonal influenza vaccination contraindicated (new)
  8I6D0 Seasonal influenza vaccination not indicated (new)
  9OX51 Seasonal influenza vaccination declined (new)

  Some of the ‘old’ codes will be detected for the ‘at risk’ flu surveillance searches as the codeset definitions for the QOF and PRIMIS at risk differ.