

### **Quality and Outcomes Framework (QOF) exception reporting 2011-12**

The QOF identifies where practices have achieved set quality measures, financially rewarding them where they are able to demonstrate that they have met that level of quality. This provides incentive to provide good patient care, and a financial reward that can be reinvested into the services provided by the practice.

However, there are cases when “target chasing” to meet those set by QOF can conflict with a clinician’s judgement about what actually may be the most appropriate treatment for an individual patient. Clinicians are permitted to “exception report” patients in such circumstances.

This summary is intended to provide clarity to GP practices in Northamptonshire NHS regarding exception coding for QOF indicators DM26, DM27, DM28, Stroke 8 and CHD8, and is authorised by the PCT’s QOF validation group.

It is not a licence to routinely exception report large numbers of patients. It is hoped that it will enable clinicians to provide patient-centred care, without concern that they are unable to “tick the QOF box” for particular patients, or that their exception reporting may appear high in these areas. Informed decision making by patients is key and this should be documented.

#### **Diabetes**

**DM26 (previously DM23): The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5\*% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months**

**DM27 (previously DM24): The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months**

**DM28 (previously DM25): The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months**

*\*This value has been increased from 7 (which it was in 2010-11) in recognition of the emerging evidence that HbA1c values below 7 may be harmful in patients with type 2 diabetes.*

NICE (CG 66 Type 2 Diabetes) advises that, “when setting a target HbA1C, involve the person in decisions about their individual HbA1C target level”.

NHS Northamptonshire does not recommend inappropriate restriction of the use of newer hypoglycaemic agents (such as “glitazones”, “gliptins” and exenatide) and insulin, where the clinical benefits are clear. However, prescribers are encouraged to consider the benefits and risks for these newer agents, and for insulin, and involve patients in informed decision making about whether they wish to have additional drugs added to their treatment.

After this discussion has taken place, if prescribers then chose to “exception code” patients with the Read Code 8BL2 (“patient on maximum tolerated therapy for diabetes”), this will be acceptable to the QOF validation team. In order for the practice to evidence that the patient has made an informed decision a note should be made in the medical record alongside the exception code. The PCT would not expect practices to use 9h% codes “such as patient unsuitable” or “informed dissent” as these operate at a clinical domain level and would therefore effectively exempt the patient from all markers within Diabetes.

**Informed decision making by patients is also encouraged by NICE in their Clinical Guideline on Medicines Adherence (CG 76) and where a patient does then chose to have another drug added to their treatment, adherence is likely to be better.**

**The QOF validation team may audit the exception reporting and would expect to see that this informed decision making had taken place and was documented in the patient record. However this would not delay payment, if stated as the reason for exception reporting.**

*NB This applies to patients with type 2 diabetes, not type 1.*

### **Cardiovascular disease**

**CHD 8 - The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less**

**Stroke 8 - The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less**

For patients with stable CVD (without diabetes) NICE (CG 67 Lipid modification) advises simvastatin 40mg as the recommended treatment. It then advises, CONSIDER increasing the dose to 80 mg simvastatin (or drug of similar efficacy and cost) if the total cholesterol does not fall below 4 mmol/l and the LDL cholesterol does not fall below 2 mmol/l. Recognise that less than half will achieve total cholesterol less than 4 mmol/l or LDL cholesterol less than 2 mmol/l. Use an ‘audit’ level of total cholesterol of 5 mmol/l.

*Note – NICE does not advocate using any alternative interventions such as ezetimibe in this situation i.e ezetimibe should not be added to simvastatin 40mg if simvastatin 80mg is not tolerated.*

There is no clinical trial evidence which demonstrates benefit from high dose statins in patients with stable CVD (there is some evidence in Acute Coronary Syndrome and hence the NICE guidance is different here).

If a patient with stable CVD (without diabetes) taking simvastatin 40mg has a total cholesterol above 5mmol/l then following the same principle as for diabetes above, the patient should make an informed decision about whether they wish to have their dose of simvastatin increased to 80mg. NICE advises that benefits and risks should be discussed with the patient in order to make this decision.

After this discussion has taken place, if prescribers then chose to “exception code” patients who do not wish to have their simvastatin dose increased to 80mg, with the Read Code 8BL1 (“patient on maximum tolerated lipid lowering therapy”), this will be acceptable to the QOF validation team. In order for the practice to evidence that the patient has made an informed decision a note should be made in the medical record alongside the exception code. The PCT would not expect practices to use 9h% codes “such as patient unsuitable” or “informed dissent” as these operate at a clinical domain level and would therefore effectively exempt the patient from all markers within CHD or Stroke.

**Informed decision making by patients is also encouraged by NICE in their Clinical Guideline on Medicines Adherence (CG 76) and where a patient does then chose to have their dose increased, adherence is likely to be better.**

**The QOF validation team may audit the exception reporting and would expect to see that this informed decision making had taken place and was documented in the patient record. However this would not delay payment, if stated as the reason for exception reporting.**

*Further background information on the evidence base for the interventions mentioned can be obtained from the PCT's Prescribing Advisory Team.*