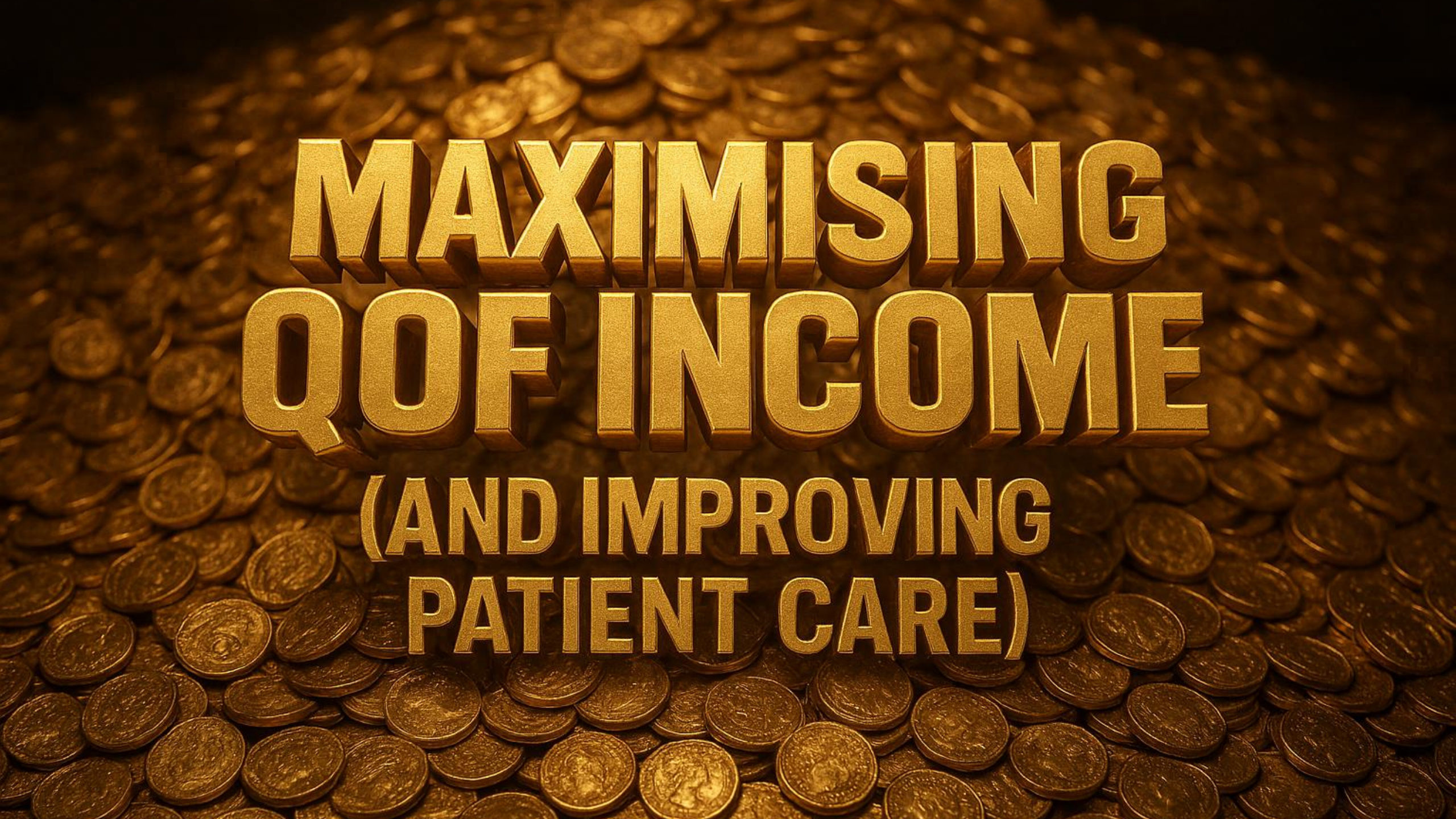
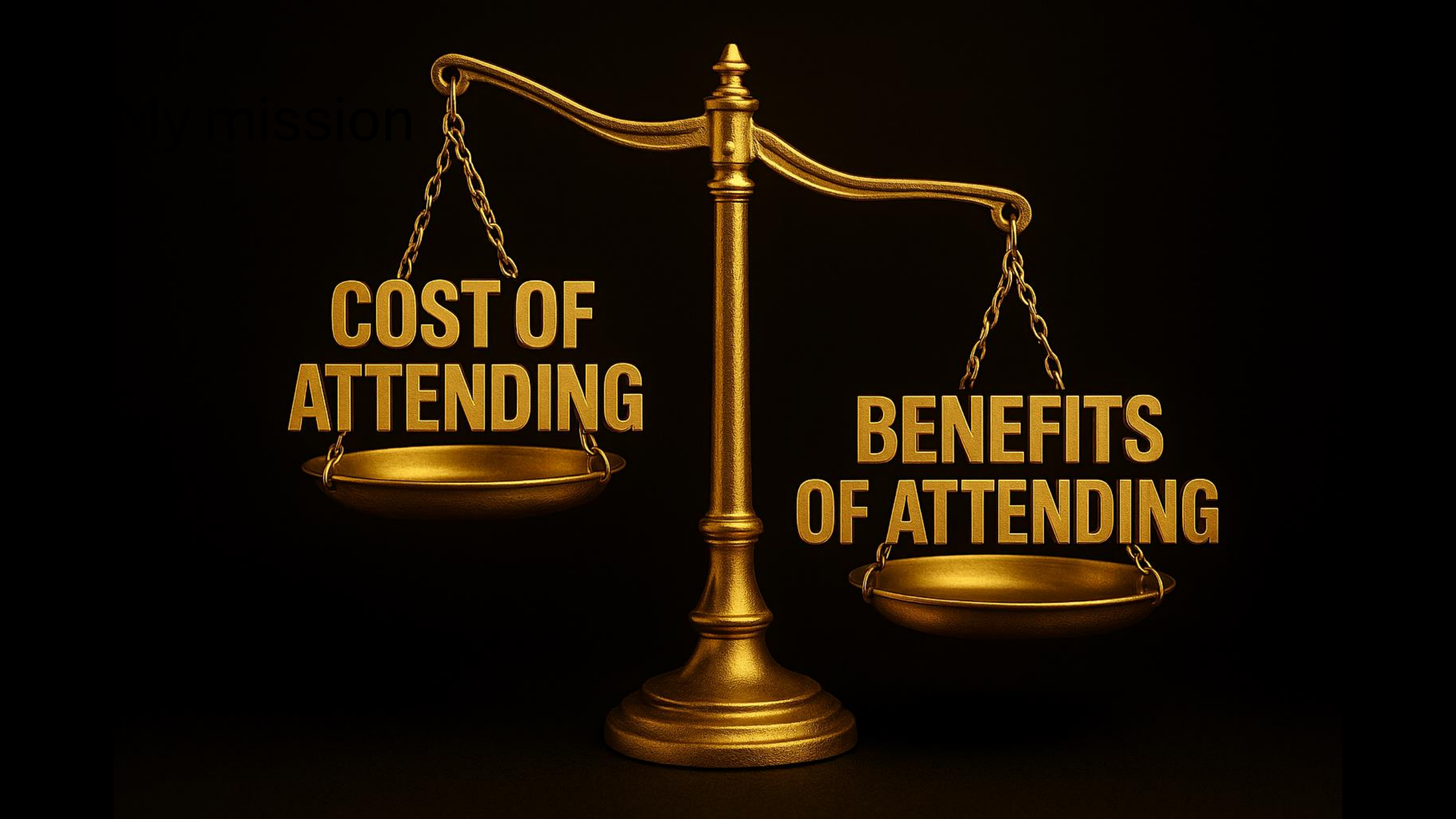
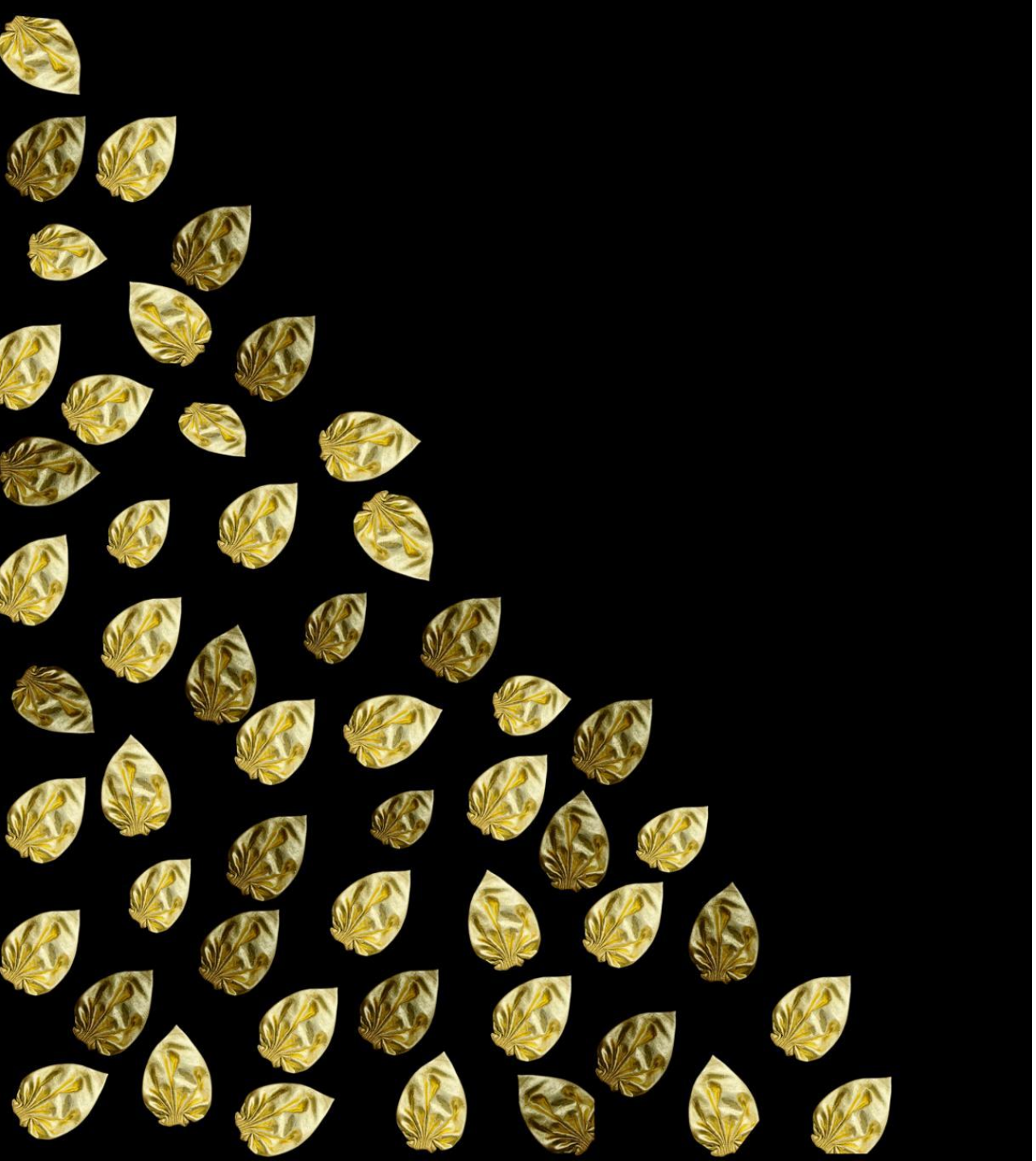

MAXIMISING
QOF INCOME
(AND IMPROVING
PATIENT CARE)


COST OF ATTENDING
BENEFITS OF ATTENDING



Who am I?

Dr James Boorer

Partner Pathfields Medical Group

Clinical director Sentinel CiC

Chair of the Western GP collaborative board

Private minor surgery

Vasectomist

Founder of Target Health Solutions

What are we going to talk about?

QOF

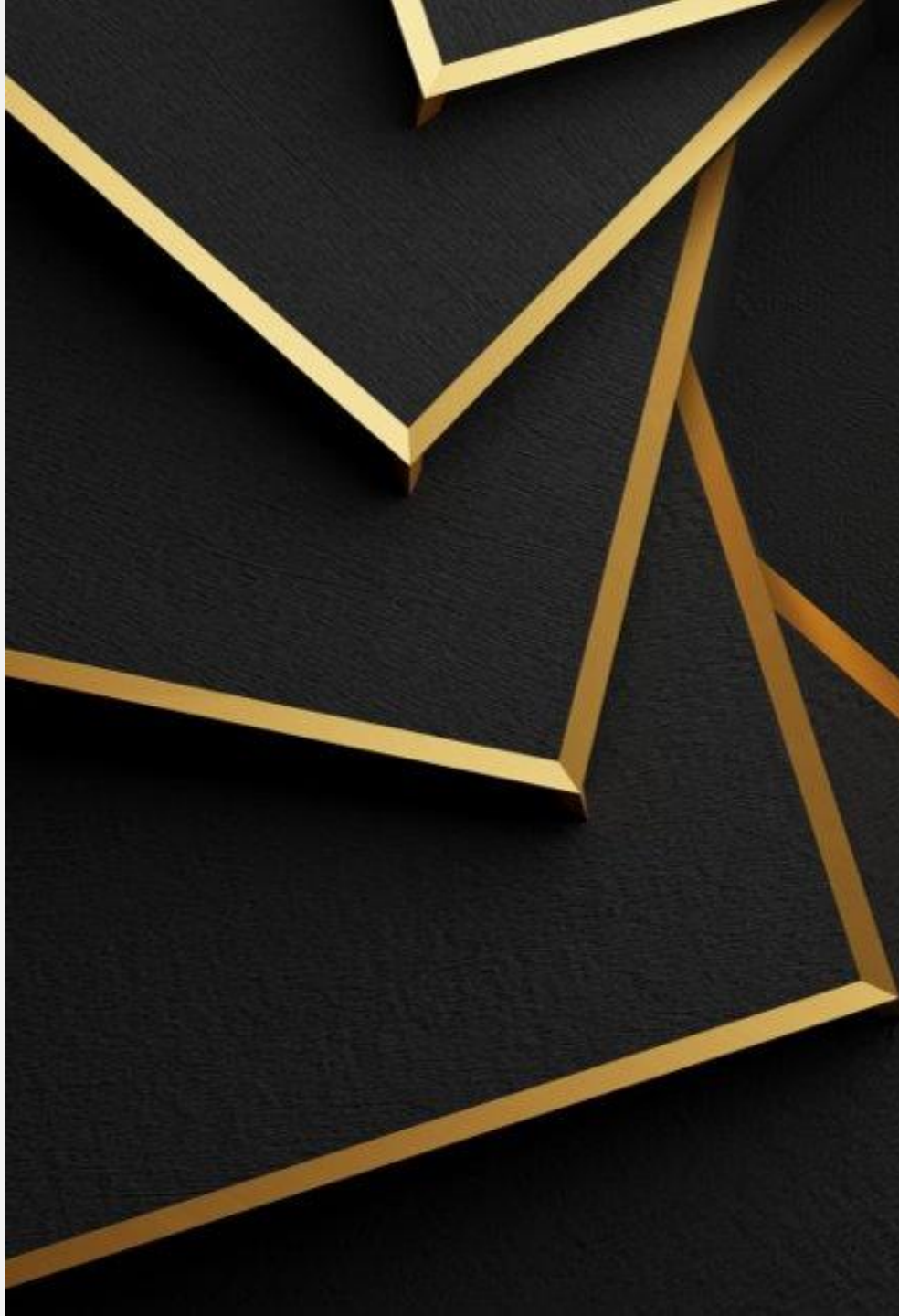
- How it works
- What it's worth

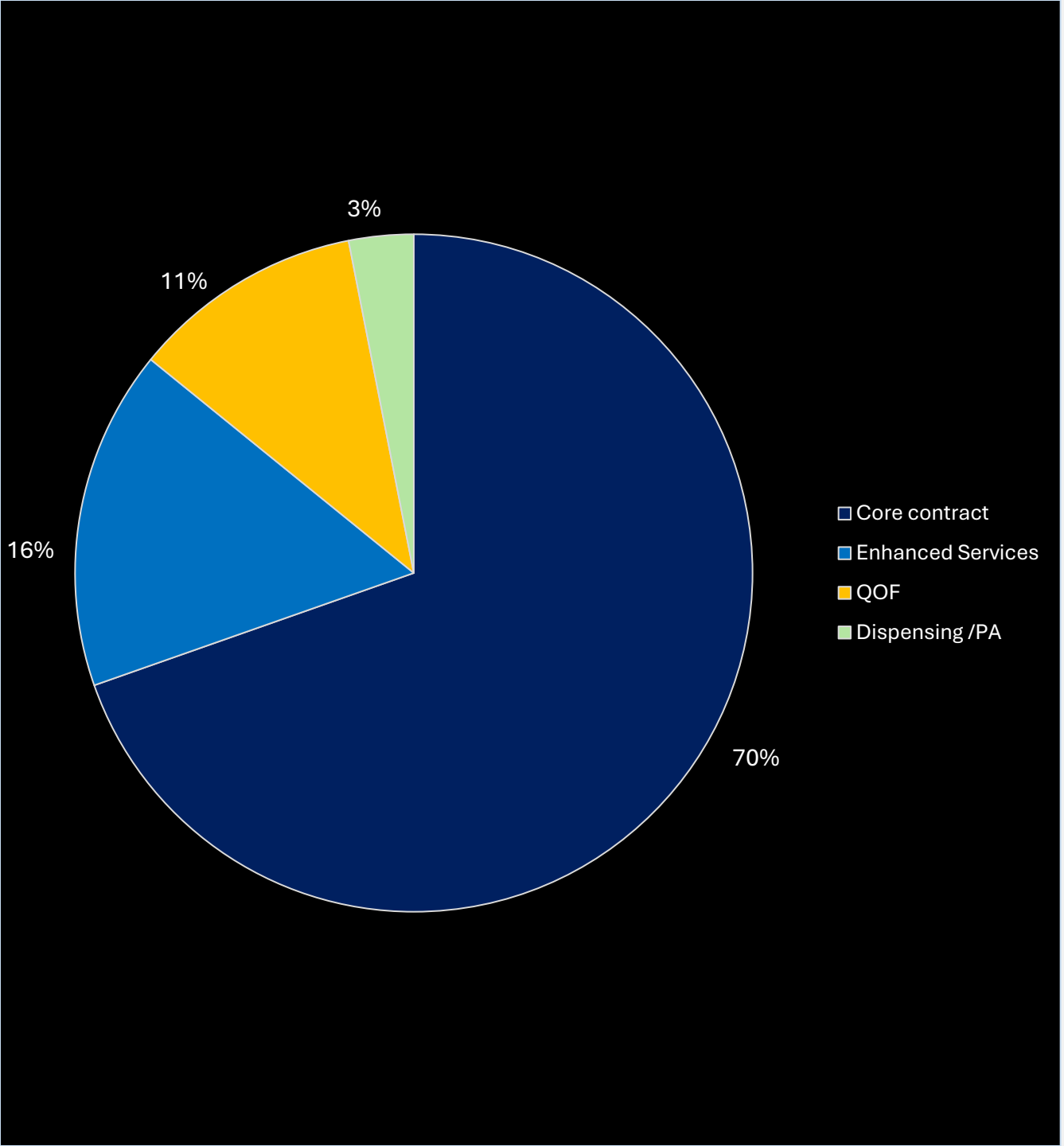
The primary focus will be on

1) Identifying your missing QOF income
2) Approach to resolving coding issues

We will start with a generic approach and principles that you can use

Finally we will showcase how we use the THS tool





Contribution of QOF

QOF worth up to £12.49 per patient in 25/26

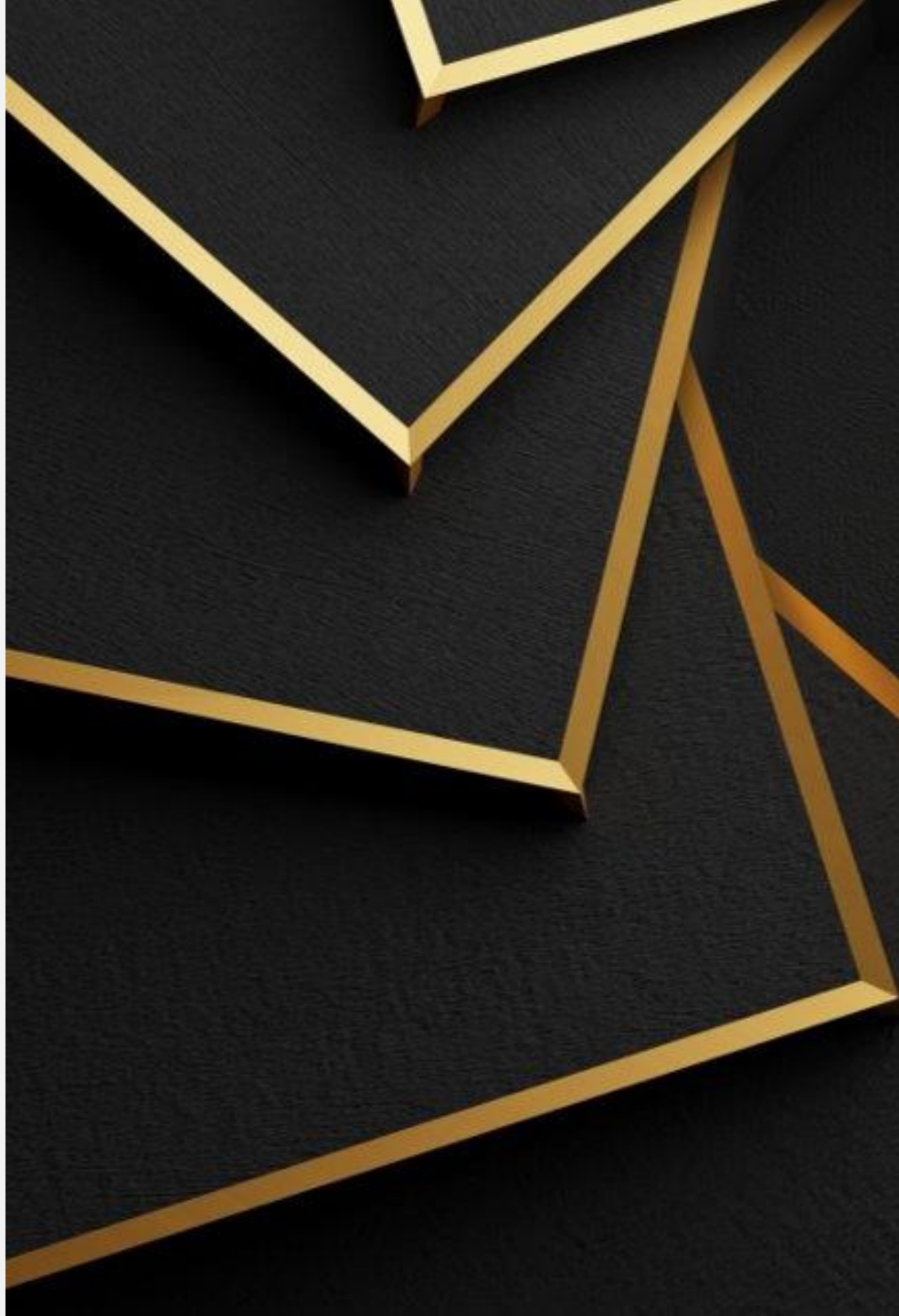
How QOF works

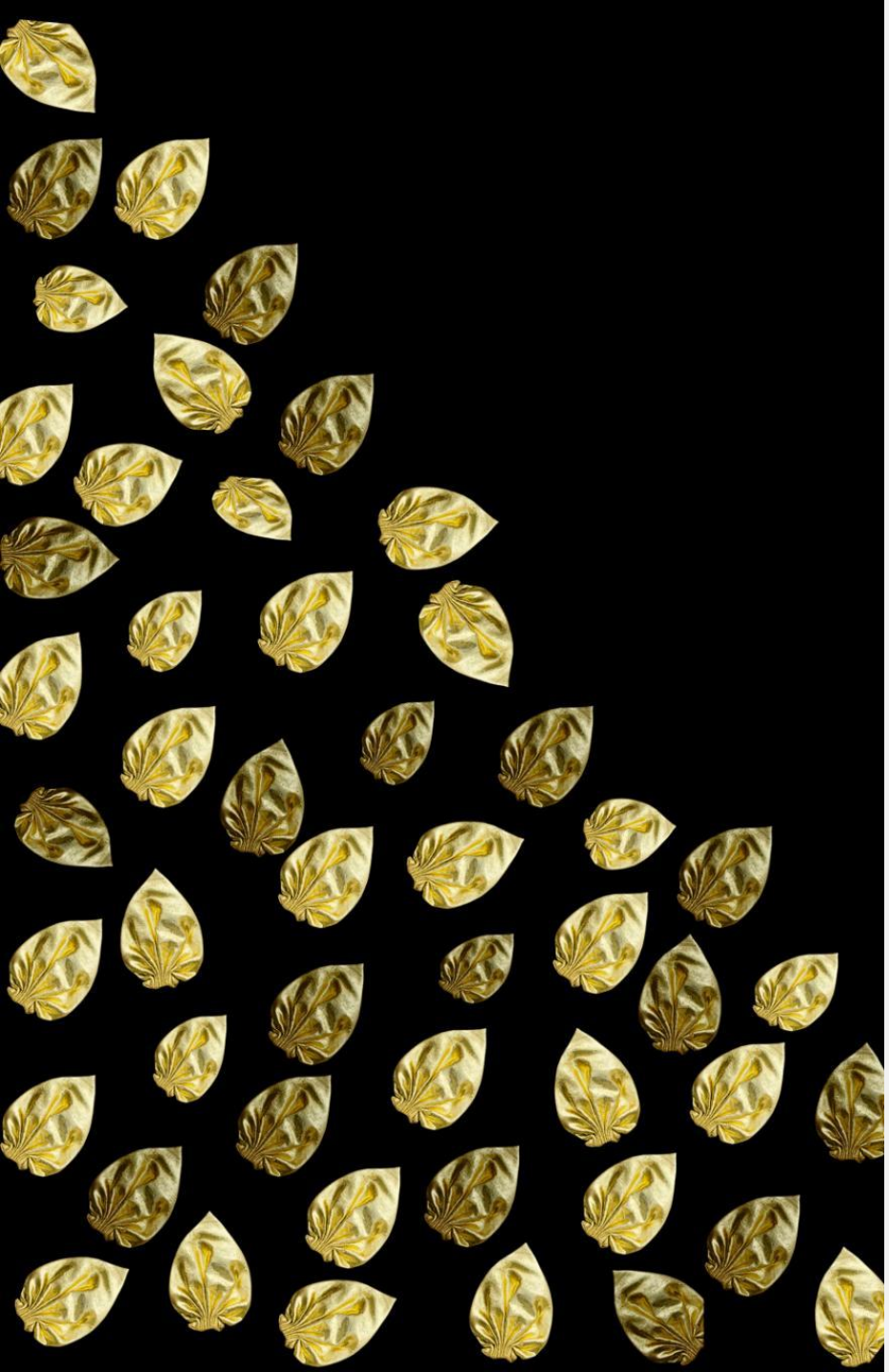
Deliberately complex?!

Payment = (Points achieved ÷ Total points available) × Indicator points × £ per point × Prevalence factor × Contractor population factor

But in essence this boils down to a fairly fixed price per patient

That price per patient goes down in value if prevalence rises across the UK





CHOL004

- 44 points at £225.49 = £9921.56
- Patients = 407
- Pounds per patient = £24.36
- Pounds per patient between thresholds = £81.19
  - Low threshold – 20%
  - Upper threshold – 50%

ALWAYS hit your upper threshold!

Focus on easy to achieve QOF domains at this time of year

NDH

- £6.19 per patient between thresholds
- Simple blood test, no subsequent action

Focus on high value domains between thresholds

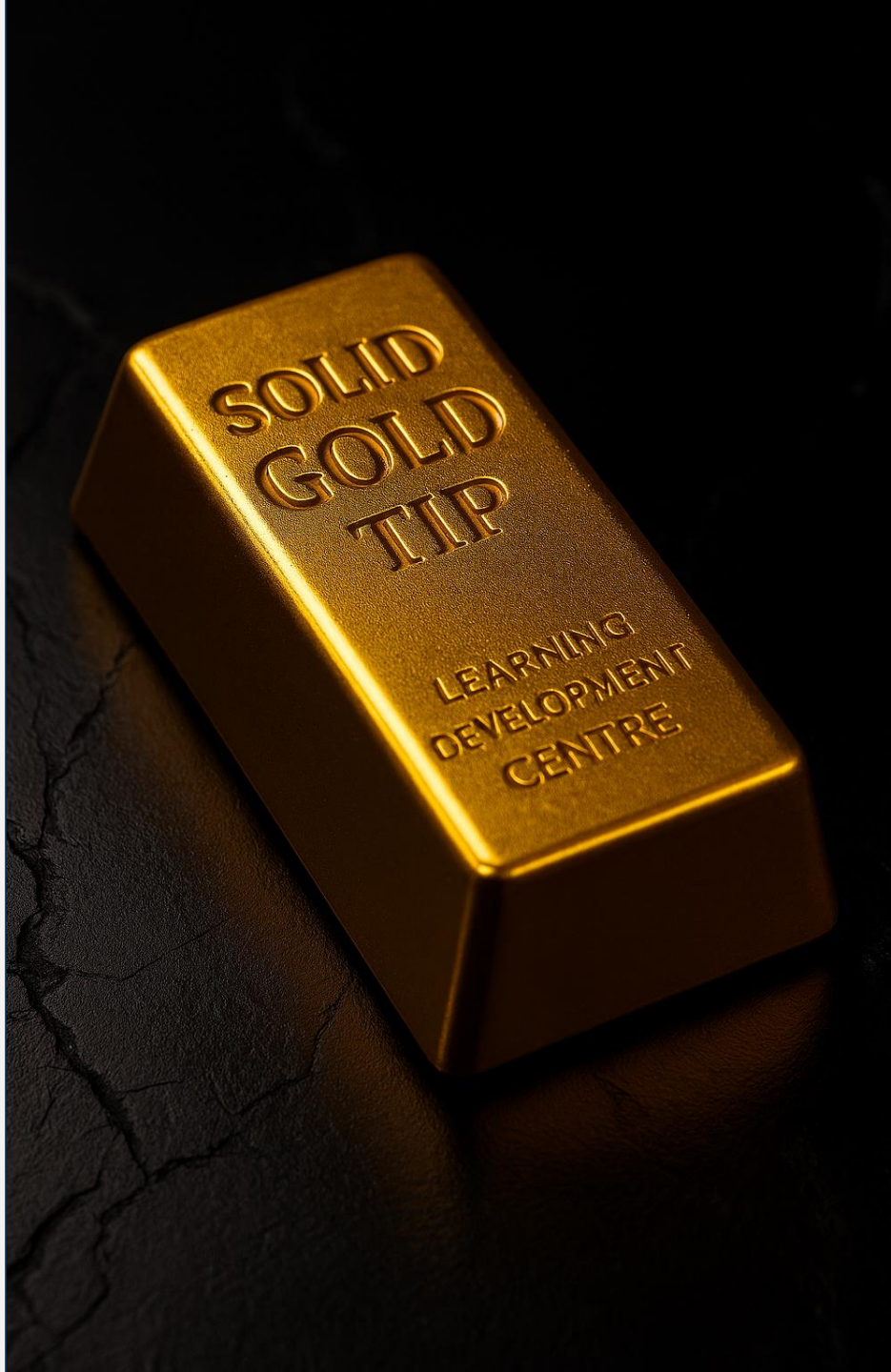
Dementia

- £124.79 between thresholds

Focus on easy domains

HF007 – assessment of NYHA status (via questionnaire?)

- £43.05 per patient between thresholds



Your missing QOF income (prevalence factor)

- The value of each QOF point is affected by your prevalence factor: ie: how many patients have that condition
- Adds unnecessary complexity to the QOF calculation – but you get paid the same for every patient
- The more patients you add to your register the more you get paid*

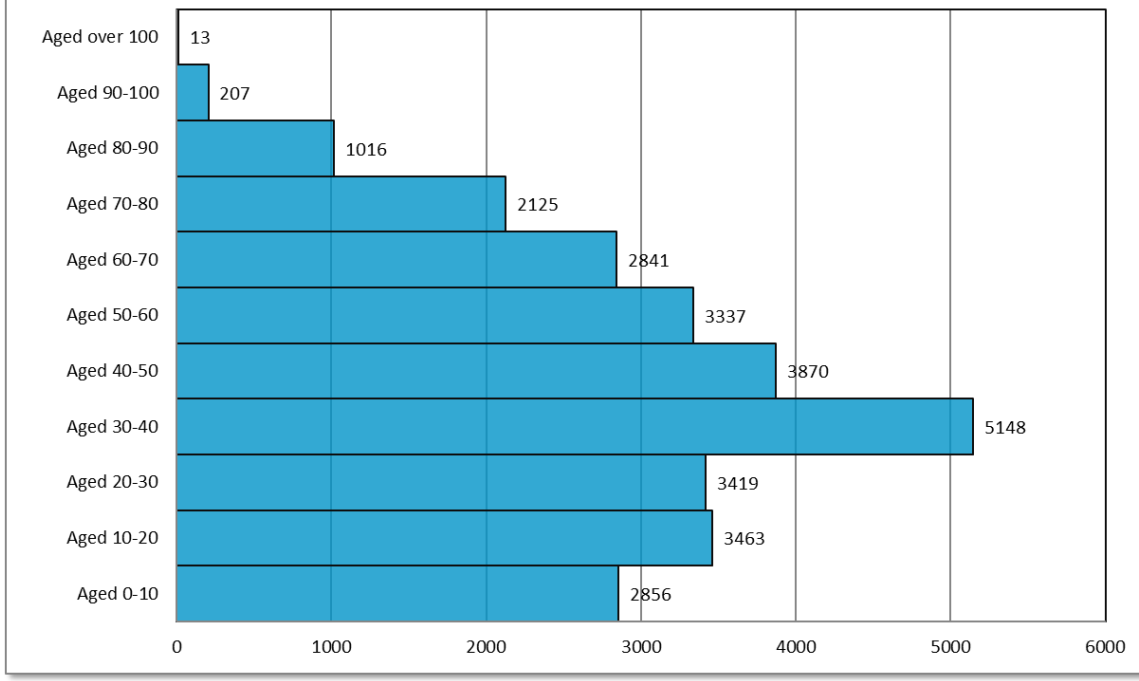
*as long as you still hit your upper threshold


50

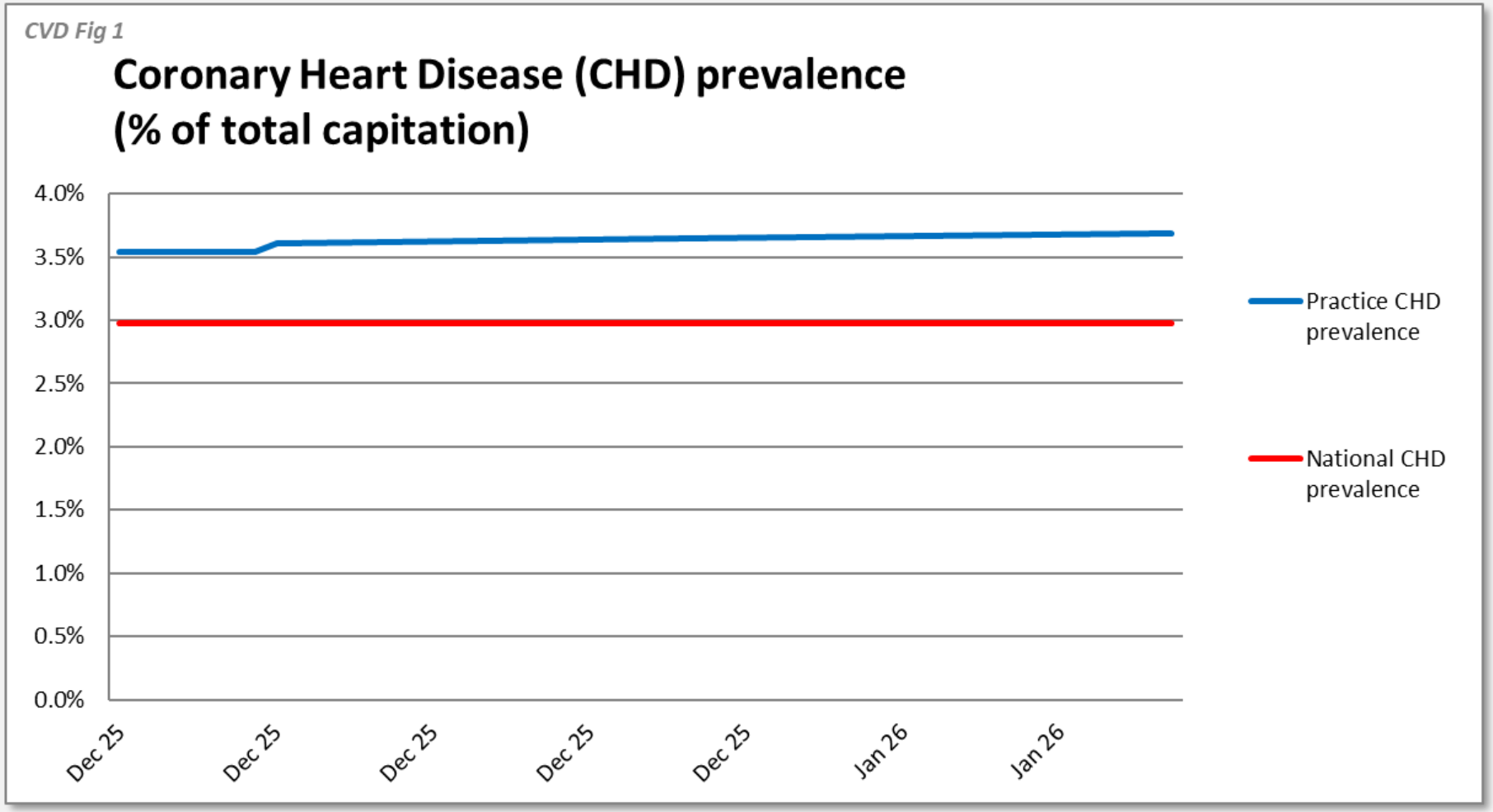
Pathfields
MEDICAL GROUP

Demographics Fig 2

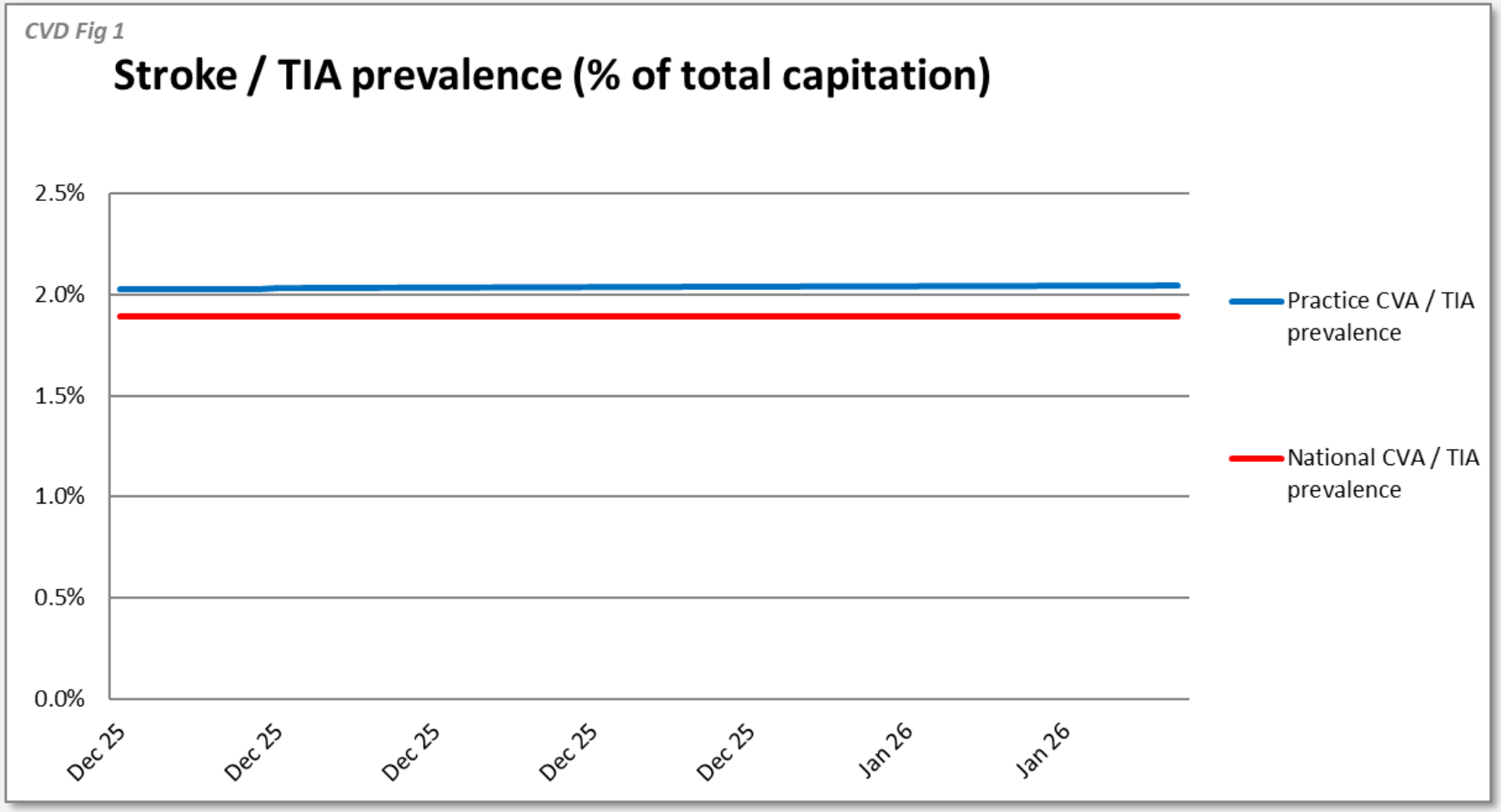
Population pyramid



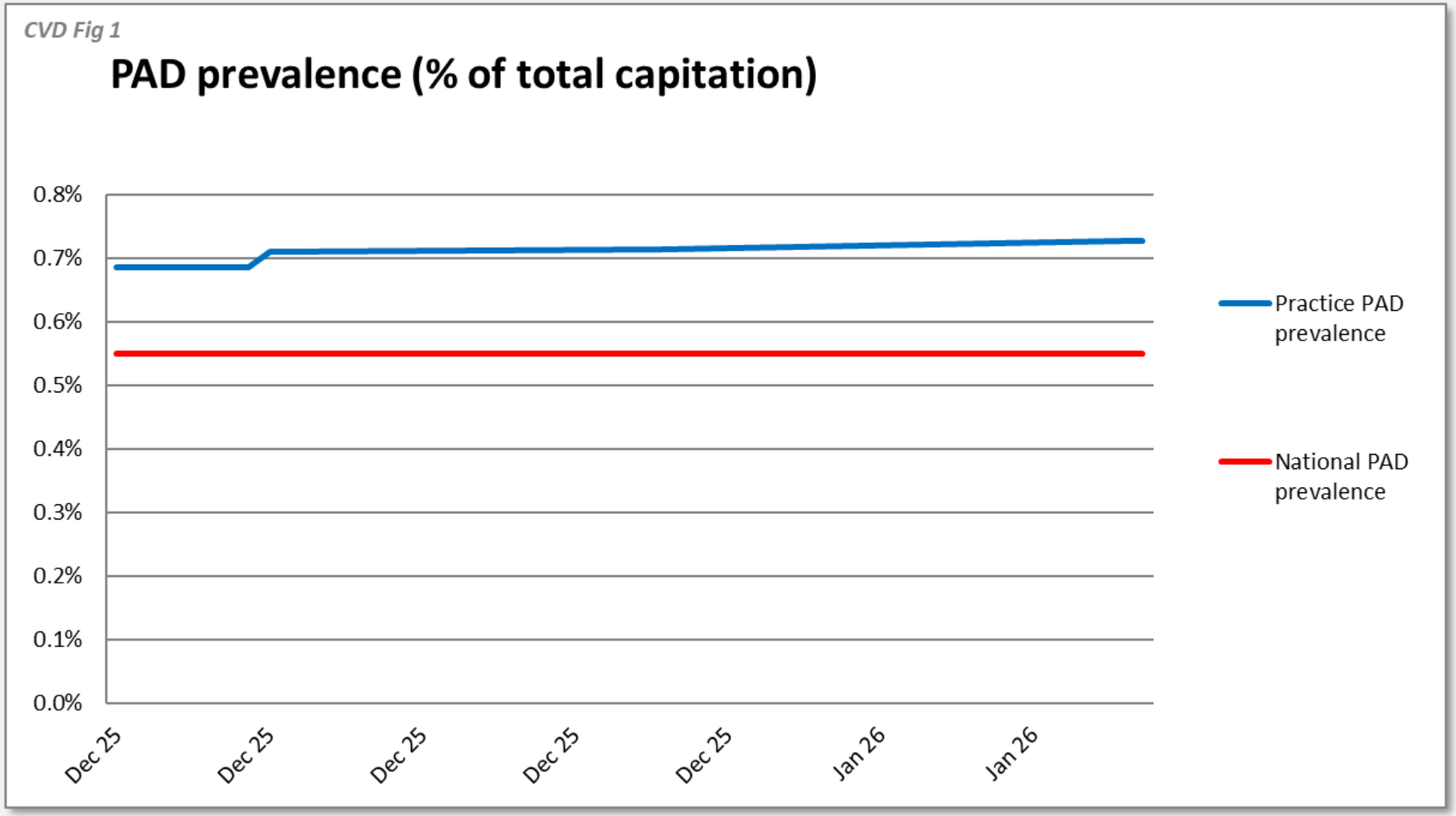
Above average prevalence of CHD



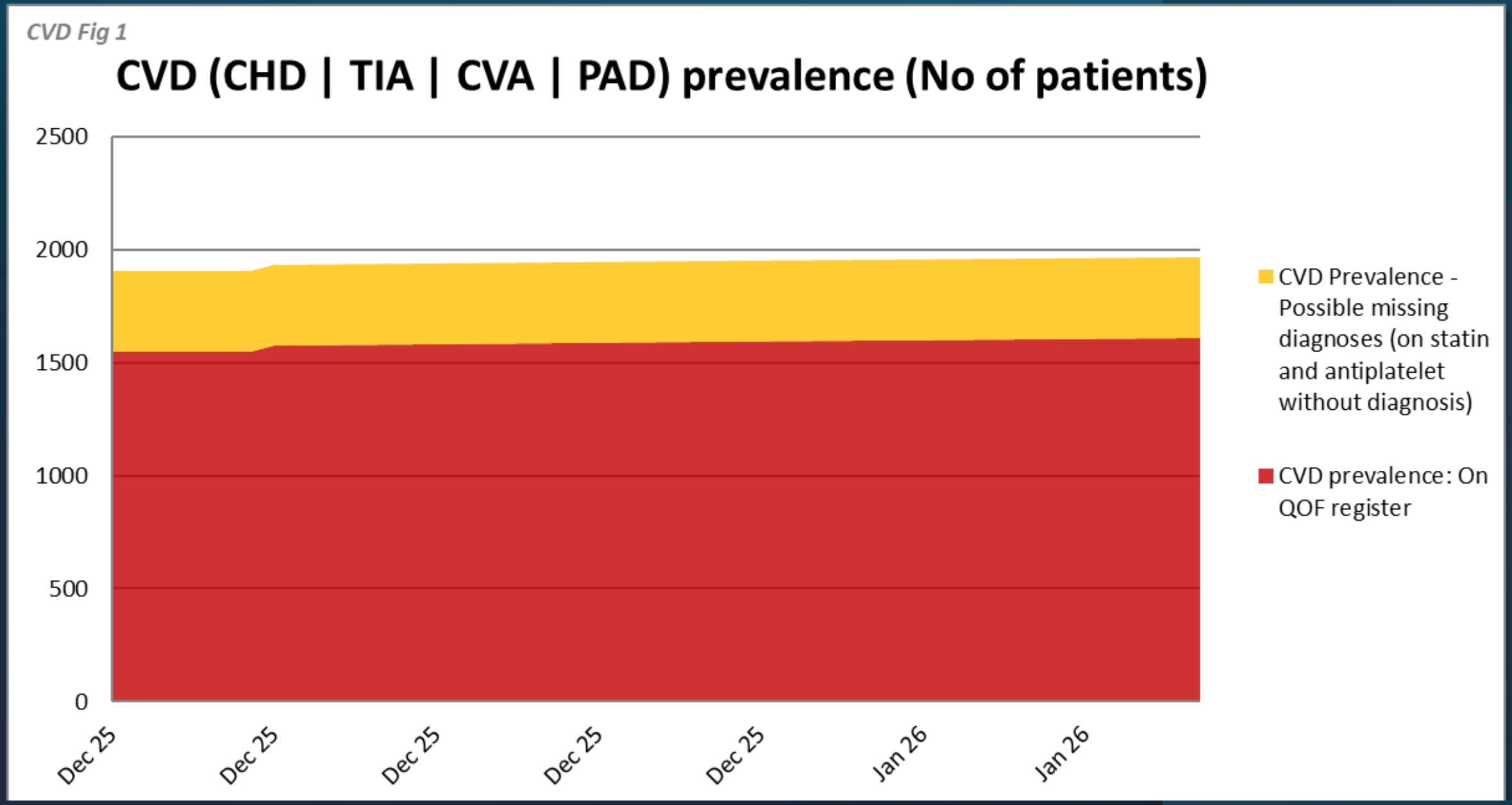
Above average prevalence of stroke / TIA



Above average prevalence of PAD

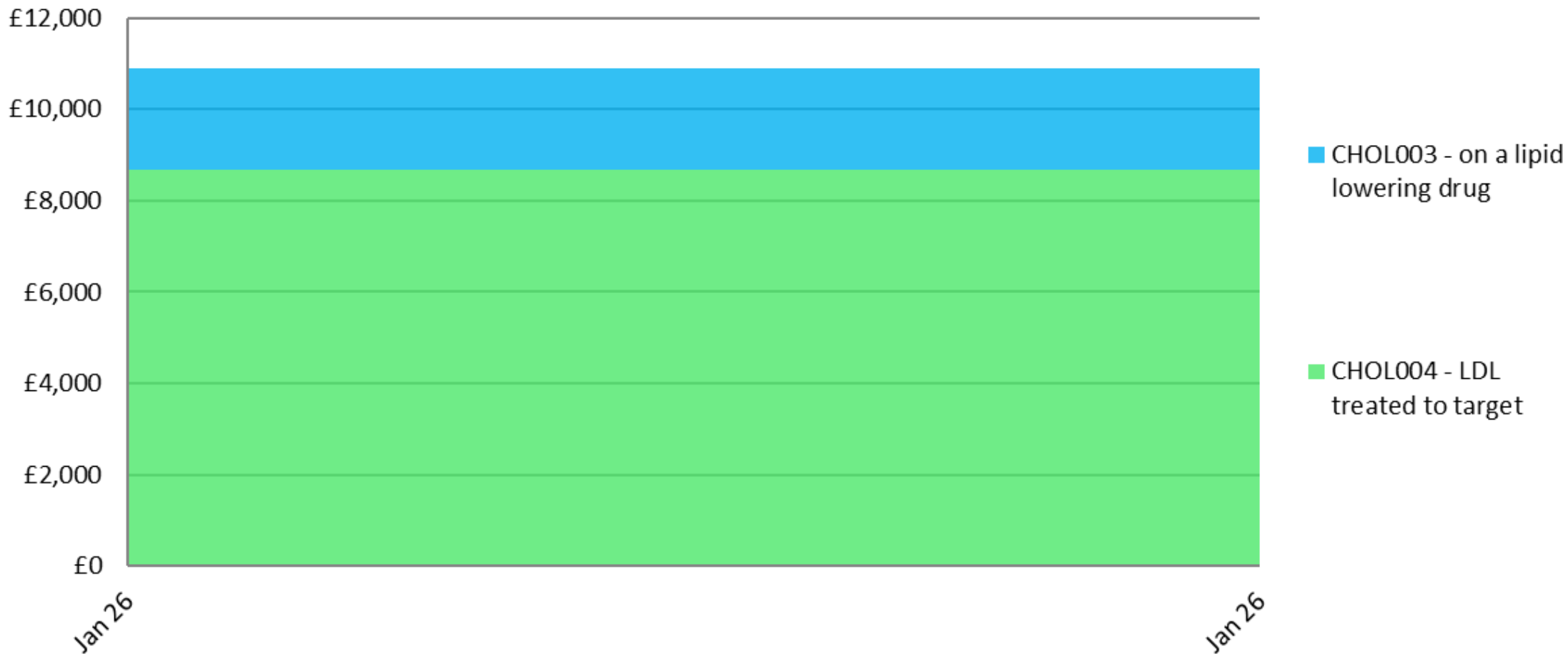


CVD Fig 1


CVD (CHD | TIA | CVA | PAD) prevalence (No of patients)
2500
2000
1500
1000
500
0
Dec 25
Dec 25
Dec 25
Dec 25
Dec 25
Jan 26
Jan 26
CVD Prevalence - Possible missing diagnoses (on statin and antiplatelet without diagnosis)
CVD prevalence: On QOF register

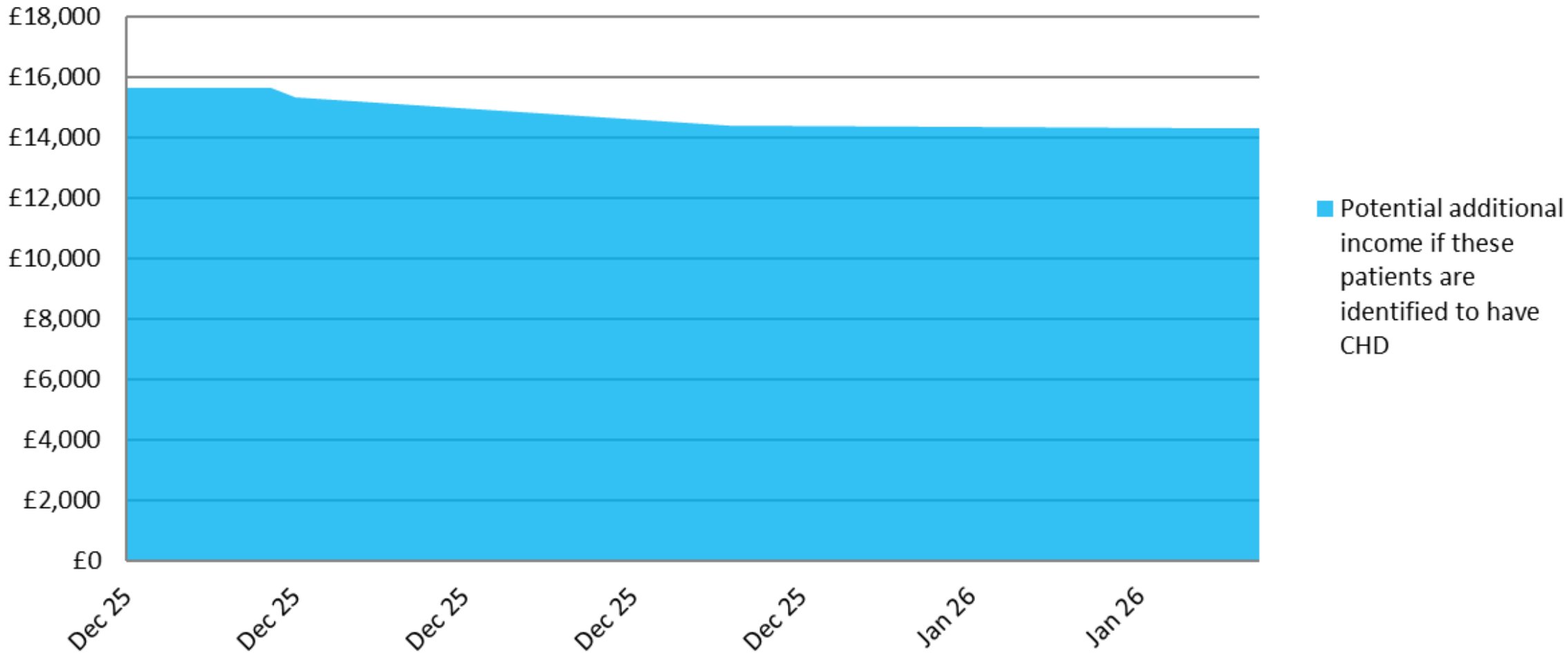
CVD Fig 1

CHOL003 & CHOL004 potential income generated from coding CVD in those on antiplatelet and statin



CVD Fig 1

Coronary Heart Disease (CHD) QOF income potential based on codes that may suggest CHD



How much is each patient coded worth?

- Each patient coded with CHD worth £69.18
  - £9.90 - CHOL003
  - £24.36 – CHOL004
  - £34.92 – CHD0015 / CHD0016
- Stroke TIA worth £56.40
  - £9.90 - CHOL003
  - £24.36 – CHOL004
  - £4.92 – STIA007
  - £17.22 – STIA014 / STIA0015
- PAD worth just cholesterol markers: £34.26

How do I find these patients

- Clinical reporting
  - Statin + Antiplatelet on repeat without a CVD diagnosis ~= 80-90% conversion rate
  - Codes for coronary angiography / CTCA / etc without a CVD diagnosis ~= 20-30% conversion rate
  - Antiplatelet on repeat without a CVD diagnosis

How do I code these patients?

- GP, AHP or clinical summariser
- Review notes look for key information: angiogram results, CTCA, brain scans, letters
    - If coronary atheroma with stenosis present - code
    - If coronary atheroma present in an under 60 year old – code
    - Non obstructing coronary atheroma in someone over 60 – debatable! (start with the youngsters!)
    - Look for atypical PAD eg: carotid atheroma
- Use templates and views to highlight cardiology letters / vascular letters / neurology letters
- Use medication history to see when antiplatelet started

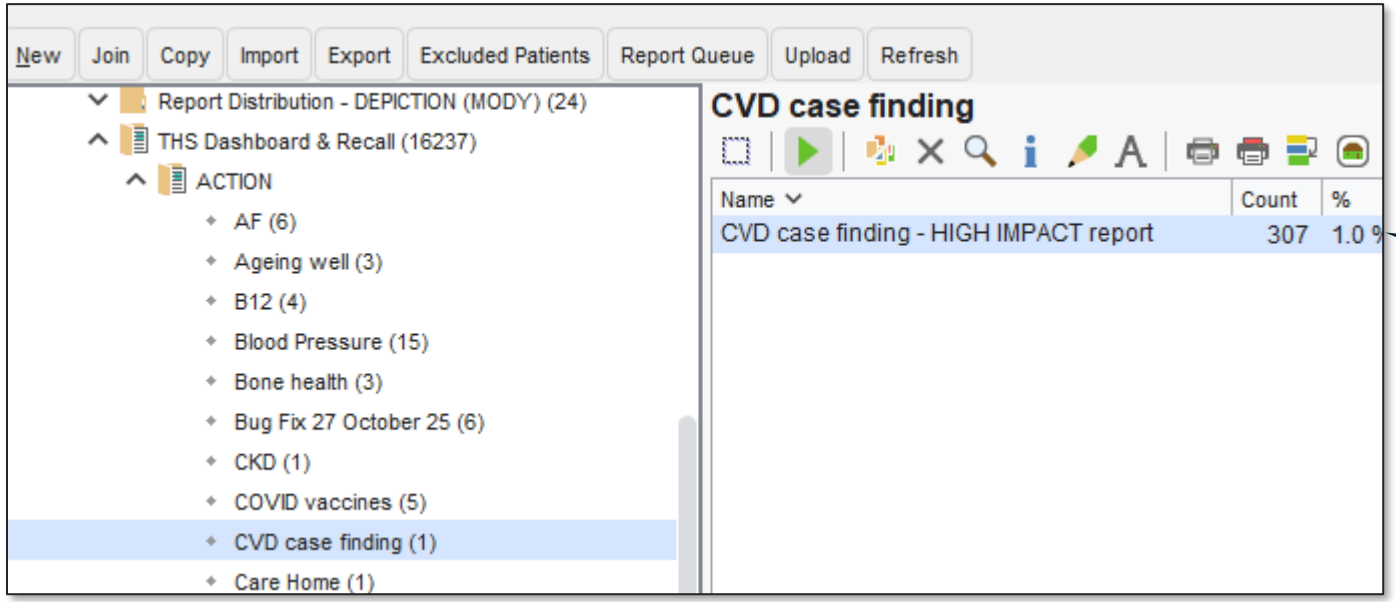
It’s not about the money, money, money

- Identifying patients gives them the opportunity for optimal care – BP control, LDL control both of which will reduce the risk of death and disability
- You will identify some patients on medication inappropriately:
  - Antiplatelets that were not stopped after normal angiography or after TIA excluded.
  - Antiplatelets have a small but significant risk of GI bleeding and cerebral bleeding
- Undertaking this work will help practice finance, but it will also **save lives**

How THS can help

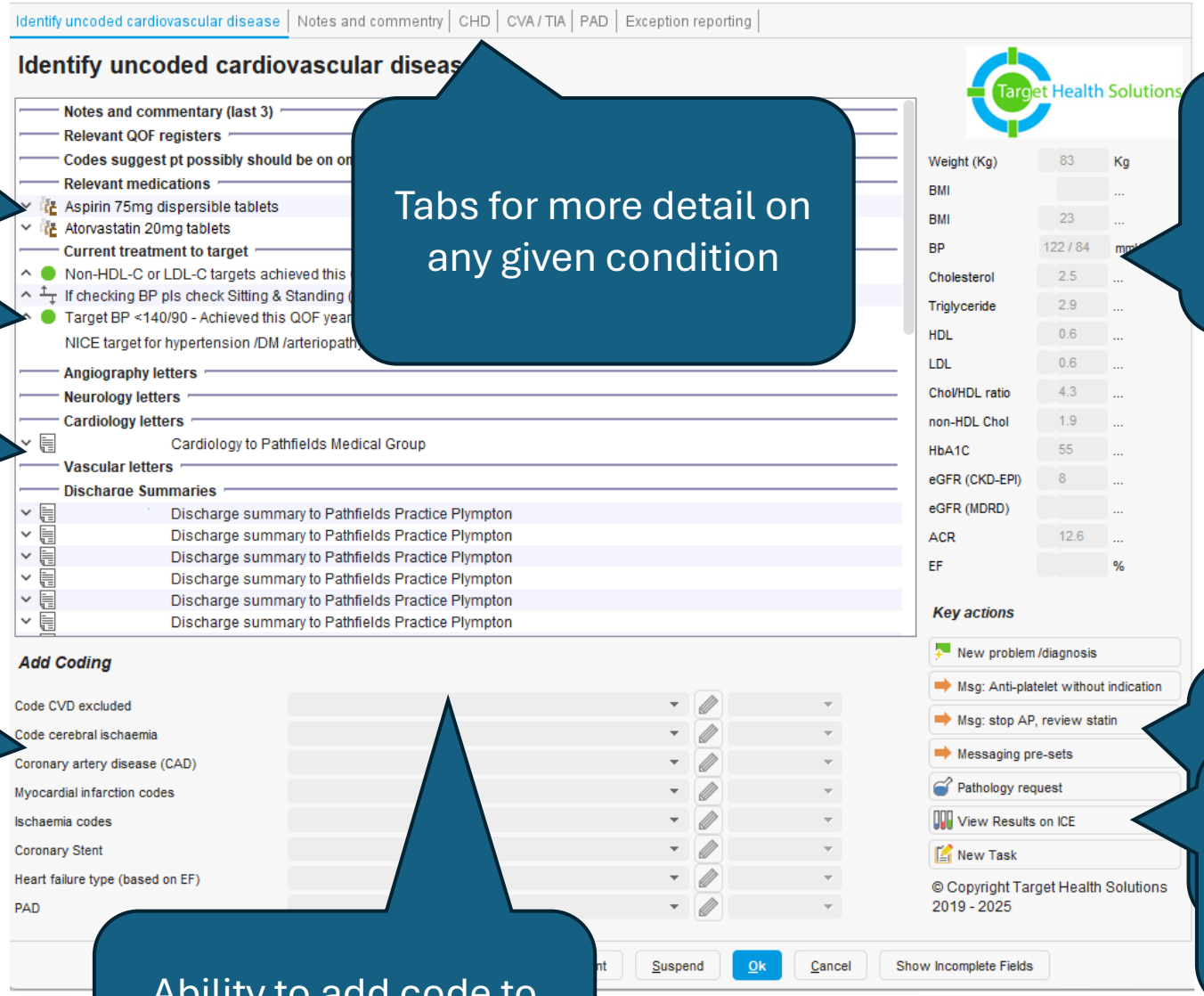
- Freely available in Devon until 1/4/28 from previous NHSE funding
- Class 1 medical device registered with MHRA
- DCB0129, DPIA squared away for Devon
- Downloadable in minutes – SystmOne only
- Following slides demonstrate how our software helps you identify CVD quickly, could inspire EMIS users to create similar content

Reporting



When designing reports also add opportunity to add a code to exclude people from the report

F12: "QOF coding checks"



Relevant repeats. Right click to see

Alerts show if there is work to be done if you

Relevant letters here – cardiology / neurology / vascular / Dx summaries

Ability to add QOF relevant codes here

Tabs for more detail on any given condition

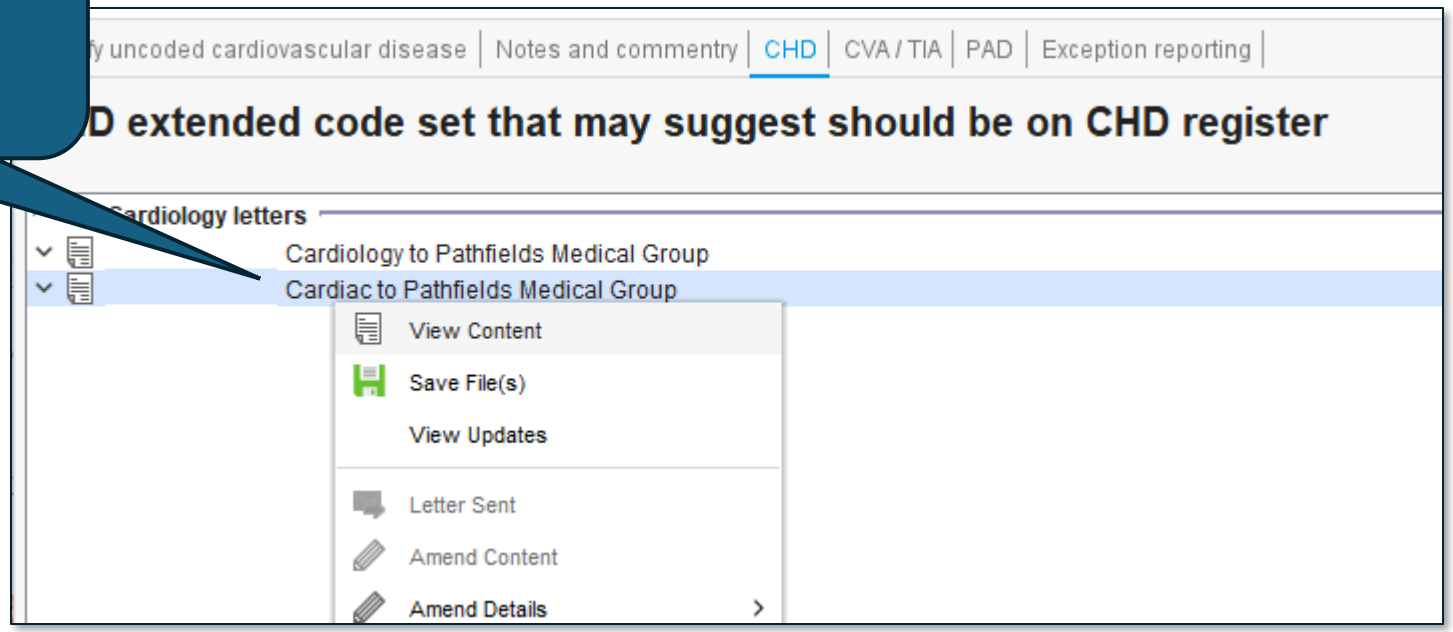
BP, LDL, HbA1C values etc here

Semi-automated

Click here to see radiology results – especially CT head for ?TIA / CVA

Ability to add code to remove them from the case finding report

Right click > View Content



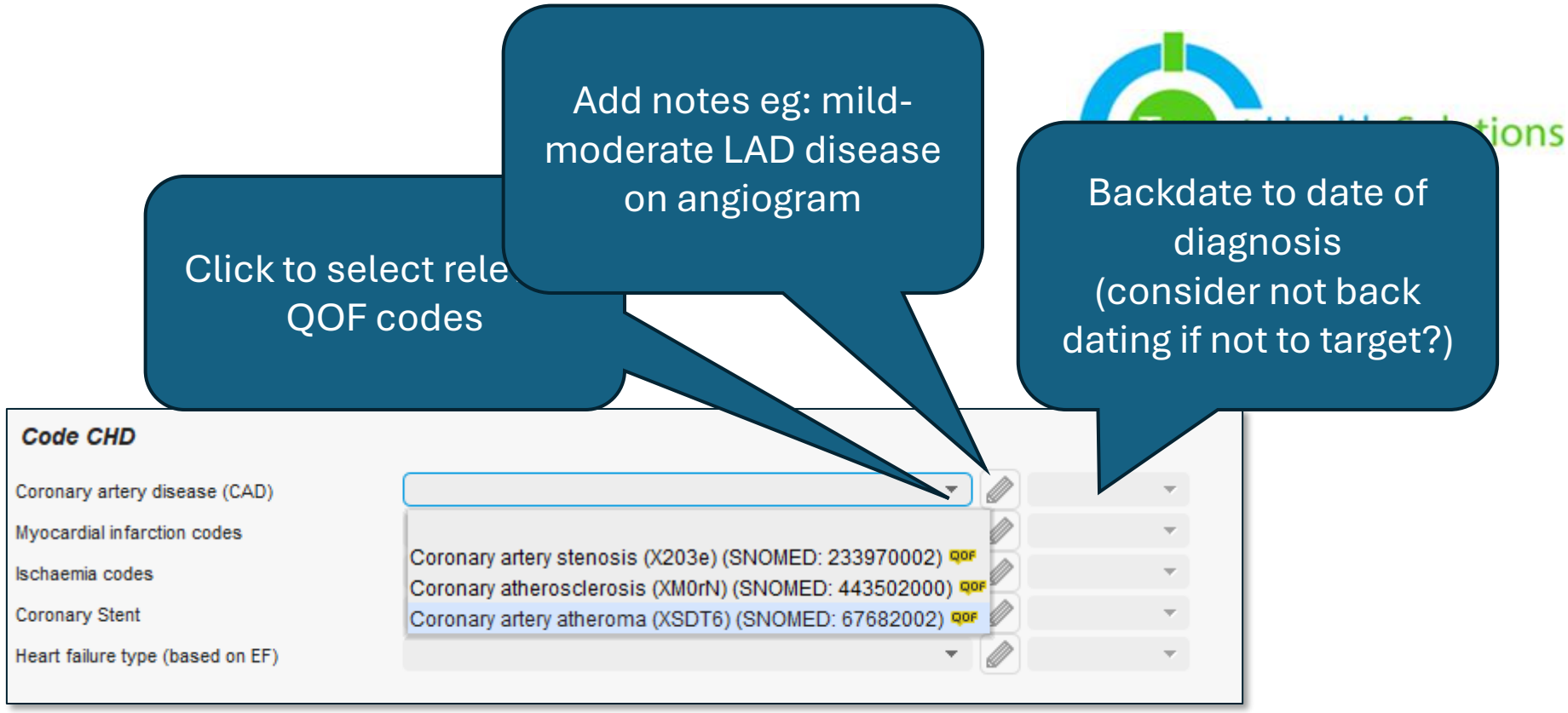
Mild to moderate atheroma
If age <60 code & treat

LMS normal.
LAD mild-mod mid vessel atheroma.
Cx mild-mod ostial atheroma.
RCA dominant, mild atheroma only.

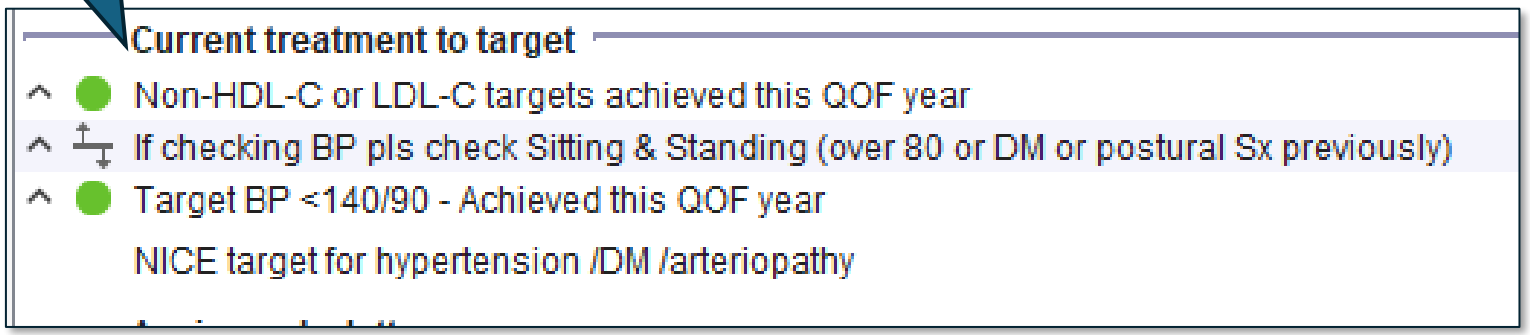
In summary no obstructive coronary disease, simply needs to continue medical therapy.

Plan:
GP please start aspirin.
Continue atorvastatin and other risk factor modification.
No further cardio review or investigation necessary.

Given colleagues are starting anti-platelet / secondary prevention even if > 60 this would suggest merit in coding


Add notes eg: mild-moderate LAD disease on angiogram
Click to select rele
QOF codes
Backdate to date of diagnosis (consider not back dating if not to target?)
Code CHD
Coronary artery disease (CAD)
Myocardial infarction codes
Ischaemia codes
Coronary Stent
Heart failure type (based on EF)
Coronary artery stenosis (X203e) (SNOMED: 233970002) QOF
Coronary atherosclerosis (XM0rN) (SNOMED: 443502000) QOF
Coronary artery atheroma (XSDT6) (SNOMED: 67682002) QOF

Back to first page – check LDL and BP to target, if not invite in




£69.18
BANKED
(future care and recall ensured)

FOR BONUS MARKS:

check not seen neurology /
had a CT head showing infarcts


On aspirin and statin that are unlikely to be indicated – STOP the aspirin
Cardiology letter states "normal coronaries"
Check CVA / TIA & PAD tabs to check for other CVD – also negative
Code "no significant history of CVD" to remove from report
Send pre-populated message about stopping aspirin and reviewing statin
Check ICE for CT head and small infarcts
rdiovascular disease
Notes and commentry
CHD
CVA / TIA
PAD
Exception reporting
coded cardiovascular disease
Target Health Solutions
commentary (last 3)
F registers
st pt possibly should be on one of the following registers
ations
mg dispersible tablets 05 Jan 2026 ONE to
tin 20mg tablets 05 Jan 2026 ONE to
reatment to target
-C or LDL-C NOT at target for secondary prevention
phy letters
letters
tters
Cardiology to Efford Medical Centre PL3 6JG
Cardiology to Laira Surgery PL3 6HG
Vascular letters
Discharge Summaries
ers"
rge Letters"
rgency Letter"
Add Coding
Code CVD excluded
No significant history of CVD
Code cerebral ischaemia
Coronary artery disease (CAD)
Myocardial infarction codes
Ischaemia codes
Coronary Stent
Heart failure type (based on EF)
PAD
t (Kg) 75 Kg
25.1
130 / mmHg
esterol 4.9
Triglyceride 2
HDL 1
LDL 3
Chol/HDL ratio 4.9
non-HDL Chol 3.9
HbA1C 32
eGFR (CKD-EPI) > 90
eGFR (MDRD)
ACR
EF %
Key actions
New problem /diagnosis
Msg: Anti-platelet without indic
Msg: stop AP, review statin
Messaging pre-sets
Pathology request
View Results on ICE
New Task
© Copyright Target Health Solutions 2019 - 2025

Dear <forename>,

You were previously investigated for chest pain, and while tests were being arranged you were started on aspirin and a statin. Your results later showed that your symptoms were not due to heart disease. At that point, these medicines should have been reviewed, but this did not happen. We apologise for this oversight.

We have now reviewed this carefully. As there is no coronary artery disease, the risks of continuing aspirin now outweigh any benefit, so we have stopped this for you. You can stop aspirin straight away. Aspirin slightly increases the short term risk of stomach irritation and bleeding, which is why we recommend stopping it.

Your statin is different. In many people, the benefits may still outweigh the risks, particularly if it has been well tolerated. This message is intended to help you understand the risks and benefits so you can decide whether to continue, reduce or stop your statin.

The risks of statins are small. The most notable risk is a small increase in the chance of developing diabetes, but for most people this does not outweigh the benefit. Statins work by lowering LDL cholesterol, often called bad cholesterol. The lower your LDL, the lower your future risk of heart attack or stroke.

To help you decide, we are asking you to use a simple online risk calculator at https://www.lpaclinicalguidance.com/

This allows you to see how stopping, reducing, or continuing a statin could affect your future risk of heart attack or stroke.

WHEN USING THE CALCULATOR PLEASE ENTER THE FOLLOWING INFORMATION. CHOLESTEROL UNITS ARE IN MMOL/L.

- Total cholesterol = 4.9
- LDL cholesterol = 3
- HDL cholesterol = 1
- Systolic blood pressure = 130
- Your height = 173cm

Target Health Solutions

Message apologises for not reviewing and stopping medication earlier but makes it clear no harm done. States Aspirin STOPPED

Discusses risks and benefits of statins and suggests the patient can make a judgement call about continuing or not

Provides a link to the Lp(a) calculator and their metrics so they can assess their life time CV risk and adjust LDLc to see what impact this has to help inform their decision

Messaging – greater detail

- The message is sent via email or letter
- Email goes with a questionnaire the patient can complete to indicate their preference for continuing / stopping statin
- Questionnaire returned with a score:

```
Pass to pharmacy team if > 0
```

How long does it take?

- Minutes per patient
- Hundreds of pounds, maybe even £1000 per hour
- Being done by a GP is likely fastest
- Summarises could pick off the easy cases but may need to defer some to GPs
- Volume of work is significant – we have 300 cases – 1% of our total capitation to review!

NEXT STEPS

Questions

James Boorer

www.targethealthsolutions.com

contact@TargetHealthSolutions.com

THS fully funded in Devon until 1/4/28

james.boorer@nhs.net & sian.lane@nhs.net
07866 482 545