



GUIDE TO CODING AND DISEASE REGISTERS FOR THE CONTRACT (Scottish) Version 1.0

July 2013

The following guidance discusses the effect of changes to the Quality and Outcomes Framework (QOF) for 2013-14 on disease populations and indicators, with practical advice for practices in relation to IT issues. This is an independently created discussion paper by SCIMP and as such does not have official ratification from the Scottish Government or SGPC. You are advised to refer to the officially released documentation for formal advice (links provided below). This document provides the best advice we are able to give at present, based on currently released documentation for the GMS Contract 2013-14, and will be updated should further information become available. Where there are on-going issues in relation to the indicators, these are highlighted.

The information in this document is based on the most recent specifications for 2013-14 (V26 of the ruleset specifications including Scottish alterations) published July 2013. The SCIMP website also lists the complete Contract v26 Read codes.

For the full Scottish official guidance for the QOF 2013-14 including information about criteria for exception coding see NHS Circular: PCA(M)(2013)03:
[http://www.sehd.scot.nhs.uk/pca/PCA2013\(M\)03guide.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2013(M)03guide.pdf)

Further Scottish guidance [NHS Circular: PCA(M)(2013) 06] has been issued (3rd July 2013) to clarify certain issues:
[http://www.sehd.scot.nhs.uk/pca/PCA2013\(M\)06.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2013(M)06.pdf)

***Note:** item 4 of the above document; there are errors in the exception codes recommended (9OH9, and 81AK.) which have been raised by SCIMP with the authors. These should **not** be used for the Rheumatoid Arthritis exception codes. Best advice is to use codes as defined in the SCIMP listing – see link above.*

Details of the QOF business rules are published at:

<http://www.psd.scot.nhs.uk/professionals/medical/qof-business-rules.html>

These currently have V25 of the specifications. For details of the latest (V26) published Department of Health technical dataset and business rules documents see:
<http://www.pcc-cic.org.uk/article/qof-business-rules-v26>

There are relatively minor differences between V25 and V26 (mainly code additions). These define in detail which Read codes are valid, the relevant timescales and the searches used by QOF Calculator.

NOTE – Indicators have all been renumbered. In the Scottish guidance some indicators have an ‘(S)’ added. This indicates differences from the English defined indicator, usually in terms of the achievement levels, but there are some more significant differences indicated in red in this document. These differences are not currently reflected in the technical datasets. Arrangements are being made to enable these differences to be reflected within the software system audits and data extractions.

A major difference across QOF is the change from 15 months to 12 months as the time within which specific reviews are required. Practices may need to consider how they run their recall systems to manage this.

INDEX**PAGE**

<u>ASTHMA</u>	4
<u>ATRIAL FIBRILLATION</u>	6
<u>CANCER</u>	8
<u>CONTRACEPTION</u>	9
<u>CORONARY HEART DISEASE</u>	10
<u>CHRONIC KIDNEY DISEASE</u>	12
<u>COPD</u>	14
<u>CVD – PRIMARY PREVENTION</u>	16
<u>DEMENTIA</u>	18
<u>DEPRESSION</u>	19
<u>DIABETES</u>	21
<u>EPILEPSY</u>	25
<u>HEART FAILURE</u>	26
<u>HYPERTENSION</u>	27
<u>HYPOTHYROID</u>	28
<u>LEARNING DISABILITIES</u>	29
<u>MENTAL HEALTH</u>	30
<u>OBESITY</u>	33
<u>OSTEOPOROSIS</u>	34
<u>PALLIATIVE CARE</u>	36
<u>PERIPHERAL VASCULAR DISEASE</u>	37
<u>PUBLIC HEALTH (Blood Pressure)</u>	38
<u>RHEUMATOID ARTHRITIS</u>	39
<u>SMOKING</u>	41
<u>STROKE / TIA</u>	43
<u>QUALITY & PRODUCTIVITY</u>	45

ASTHMA

[Index](#)

Population AST001. *The contractor establishes and maintains 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.
- 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

- Patients with Asthma age 20 and over are included in the indicators SMOK002 and SMOK005(S). The Asthma exception codes do not apply and there are separate 'Smoking' exception codes that can be used for this group.

AST002. *The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis.*

Range 45-80%

Points 15

- This indicator now specifies that the diagnosis tests should include measures of variability or reversibility.
- Spirometry also applies to patients with COPD but there is a much smaller group of acceptable spirometry codes in COPD compared with Asthma. Care will be needed in patients who have both conditions.

AST003. *The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 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 your usual activities (for example, housework, work/school etc.)?
- There are separate codes for each of these questions. To meet the indicator requires a code for an asthma review AND a code for each of the questions, all entered with the same date.
- Note now required within last 12 months (previously 15 months)

AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months.

Range 45-80%

Points 6

- Patients with Asthma are included in the indicators SMOK002 and SMOK005. The Asthma exception codes do not apply for the SMOK002 and SMOK005 indicators. There are separate 'Smoking' exception codes that can be used.
- Note now required within last 12 months (previously 15 months)

ATRIAL FIBRILLATION

[Index](#)

Population AF001. *The contractor establishes and maintains 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

AF002. *The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1).*

Range 40-90%

Points 10

The revised CHADS2 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)
 - S2 - previous stroke or TIA (2 points).
- Patients are excluded from this indicator if they have had a CHAD2 score of >1 in the past (i.e., more than 12 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 in the last 3 months, have registered with the practice in the previous 3 months, or have a valid exception code in the last 12 months.
 - Note now requires coding within last 12 months (previously 15 months)

AF003(S). *In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 12 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 12 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.
- Acceptable anti-platelets are Aspirin, Dipyridamole and Clopidogrel

- Anticoagulants include prescriptions for warfarin, phenindione, dabigatran, rivaroxaban and apixaban. 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 circumstances 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.
- To exception code from this indicator an exception code for each of the 4 different drugs (Aspirin, Clopidogrel, Dipyridamole and Warfarin / anticoagulant) needs to be entered within the appropriate time scale (some codes are permanent and some expire after 12 months).

AF004. 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 12 months' as for AF6).
- Anticoagulants picked up by the search specifications include prescriptions for warfarin, phenindione, dabigatran and rivaroxaban. The search specifications will pick up patients prescribed any of these medications in the previous 6 months.

CANCER

[Index](#)

Population CAN001. *The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'.*

Points 5

Indicators

CAN002. *The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis.*

Range 50-90%

Points 6

- The review code requires entry within the previous 12 months and also within 3 months of the first occurrence of the Cancer code (previously was 6 months). It is possible that some patients diagnosed 12-15 months ago may have a review code more than 12 months ago. These reviews will not count for the year 2012-13 but will have been included in 2013-14
- A new diagnosis in the last 3 months will be excluded if no review has been done. This allows the full 3 months in which to do a review. These patients will count for the following year so a review is still required within the 3 month period.

Contraception

Index

Population CON001. The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically 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. See on link (page 2) for SCIMP Contract Read code guidance and time intervals.
- There are overall exception codes available for patient unsuitable and informed dissent.

CON002. The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long-acting reversible methods of contraception in the preceding 12 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 12 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.

CON003. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long-acting reversible methods of contraception at the time of or within 1 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.
- Searches will look for patient prescribed EHC in last 13 months so that, if patient excluded in previous year they will be included in the subsequent 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.

CORONARY HEART DISEASE

[Index](#)

Population CHD001. *The contractor establishes and maintains a register of patients with coronary heart disease.*

Points 4

Indicators

- Patients with CHD are included in the indicators SMOK002 and SMOK005(S). The CHD exception codes do not apply and there are separate 'Smoking' 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

CHD002(S). *The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.*

Range 50-85%

Points 17

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

CHD003(S). *The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less.*

Range 50-80%

Points 17

CHD004(S). *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

- Care needed with coding of vaccinations given and for exception codes as there are historic codes that are no longer acceptable for QOF. For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted. In V26 the only acceptable codes are:-
 - 65ED. Seasonal influenza vaccination
 - 65E20 Seasonal influenza vaccination given by other healthcare provider
 - 65ED0 Seasonal influenza vaccination given by pharmacist

- 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.
 - 8I2F0 Seasonal influenza vaccination contraindicated
 - 8I6D0 Seasonal influenza vaccination not indicated
 - 9OX51 Seasonal influenza vaccination declined

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.

CHD005(S). *The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.*

Range 50-90%

Points 7.

CHD006(S). *The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I 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 of medication in the last 6 months (or OTC code for aspirin in last 12 months), or have a combination of these plus exception codes for any they are not taking.
- 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

CHRONIC KIDNEY DISEASE

[Index](#)

Population CKD001. *The contractor establishes and maintains a register of patients aged 18 or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).*

Points 6

- **NOTE** the Contract guidance states that ‘This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m² confirmed with at least two separate readings over a three 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.

For Read codes see the link (page 2) for SCIMP list of V26 Contract Read 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.
- If lab reports eGFR results as >60 then it is suggested the patient is coded as CKD2 if wishing to remove patient from CKD population.

Indicators

- Patients with CKD are included in the indicators SMOK002 and SMOK005(S). The CKD exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

CKD002(S). *The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less.*

Range 45-70%

Points 11

- Exception codes exist for blood pressure procedure refused and on maximal tolerated hypertensive treatment (applies to Indicator CKD3).

CKD003. *The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or 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.
- 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 12 months).

CKD004. *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 preceding 12 months.*

Range 45-80%

Points 6

- Acceptable codes are:
44ID. Urine protein/creatinine ratio
46TC. Urine albumin: creatinine ratio
46TD. Urine microalbumin: creatinine ratio
- It is possible to exception code from this indicator using:-

9RX.. Declines to give urine specimen

This requires re-entry every 12 months

Population– COPD001. The contractor establishes and maintains a register of patients with COPD.*Points 3*

The NICE clinical guideline on COPD provides the following definition of COPD:

- airflow obstruction is defined as a reduced FEV1/FVC ratio (where FEV1 is forced expired volume in one second and FVC is forced vital capacity), such that FEV1/FVC is < 0.7l;
- if FEV1 is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

See <http://guidance.nice.org.uk/CG101> for further details plus summary given in the Scottish QOF guidance document.

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

Indicators

- Patients with COPD are included in the indicators SMOK002 and SMOK005(S). The COPD exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.

COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.*Range 45-80%**Points 5*

- NICE clinical guideline 101 recommends changes to the diagnostic thresholds for COPD. See page 97 of Scottish QOF guidance document (link at beginning of document) or NICE website for full guidance :- <http://guidance.nice.org.uk/CG101>
- 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 12 months.
- See the link (page 2) for SCIMP Contract Read 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.

COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months.*Range 50-90%**Points 9*

- Patients require both a COPD review code AND an MRC dyspnoea score code entered in the last 12 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.

COPD004(S). The percentage of patients with COPD with a record of FEV1 in the preceding 12 months.

Range 50-85%

Points 7

COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months.

Range 50-90%

Points 6

- There are no specific exception codes for oxygen saturation testing.
- There are currently three codes that meets this indicator:-
 - 44YA0 Oxygen saturation at periphery
 - 44YA1 Peripheral blood oxygen saturation on room air at rest
 - 44YA3 Peripheral blood oxygen sat. on supplemental oxygen at rest

The Vision software system plans to make adjustments so that values can be added to these codes (not currently available).

Note that codes 8A44. (Pulse oximetry) and 44Y9. (Blood oxygen saturation (calculated)) do not count for this indicator.

COPD006(S). The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March.

Range 50-90%

Points 6

- Care needed with coding of vaccinations given and for exception codes as there are historic codes that are no longer acceptable for QOF.
For vaccinations given, the previous codes, 65E...-65E4. and ZV048 are no longer accepted. In V26 the only acceptable codes are:-
 - 65ED. Seasonal influenza vaccination
 - 65E20 Seasonal influenza vaccination given by other healthcare provider
 - 65ED0 Seasonal influenza vaccination given by pharmacist
- 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.
 - 8I2F0 Seasonal influenza vaccination contraindicated
 - 8I6D0 Seasonal influenza vaccination not indicated
 - 9OX51 Seasonal influenza vaccination declined

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](#)

CVD-PP001. *In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins.*

Range 40-90%

Points 10

- Patients with codes for IHD, Diabetes, Stroke, TIA, CKD, PVD or Familial hypercholesterolaemia are excluded from this population requiring CHD Risk assessment. See link (page 2) 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.
- Within the V26 specifications ASSIGN is not currently included as an acceptable assessment tool. However, as this is the recommended tool for use in Scotland, arrangements are being made to include this within the software systems and for payment data extractions. The code for ASSIGN is :-

38D6. Assessing cardiovascular risk using SIGN score

- See <http://assign-score.com/> for details of ASSIGN risk assessment.
- Patients newly diagnosed with hypertension age under 30 or more than 75 do not require CVD Risk assessment but do still require lifestyle advice and Scot-PASC if appropriate as per CVD-PP002(S) and CVD-PP003(S) (no age limit applied to these indicators).
- There are overall exception codes available for patient unsuitable and informed dissent. For Indicator CVD-PP002 these will require re-entry every 12 months.
- There are codes that exception code patients specifically from requiring risk assessment. New codes have been requested to exception code from ASSIGN risk assessment. The earliest these could be available is November 2013. In the meantime it is acceptable to use the codes currently specified in V26.
 - 8IAK. (Cardiovascular disease high risk review declined)
 - 9Oh9. (Cardiovascular disease risk assessment declined)
 - 8IEL. QRISK cardiovascular disease risk assessment declined.
 - 8IEV. QRISK2 cardiovascular disease risk assessment declined
 - 9NSB. Unsuitable for QRISK2 cardiovascular disease risk assessment

CVD-PP002(S). The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Range 40-75%

Points 5

There are two Read codes that counts for this indicator:-

- 67H.. Lifestyle counselling
- 67H8. Lifestyle advice regarding hypertension

However the BMA QOF Guidance states:-

‘Verification – the NHS Board may request that the contractor randomly selects a number of patient records of patients in which this advice has been recorded as taking place to confirm that the three 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

CVD-PP003(S). The patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who require lifestyle advice on increasing physical activity, as identified in CVD-PP002, in the preceding 12 months, are given that advice utilising the Scottish Physical Activity Screening Questions (Scot-PASQ).

Points 5

- There is no data extraction for this, achievement is based on a web based, yes / no entry by practice.
- A new Read codes has been requested for Scot-PASQ. The earliest this could be available is November 2013. An alternative recommended code to use is

68L.. Exercise status screening

- Practices will need to be able to demonstrate achievement for this indicator in the event of payment verification. A standard of 90% has been set to indicate achievement for this indicator.
- Scot-PASC can be accessed from the following link:-
<http://www.healthscotland.com/documents/6255.aspx>

DEMENTIA

[Index](#)

Population DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia.

Points 5

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

Indicators

DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months.

Range 35-70%

Points 15

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

DEM003. The percentage of patients with a new diagnosis of dementia recorded in 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 between 6 months before or after entering on to the register.

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
- 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 year's figures. This ensures all patients will be included, but only once, in the yearly figures.

DEPRESSION

[Index](#)

Screening of patients with CHD or Diabetes for depression has been removed from QOF in 2013-14.

- Note clarification is being sought regarding the population for depression on which prevalence data will be based. There is no point allocation for maintaining a register of patients with unresolved depression.

Indicators

DEP001. *The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a biopsychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.*

Range 50-90%

Points 21

- 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.
- 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.
- Guidance states that whilst the assessment can be carried out over more than one consultation as clinically appropriate the assessment code requires to be entered on the same date as the diagnosis date.
- See link to QOF guidance for more details of details that should be included in the assessment. Formal assessment questionnaires such as PHQ9, HADS and BDI-II may form part of this assessment. However there is only one code that will show achievement for this indicator:-

38G5. Biopsychosocial assessment

- Guidance states that if a diagnosis is made in secondary care and it is unknown if a BPA assessment has been made, then the patient should be exception coded.
- QOF guidance states that '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.

DEP002. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 and not later than 35 days after the date of diagnosis.

Range 45-80%

Points 10

- See QOF guidance link for information of areas to cover in a review.
Guidance states that a telephone consultation for review would be acceptable in specified circumstances. It is advisable to keep a record of these encounters as the QOG Guidance document state 'Verification - the NHS Board may wish to ask contractors about the percentage of telephone reviews conducted and who they were delivered by'.
- There are two possible codes to use for this review:-
 - 9H91. Depression medication review
 - 9H92. Depression interim review
- Care is needed to ensure that a capital 'H' is used in this code. The similar codes with a lower case 'h' are exception codes for mental health.

DIABETES

[Index](#)

Population DM001. *The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.*

Points 6

- 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 SMOK002 and SMOK005(S). The Diabetes exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

DM002(S). *The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.*

Range 45-71%

Points 8

DM003(S). *The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.*

Range 40-65%

Points 10

DM004. *The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.*

Range 40-75%

Points 6

DM005. *The percentage of patients with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months.*

Range 50-90%

Points 3

- V26 (for 2013-14) has reduced the range of codes that can be used to meet this criteria. There are now only two codes:-
 - 46TC. Urine albumin: creatinine ratio
 - 46TD. Urine microalbumin: creatinine ratio
- It is possible to exception code from this indicator using:-
 - 9RX.. Declines to give urine specimen
 This requires re-entry every 12 months

DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).

Range 50-90%

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).

DM007(S). The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c is 59 mmol/mol or less in the preceding 12 months.

Range 40-50%

Points 17

DM008(S). The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c is 64 mmol/mol or less in the preceding 12 months.

Range 45-70%

Points 8

DM009(S). The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c is 75 mmol/mol or less in the preceding 12 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 from the HbA1c indicators, for patients on maximum tolerated diabetes treatment.

DM010(S). The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March.

Range 50-90%

Points 3

- Care needed with coding of vaccinations given and for exception codes as there are historic codes that are no longer acceptable for QOF.
For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted. In V26 the only acceptable codes are:-
 - 65ED. Seasonal influenza vaccination
 - 65E20 Seasonal influenza vaccination given by other healthcare provider
 - 65ED0 Seasonal influenza vaccination given by pharmacist
- 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.
 - 8I2F0 Seasonal influenza vaccination contraindicated
 - 8I6D0 Seasonal influenza vaccination not indicated
 - 9OX51 Seasonal influenza vaccination declined

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.

- As the population for diabetes does not include children, the new codes for intra-nasal flu immunisation are not included in the QOF searches.

DM011. The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 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.

DM012. The percentage of patients with diabetes, on the register, 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 12 months.

Range 50-90%

Points 4

- 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

DM013. The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months.

Range 40-90%

Points 3

- Guidance states "If there is no one in the practice competent to provide this level of dietetic advice to patients then the contractor should refer the patients to a local dietetic service for that advice. If a local service does not exist then the practice can exception report the patients."
- Code to specifically exception report from this indicator is

8IAs. Diabetic dietary review declined

This requires entry every 12 months

DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.

Range 40-90%

Points 11

- Patients are excluded if they have been diagnosed within the last 9 months AND not been referred to a structured education programme. This is to allow the required time for this referral to be done. Note that, if excluded in this QOF year, these patients will be included in the next year. Although the indicator states 'in the preceding 1 April to 31 March' the ruleset searches for diagnosed within the last 21 months but then excludes those diagnosed 12-21 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.
- As this is a new indicator no patients diagnosed before this date are included.
- To exception code there is currently a code for declined:-
9OLM. Diabetes structured education programme declined

It is recognised that the availability of diabetes structured education programmes may be variable across Scotland. There is no code available at present to exception code if this is not available. A code has been requested for 'Diabetes structured educational programme unavailable'. If accepted this should be available towards the end of 2013 and arrangements will be investigated to incorporate this into the reporting for practices. Further information will be made available in relation to this. If in an area affected by lack of availability, this is likely to affect all patients in a practice, it is suggested that practices await this new specific exception code and do block read code entry once available. However in this situation, use of a block exception code for service unavailable will result in a '0' population for this indicator. There would therefore need to be end of year manual adjustments of figures. Discussion with SGPC and SGHD is on-going in relation to this.

DM015. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months.

Range 40-90%

Points 4

- Patients require one of the following two codes, entered in the previous 12 months, to meet this indicator:-
1D1B. C/O erectile dysfunction
1ABJ. Does not complain of erectile dysfunction
Those codes with 1D1B. will be included in the denominator for DM016.

DM016. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months.

Range 40-90%

Points 6

- Along with the usual exceptions for newly registered or newly diagnosed, patients are also excepted if their first ever erectile dysfunction code (1D1B.) has been entered in the previous 3 months

EPILEPSY

[Index](#)

Population – EP001. *The contractor establishes and maintains a register of patients aged 18 or 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 12 months.

Indicators

EP002. *The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months.*

Range 45-70%

Points 6

- Patients can be specifically excluded from this indicator if they are considered to be on maximum anticonvulsant therapy.

EP003. *The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months.*

Range 50-90%

Points 3

- Patients require a separate code for each of the 3 types of counselling, entered within the last 12 months, to meet this 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 HF001. *The contractor establishes and maintains 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 12 months. It is important to ensure that it is the Heart Failure exception codes (all codes with first three characters = 9hH..) that are used rather than the LVD exception codes. The latter were removed from the specifications in Version 10.
- In V26 (2013-14) there has been a widening of the diagnostic codes both for HF and LVSD. This includes the re-introduction of the New York Heart Association Classification codes that had previously been removed.

Indicators

HF002. *The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register.*

Range 50-90%

Points 6

- There are specific codes to exclude patients from this indicator (Echo declined or Angiocardiology declined)

HF003(S). *In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.*

Range 50-80%

Points 10

- The population for this indicator is a subgroup of the Heart Failure population. They require a specific code for Left Ventricular dysfunction.
- 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.

HF004(S). *In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.*

Range 50-75%

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](#)

Note – In England there are additional indicators requiring tighter BP targets and also for exercise assessment and advice. These will not be measured in Scotland. However there are similar indicators specific to Scotland in CVD-Primary Prevention with the requirement to assess exercise levels using Scot-PASQ and giving advice for patients diagnosed with hypertension since 1.4.2009.

Population HYP001. *The contractor establishes and maintains 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 12 months.

Indicators

- Patients with Hypertension are included in the indicators SMOK002 and SMOK005(S). The Hypertension exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

HYP002(S). *The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.*

Range 45-80%

Points 55

HYPOTHYROID

[Index](#)

Population THY001. *The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine.*
Points 1

Indicators

THY002. *The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months.*

Range

50-90%

Points 6

LEARNING DISABILITIES

[Index](#)

Population – LD001. *The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities.*

Points 4

Indicators

LD002. *The percentage of patients on the learning disability register with Down's Syndrome aged 18 or over who have a record of blood TSH in the preceding 12 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 12 months. Prescription of levothyroxine requires to be in the previous 6 months
- There are specific exclusion codes for patient not suitable and patient refused.

Population- MH001. *The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.*

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.

Notes

- Indicators MH002 – MH008(S) relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders. Indicators MH009 and MH010 relate to the care of patients who are currently prescribed lithium.
- The concept that a patient may opt out of review (i.e. 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 indicators MH002 – MH008(S) inclusive unless a subsequent MH code is added to their record. Guidance states that remission could be considered if there is no record in the previous 5 years of antipsychotic medication, in-patient episodes or secondary / community mental health follow-up. This should be reviewed yearly

Indicators

- Patients with schizophrenia, bipolar or other affective disorders are included in the indicators SMOK002 and SMOK005(S). The MH exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

MH002. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.*

Range 40-90%

Points 6

- Only patients qualifying under 1 above are included for this indicator.
- The Mental Health care plan code used to be required to be entered any time after the earliest Mental Health diagnosis code (up to 2012), but now is required entry within the previous 12 months.
- There is guidance information regarding what should be covered in a care plan see page 117 of Scottish QOF guidance documentation:-
[http://www.sehd.scot.nhs.uk/pca/PCA2013\(M\)03guide.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2013(M)03guide.pdf)

MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months.

Range 50-90%

Points 4

- Patient can be coded as refusing blood pressure monitoring using code:-
8I3Y. Blood pressure procedure refused
This code requires re-entry every 12 months

MH004. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months.

Range 45-80%

Points 5

- MH patients who have existing diagnoses for hypertension, CHD, familial hypercholesterolaemia, CKD (Stage 3-5), CVD, Stroke / TIA, PVD, or Diabetes are automatically excluded from this indicator

MH005. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months.

Range 45-80%

Points 5

- Patients with Diabetes diagnosed more than 12 months ago will be excluded from this indicator unless they have a subsequent 'Diabetes resolved' code.
- Patients can be excluded from this indicator using code:-
8IEG. Blood glucose test declined.
This requires entry within the previous 12 months.

MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months.

Range 50-90%

Points 4

MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.

Range 50-90%

Points 4

- Patients can be coded as having refused Alcohol consumption screening using codes :-
8IA7. Alcohol consumption screening test declined
8IAAt. Extended intervention for excessive alcohol consumption declined
These codes require entry within the previous 12 months.

MH008(S). *The percentage of women aged 20 or over and who have not attained the age of 60 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 entry within the previous 5 years.

MH009. *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

MH010. *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

OBESITY

[Index](#)

Population - OB001. *The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥ 30 in the preceding 12 months.*

Points 8

- It is the latest recorded 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
- Guidance states that this is a prospective register of patients that have had their BMI measured as part of routine care.

OSTEOPOROSIS

[Index](#)

:Secondary prevention of fragility fractures (OST)

Population - OST001. *The contractor establishes and maintains a register of patients:*

1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and

2. Aged 75 or over with a record of a fragility fracture on or 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 unfeasible¹⁹⁰. 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.
- If, a patient aged 80 or over is considered to have had a fragility fracture but has a DXA scan that shows the patient not to have osteoporosis then the patient can be exception reported.

Indicators

OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, 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, Disodium Etidronate, Alendronic acid, Risedronate, Zoledronic acid, Ibandronic acid, Raloxifene, Teriparatide, Strontium, Denosumab prescriptions , plus read codes for:-

8BP1. Teriparatide therapy

8B6c. Intravenous bisphosphonate prophylaxis

8B6b. Osteoporosis medication prophylaxis

- 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 can be exception codes either using a 'persistent' code (allergy) which requires entry once only, or using an 'expiring code' (refused, not indicated, not tolerated, contraindicated) which require entry every 12 months

OST003. *The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, 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, Disodium Etidronate, Alendronic acid, Risedronate, Zoledronic acid, Ibandronic acid, Raloxifene, Teriparatide, Strontium, Denosumab prescriptions , plus read codes for:-

8BP1. Teriparatide therapy

8B6c. Intravenous bisphosphonate prophylaxis

8B6b. Osteoporosis medication prophylaxis

- 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 can be exception codes either using a 'persistant' code (allergy) which requires entry once only, or using an 'expiring code' (refused, not indicated, not tolerated, contraindicated) which require entry every 12 months

PALLIATIVE CARE

[Index](#)

Population – PC001. *The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.*

Points 3

- This indicator applies to patients with an appropriate Palliative Care code dated after 1.4.08.
- In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register in the financial year then they will be eligible for payment.

Indicators

PC002. *The contractor 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.’

Peripheral Arterial Disease

[Index](#)

Population PAD001. *The contractor establishes and maintains 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 12 months.

Indicators

- Patients with PAD are included in the indicators SMOK002 and SMOK005(S). The PAD exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

PAD002. *The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.*

Range 40-90%

Points 2

- Exception codes exist for blood pressure procedure refused and on maximal tolerated hypertensive treatment. These require entry every year.
- QOF guidance document refers to NICE guidance regarding hypertension, see:- <http://guidance.nice.org.uk/CG147/Guidance>

PAD003. *The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less.*

Range 40-90%

Points 3

- QOF guidance document refers to NICE guidance regarding lipid modification, see <http://www.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.

PAD004. *The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.*

Range 40-90%

Points 2

- Patients on Warfarin are excluded from this denominator.
- Salicylate or Clopidogrel prescriptions and Read codes for OTC Salicylates are acceptable to meet this indicator.
- The time period for prescriptions or codes to meet this indicator is 'in the last 12 months'.

PUBLIC HEALTH

[Index](#)

One indicator to replace the previous two indicators in the Organisational Domain (Records11 and 17) for blood pressure measurements.

Blood Pressure

BP001. *The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years.*

Range 40-80%

Points 15

- There is no upper age limit for this indicator
- No exception coding is currently available (other than patients newly registered with the practice in the last 3 months). **There is on-going discussion with SGPC and SGHD in relation to this and there may be future change to enable exception coding.**

Rheumatoid Arthritis

[Index](#)

Population RA001. *The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis.*

Points 1

Indicators

RA002. *The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months.*

Range 40-90%

Points 5

The Scottish QOF guidance document details recommendations for a review:-

“It is recommended that contractors review the following aspects of care with a patient:

- disease activity and damage, which may include requesting C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) or plasma viscosity test;
- a discussion of DMARDS, if relevant;
- the need for referral for surgery;
- the effect the disease is having on their life, for example employment or education;
- the need to organise appropriate cross-referral within the multi-disciplinary team.

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease upon the patient's life and whether they would benefit from any referrals to the multi-disciplinary team.”

RA003. *The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months.*

Range 40-90%

Points 7

- Current business rules, written for the English version of QOF, do not include codes for ASSIGN as a tool for assessing CVD risk. However ASSIGN is the recommended tool for use in Scotland as it uses data that is specific to the Scottish population (Scottish Index of Multiple Deprivation). Both ASSIGN and QRISK2 tool will be accepted in the business rules, however QRISK2, where the data is specific to England, may falsely estimate the risk for patients.

NOTE that CVD-PP001 allows a wider range of tools that are acceptable for risk estimation compared to RA003.

Currently ASSIGN does not have the facility to factor an additional risk due to RA. As a consequence ASSIGN2 is being developed to reflect these changes

but in the meantime SGHD have consulted on this and advise that the risk conferred by RA has an equivalence to that of diabetes mellitus (which is a risk factor in the currently available ASSIGN tool). ASSIGN may be used with an affirmative entry to personal history of diabetes used as a proxy during the calculation process.

ASSIGN is embedded into some GP IT systems. Care should be taken in using the currently available, embedded calculators both in whether they give an accurate estimation of risk, and as an affirmative declaration of diabetes may result in a Read code entry to the record. ASSIGN is available as a web-based tool, see <http://www.assign-score.com/>. This is the recommended route for using ASSIGN to calculating the risk score for RA patients until the necessary changes are made by GP IT suppliers. The result should be entered manually to the patients' record using code 38D6. (Assessing cardiovascular risk using SIGN score).

- Exception codes are available specifically for this indicator and require entry in the previous 12 months. New codes have been requested to exception code from ASSIGN risk assessment. The earliest these could be available is November 2013. In the meantime it is acceptable to use the codes currently specified in V26.

9NSB. Unsuitable for QRISK2 cardiovascular disease risk assessment
8IEV. QRISK2 cardiovascular disease risk assessment declined

NOTE that these exception codes are a subset of the possible exception codes for CVD-PP001, not all of the CVD-PP001 exception codes are recognised for this indicator.

- Patients are excluded from this indicator if they have pre-existing IHD, Stroke, TIA or familial hypercholesterolaemia.

RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months.

Range 40-90%

Points 5

- Guidance documents recommends two tools that may be used to determine fracture risk. Both are available free of charge. See:-
FRAX. - <http://www.shef.ac.uk/FRAX/>
Qfracture. - <http://www.qfracture.org/>
- Exception codes are available specifically for this indicator
9OdB. Osteoporosis risk assessment refused
9OdC. Osteoporosis risk assessment defaulted
- Patients are excluded from this indicator if they have a pre-existing diagnosis of osteoporosis more than 24 months ago, a scan result indicating osteoporosis more than 24 months ago or received a prescription for a bone sparing agent in the 6 months before the previous 24 months.

SMOKING

[Index](#)

Population SMOK001. *The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months.*

Range 50-90%

Points 11

- Smoking status is required in last 24 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 24 months or recorded for 3 years in succession. Subsequent smoking status recording will negate these 3 years of ex-smoker recording.

SMOK002. *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 12 months.*

Range 50-90%

Points 25

- 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.
- There are some age limits for some of the disease areas. Asthma ≥ 20 (age 14-19 covered by AST004), CKD ≥ 18 , diabetes ≥ 17 .
- 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.

Indicators

SMOK003. *The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.*

Points 2

- There is no data extraction for this indicator. For verification the guidance states that “the NHS Board may choose to review prescribing data and may also examine the literature available for patients who wish to quit smoking. Signs of implementation may be evident in the contractor's prescribing data or in the patient leaflets that are used by the contractor.”

SMOK004. *The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support ~~and~~ OR treatment within the preceding 24 months.*

Range 40-90%

Points 12

- The population is patients whose latest code is for a 'current smoker'. This can have been recorded at any time (i.e. not limited to those entered in the last 12 months)
- In 2012 the specifications were modified. Originally this indicator required two separate codes, one each for support and for treatment. The modification meant that only one code was required for either support OR treatment. (See Read code list on SCIMP website for details of appropriate codes). On review in July 2013, the wording for the indicator in Scotland has been adjusted accordingly.

SMOK005(S). *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 are recorded as current smokers who have a record of an offer of support ~~and~~ OR treatment within the preceding 12 months.*

Range 50-90%

Points 25

- The population is patients with listed conditions whose latest code is for a 'current smoker'. This can have been recorded at any time (i.e. not limited to those entered in the last 12 months)
- In 2012 the specifications were modified. Originally this indicator required two separate codes, one each for support and for treatment. The modification meant that only one code was required for either support OR treatment. (See Read code list on SCIMP website for details of appropriate codes). On review in July 2013, the wording for the indicator in Scotland has been adjusted accordingly.

STROKE / TIA

[Index](#)

Population- STIA001. *The contractor establishes and maintains a register of patients with stroke or TIA.*

Points 2

Indicators

- Patients with Stroke or TIA are included in the indicators SMOK002 and SMOK005(S). The Stroke exception codes do not apply and there are separate 'Smoking' exception codes that can be used.

STIA002(S). *The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or TIA.*

Range 50-90%

Points 2

STIA003(S). *The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.*

Range 50-85%

Points 5

STIA004. *The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months.*

Range 50-90%

Points 2

STIA005. *The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5mmol/l or less.*

Range 40-65%

Points 5

- This now only applies to the subgroup of non-haemorrhagic stroke and TIA. In previous years has included all Strokes.

STIA006(S). *The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March.*

Range 50-90%

Points 2

- Care needed with coding of vaccinations given and for exception codes as there are historic codes that are no longer acceptable for QOF.
For vaccinations given, the previous codes, 65E..-65E4. and ZV048 are no longer accepted. In V25 the only acceptable codes are:-
65ED. Seasonal influenza vaccination
65E20 Seasonal influenza vaccination given by other healthcare provider

65ED0 Seasonal influenza vaccination given by pharmacist

- 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.
 - 8I2F0 Seasonal influenza vaccination contraindicated
 - 8I6D0 Seasonal influenza vaccination not indicated
 - 9OX51 Seasonal influenza vaccination declined

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.

STIA007(S). *The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken.*

Range 50-90%

Points 4

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.*

- Acceptable antiplatelet agents are aspirin, clopidogrel and dipyridamole. Anticoagulants include prescriptions for warfarin, phenindione, dabigatran and rivaroxaban.
- 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.

QUALITY & PRODUCTIVITY (QP) Domain

[Index](#)

Indicator	Points
QP001(S). The contractor meets internally to review data on secondary care outpatient referrals, for patients on the contractor's registered list, provided by the NHS Board.	5
QP002(S). The contractor participates in an external peer review with either a group of local practices, or practices from within the NHS Board area, to compare its secondary care outpatient referral data with that of the other contractors. The contractor proposes areas for internal practice improvement and service design improvements for the NHS Board.	5
QP003(S). The contractor engages with the development of and follows 3 care pathways, agreed with the NHS Board for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals.	11
QP004(S). The contractor meets internally to review data on emergency admissions, for patients on the contractor's registered list, provided by the NHS Board and the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S).	7
QP005(S). The contractor participates in an external peer review with either a group of local practices, or practices from within the board area, to compare its data on emergency admissions and to share the learning from at least 25 per cent of the Anticipatory Care Plans (ACPs) completed for QP007(S), and proposes areas for internal practice improvement and service design improvements for the NHS Board.	17
QP006(S). The contractor produces a list of 5 per cent of patients in the practice, who are predicted to be at significant risk of emergency admission or unscheduled care. This list can be produced using a risk profiling tool accessible to practices e.g. SPARRA, or where this is not available/required (by local agreement), alternative arrangements can be agreed between the NHS Board and LMC.	5
QP007(S). The contractor identifies a minimum of 15 per cent (in 2014/15, 30 per cent) of those patients from the list produced in indicator QP006(S) who would most benefit from an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient's review should be determined in the light of their clinical and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.	30
QP008(S). The contractor holds at least 4 meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice's patients.	10

<p>QP009(S). The contractor produces and submits a report to the Board before 15 March 2014 on internal practice and wider NHS Board system changes that may benefit patients with Anticipatory Care Plans (ACPs). The report should include Significant Events Reviews (SERs) on 1/1000, to a maximum of 3 patients per practice, of patients with ACPs from the cohort in QP007(S), who were admitted during the QOF year, after their ACP had been created. If less than the required number of patients with ACPs were admitted during the QOF year then the practice should write SERs of the care of an equivalent number of these patients who remained in the community.</p>	10
--	----

Notes on QP Domain that involve coding / IT related considerations

Whilst there is no data extraction for payment purposes relates to the QP indicators, practices should consider coding in relation to some of these indicators to assist in their own management of these areas, plus to enable them to demonstrate what they have done in the event of payment verification.

QP006(S). – Practices are required to produce a list of 5% of patients on their list who they consider to be at risk of emergency admission or unscheduled care. There are a variety of systems that practices may use to identify these patients. Utilising risk profiling tools such as the SPARRA list is recommended but the guidance also acknowledges that other systems may be utilised by agreement with local Health Boards. It is also acknowledged that some patients may be chosen at the discretion of the clinical team.

A new code for SPARRA has been released, 38Gq. - SPARRA (Scottish patients at risk of readmission and admission) algorithm. This may be helpful for practices to utilise as a means of electronically tagging patients who appear on these lists. However if all patients on the SPARRA list are coded and this is used to show achievement for QP006(S) it is possible that more than 5% of the population are identified. This would then impact on QP007(S), increasing the number of patient requiring ACPs and polypharmacy reviews.

It is therefore recommended that:-

- Practice establish number of patients needed to meet the exact 5% requirement.
- A unique code is utilised that would only be used for this population. A recommended code is:-

13Zu. At risk of emergency hospital admission

However practices could use their own preferred alternative.

- Guidance recommends targeting those with SPARRA score of 20%-60%.

QP007(S). - For 2013-14, practices are required to develop Anticipatory Care plans (ACPs) including polypharmacy reviews, for 15% of the population identified in QP006(S). This rises to 30% in 2014-15. The Scottish QOF guidance document (page 192) details the minimum information that should be included in an ACP. See: - [http://www.sehd.scot.nhs.uk/pca/PCA2013\(M\)03guide.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2013(M)03guide.pdf)

- Recommended coding for ACP:-

8CMM. Has anticipatory care plan

- Consideration should be given to setting up a recall system for review of ACP's as these will count for future years. Review period should be patient specific. In doing this it may be helpful to also look at how the review workload may be spread out through the year.
- The eKIS (Key Information Summary) is the only electronic tool to use for an ACP. This is in the process of being made available through the software systems to enable electronic sharing of ACP's. The KIS form will guide on coding to use for specific information such as resuscitation status etc.

- Recommended minimum coding for a polypharmacy review:-

8B31B Polypharmacy medication review

- This may require retrospective date entry as it is recognised that complex medication reviews may occur over time.
- Detailed guidance relating to Polypharmacy can be accessed via:-
<http://www.central.knowledge.scot.nhs.uk/upload/Polypharmacy%20full%20guidance%20v2.pdf>
- There is no electronic extraction of data for this but it may be advisable that practices maintain records of what has been involved within the medication review either as freetext or by utilising more detailed coding – SGPC advice is that this is not a specific requirement to meet this indicator. If a practice wish to record more detailed codes for their own records there are a wide range of possible codes to use within the Read hierarchy. Some that may be useful are:-
 - 8BIK. Indication for each drug checked
 - 8BID. Optimisation of drug dosage
 - 8BIR. Efficacy of all medication checked
 - 8BIw. Inappropriate medication stopped
 - 8BID. Optimisation of drug dosage
 - 8BIP. Drug interactions identified - drug changed
 - 8BIb. No significant drug interactions
 - 8B3x. Medication review with patient

NOTE – this is not an exhaustive list of available codes, plus **there is no Contract requirement for practices to use these codes.**

- It is recognised that some Health Board areas have established systems within primary care for elements of medication reviews with recommended coding specified. With local agreement these can be utilised in meeting this indicator.