NHS

Primary Care Contracting

QOF Queries August - November 2008

Records 23

I notice that Records 22 has disappeared and Records 23 has been added to the 08/09 guidance. I wasn't previously aware of this, as I don't think it was included in the notification of changes. Am I right in thinking that the change consists of no longer accepting a once-off recording of 'never smoked' as the patient's status? If so, I foresee patients and clinicians being irritated by (presumably annual) repetition of the "do you smoke?" question.

Page 114 of The Quality and Outcomes Framework Guidance for GMS contract 2008/09 states 'This indicator examines whether smoking status is recorded in the clinical record. Non-smokers should be recorded as such up to and including 25 years of age. Ex-smokers should be recorded as such for at least three years since they last recorded a smoking habit. Thereafter smoking status only needs to be recorded should habits change.'

This change brings the smoking indicator within the organisational domain in line with the indicators within the Smoking domain. It has also been reflected in version 12 of the business rules.

So in answer to the question, patients who have never smoked will need to be recorded as such on an annual basis up to and including the age of 25 years. The rationale behind this is that people over the age of 25 who have never smoked are unlikely to become smokers.

The other impact of the change to Records 23 is that ex-smokers will only need to be recorded as such for 3 consecutive QOF years after which smoking status should only be recorded if their habits change, rather than every 27 months as before.

Confirmation of Year-End

Can you please confirm that the year end for QOF 2008/09 is the end of Quarter one 2009, so 1st June?

Yes.

Patient Experience Domain

Has any information been released yet on how the PE7 and PE8 indicators for QOF are going to be administered?

The latest information relating to these indicators was released as part of the October QMAS Bulletin (www.connectingforhealth.nhs.uk/systemsand services/gpsupport/qmas/Bulletin-071008.pdf). This stated that 'NHS CFH has been advised that the survey results will not be available prior to 31st March 2009. QMAS has been updated to support these two indicators, but practices will not be able to enter values for this year 2008/09. Instead the PCT will enter the data for PE7 and PE8 as part of the PCT Adjustment Function after the 2008/09 Year End report has been generated.'

Further information will be available from the PCC website when it is released by the DH.

Exception Reporting

On sending a third letter for retinopathy screening (DM21), can practices only use code 8I3X if they have an actual refusal (i.e. by phone) or can they except on sending a third letter (point 4.1.1 in BMA Guidance on exception reporting). There does not seem to be any benefit to patient care to code after sending this letter i.e. the patient should respond to a third letter sent before the code is applied.

Code 8I3X. is a version 2 code for 'diabetic retinopathy screening refused'. The criteria for exception reporting are outlined in the Quality and Outcomes Framework Guidance for GMS Contract 2008/09 available from NHS Employers (www.nhsemployers.org). In order to exception report a patient for refusal of an intervention then the patient should have been invited on at least three occasions during the preceding 12 months or they should complete an informed dissent form.

It would be good practice to give the patient time to respond to the third letter before entering an exception code. In the case of retinal screening there are specific exception codes for this indicator. It may be preferable for practices to use these rather than the diabetes exception codes as this will not exception report the patient from the wider indicator set.

What code should practices use when they send out a third letter to patients to attend retinal screening, after they have been informed by the national screening programme that they have sent out the second reminder? Is 8I3X allowed 'diabetic retinopathy screening refused' or does the practice need to have a written disclaimer, issued by the national screening programme and completed by the patient, forwarded to them?

The QOF business rules do not specify codes to be used for the sending of reminder letters, although codes are available to record this activity. It would be good practice for practices to use these so that they have an audit trail to support the entry of exception codes.

In relation to the question of a written disclaimer for retinal screening this is not required under the current QOF Guidance. As stated above the use of indicator specific exception codes is preferred as these do not exception report the patient from the wider indicator set.

I've been asked by a practice if there is an exception code for a patient who has diabetes and anuric therefore microalbuminuria cannot be tested. I can't seem to find one and wondered if you could possibly advise?

The technical answer to this question is that the most appropriate code is probably that for 'patient unsuitable'. However, if you are anuric i.e. not producing any urine (other than for a few hours e.g. when very dehydrated on a very hot day with no fluid intake) then this means that you are in absolute kidney failure. If this is permanent then the patient will be on dialysis. Even if this is temporary then the patient is still very ill and the delivery of appropriate care should take precedence over QOF points. This is one of the reasons why upper payment thresholds are less than 100%.

It might be worth checking whether the patient is on dialysis.