

# Publication Report



## Quality & Outcomes Framework (QOF) of the new GMS contract

**Achievement, prevalence  
and exception reporting data 2010/11**

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## About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

**Purpose:** To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

**Mission:** Better Information, Better Decisions, Better Health

**Vision:** To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

## Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of 'Official Statistics'. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD's statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD's statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the [ISD website](#).

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

## Introduction

The Quality & Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract, introduced in 2004/05. The QOF measures a general practice's achievement against a set of evidence-based indicators, with payments made to practices on the basis of their achievements. Published here are Scotland's 2010/11 QOF data for individual general practices (GP surgeries) as well as figures at Scotland, NHS Board and Community Health Partnership level. This publication is in addition to QOF data already published and available on ISD's website for the previous six years (2004/05 to 2009/10).

The data presented include points achieved by each participating practice, overall and for individual QOF indicators and indicator groups, as well as crude prevalence rates for selected health conditions, drawn from QOF registers. The total QOF payment is shown for each practice with a standard GMS contract. (Approximately 87% of practices in Scotland had a GMS contract at the end of the 2010/11 QOF year). For practices with contract types other than a standard GMS one, the payment value is in some instances indicative, showing the amount that they would be paid for their QOF achievements if they were a GMS practice.

The release also includes information on exception reporting in 2010/11. Exception reporting allows practices to pursue the quality improvement agenda and not be penalised when, for example, patients do not attend for review or a medication cannot be prescribed due to a contraindication or side-effect. Exception reporting is a specialist area of the QOF and separate explanations of this are given on a page specifically covering this area.

The QOF is a major part of the GMS contract and the information published by ISD on the QOF is of interest to a wide variety of people and groups. Some examples of the ways in which QOF data are used are as follows:-

- NHS Boards and Community Health Partnerships can use various elements of the results (points achieved, QOF-reported prevalence of health conditions, proportions of patients for whom indicator success criteria have been achieved) to see how the practices in their areas fare compared to others, and use this in supportive quality improvement work together with practices.
- Practices and patients can use the published tables to see how the results for their practice compare broadly with those for other practices (although it can not simply be said that a practice with relatively lower points than other ones is automatically "worse" - see the 'Overall Achievement' section below for further interpretation).
- Government Health Departments and the British Medical Association (BMA) examine the QOF results in each UK country and take observed achievements into account when negotiating and agreeing changes to QOF indicators and payment calculations in successive years.
- The NHS, Government, GPs, academic researchers and others have used QOF data in a variety of research projects and in work to support health service planning.
- Data on the prevalence of specific diseases or health conditions are an important element of the QOF and are of interest to many people in Government, the NHS, academia and charities. For example, the QOF is the main source of data used for monitoring progress against a Governmental and NHS "HEAT" target for improving case-finding of patients with dementia.

## Key points

- The average number of points achieved by GMS practices increased from 972.2 in 2009/10 to 976.3 in 2010/11 out of a maximum of 1,000 points in each year.
- The largest increase in points achieved for a group of indicators was in the Depression indicator group which showed an increase in average achievement of 1.4 points, from 45.4 to 46.8, out of a potential achievement of 50.
- The average QOF payment to a GMS practice for 2010/11 was £132,592. This was up slightly from £130,778 in 2009/10.

## Results and Commentary

### Missing Data

There are a few groups of practices who, although they take part in QOF, have part or all of their data excluded from this publication. These groups and the reasons why their data are excluded are described below.

There is no achievement or payment data published for any of the 8 practices with a 17C contract in NHS Grampian as these practices use only a subset of the GMS QOF indicators in their own quality work. However, data from these practices are included in the prevalence tables. As outlined in detail below in the 'Overall Achievement' section, the QOF is part of the GMS contract (the main contract type for general practices) and practices with other contract types may choose not to use the QOF at all, or use only parts of it.

A number of practices in NHS Lothian changed their practice software system in 2010/11 or early 2011/12. Because of this, the data submitted from the software system to calculate achievement and payment for 34 of these practices was incomplete. This meant that the achievement and payment calculated were lower than expected. An agreement was reached between the board and the practices concerned that these practices would receive payment based on an average of their achievement scores from the previous 3 years. As a result this publication shows only practice level achievement and payment data for these practices since there are no data available at individual indicator level. No prevalence data for these practices are published.

Since prevalence data are missing for such a large number of practices, care should be taken when interpreting the prevalence and, in particular, the register sizes of individual conditions for NHS Lothian and Scotland. This is particularly relevant when comparing this year's prevalence and register size data to those from previous years since data for this year are based on fewer practices.

In NHS Highland, 6 practices changed their software system in 2010/11 causing a similar problem with data submission. For these 6 practices a local agreement was reached between the board and practices concerned regarding payment meaning that no achievement and payment data are available for these at any level. However, for the majority of conditions, prevalence data are available for these practices.

### Overall achievement

Amongst Scottish general practices with a standard GMS contract type, the average number of QOF points achieved in 2010/11 was 976.3 (out of a maximum of 1000). 97.7% of GMS practices had a total achievement of at least 900 QOF points and 88.7% of practices had an achievement of at least 950 QOF points. Overall, the average number of points achieved in 2010/11 shows a slight increase from the 2009/10 average of 972.2 points. Each year the QOF is subject to formal review and as a result new indicators can be introduced and existing indicators dropped or re-defined. Achievement tends to be lower for newly introduced indicators whilst achievement for established indicators tends to increase year upon year. As a result increases in some areas are offset by relatively lower achievement for newly introduced indicators. In 2009/10, a number of new indicators were introduced and some existing ones revised. As there were no further changes in 2010/11,

an increase in achievement for the new indicators that were introduced in 2009/10 would be expected as they become more established.

Whilst individual practices may not achieve full points for every QOF indicator because they have genuinely not been able to meet some or all of the requirements for that indicator, it can not simply be said that a practice with relatively lower points than other ones is automatically "worse". There may be other reasons for apparently lower levels of achievement against the QOF. These include the following:

- Participation in the QOF is voluntary; practices may aspire to achieve all, some, or none of the points available (currently a maximum of 1,000). In particular, some practices that do not have a standard GMS contract may only record QOF data for selected indicators and have separate, locally tailored quality frameworks to cover other aspects of the care that they provide. The contract type of individual practices is given in the publication data tables; "17C" indicates that the practice has a tailored, locally agreed contract with their NHS Board, whilst "2C" usually indicates that the practice is run by the NHS Board and therefore collates QOF information chosen by the Board.
- Whilst most Scottish general practices with GMS contracts have participated fully in the QOF, it is important to note that for some of them it may be impossible to achieve all of the points available in the framework. For example, some of the clinical indicators relate to very specific subgroups of patients, and if the practice does not have any patients in that particular subgroup, they can not score any points against the relevant indicator(s). This is more likely to happen in very small practices, which are more common in the remote and rural areas of Scotland.

### **Achievements within indicator groups**

For practices with a GMS contract, 27 out of the 30 QOF indicator groups had an overall achievement against available points of over 95%. Of the indicator groups comprised of two or more indicators, the highest percentage of points achieved for an indicator group was for Hypothyroidism, which had achievement of 99.9%. This condition, a failure of the thyroid gland to function properly, has been included in the QOF since its first year, 2004/05.

For practices with GMS contracts, the lowest proportion of points achieved was in the depression indicator group, at 88.3%. This is up from 85.6% for the depression indicator group in 2009/10. The lower figure for 2009/10 reflects the fact that a new indicator, DEP03, was introduced that year and achievement for this would be expected to increase in subsequent years as the indicator becomes more established. This indicator is designed to reward practices for good practice in reducing the early cessation of treatment for depression. Across Scotland, GMS practices achieved on average 68.4% of the 20 points available for the DEP03 indicator in its first year of inclusion in the QOF, increasing to 75.3% in 2010/11.

Amongst GMS practices, the palliative care indicator group had the largest overall increase in the percentage of available QOF points achieved between 2009/10 and 2010/11. The overall percentage of available points achieved for the palliative care indicators rose from 95.3% in 2009/10 to 98.0% in 2010/11. It should be noted, however, that the palliative care indicator group only has a maximum achievement of 6 points. The second highest increase in percentage achieved for an indicator group was in depression (as described

above), from 85.6% to 88.3%. This percentage increase is relevant to a total of 53 points available for each practice for depression indicators.

Amongst GMS practices, the overall percentage of available points achieved for the patient experience indicators rose from 91.8% in 2009/10 to 92.5% in 2010/11. This increase is down to an improvement in achievement in PE08, one of the two indicators around access to practices (PE07 and PE08):

- PE08 showed improvement between the two years (up from 80.2% of available points to 82.2%). PE08 measures, for a sample of patients in each practice, "The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead".
- PE07 indicates the percentage of surveyed patients who said they could get an appointment with their practice within 48 hours of requesting one. As recent historical targets have focussed in particular on patients being able to gain access to a member of the practice clinical team within 48 hours (subject to clinical need), on the whole practices have tended to achieve higher scores against this indicator than for PE08. However, though this remains the case, there has been a slight decrease in percentage achieved this year when compared to last (from 98.0% of points in 2009/10 to 97.7% of points in 2010/11).

PE07 and PE08 indicator achievement is based for each practice on results of the GP Patient Experience Survey. This survey was sent to a random sample of patients registered with 161 GP practices in Scotland that opted into the survey. For other practices, the results from the 2009/10 survey have been used. The results of this survey were published earlier in 2011 on the Scottish Government website at <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPAccessSurveyResults>

## Payments

The average QOF payment to a GMS practice for 2010/11 was £132,592. This is up slightly from £130,778 in 2009/10. Total QOF funding to practices in Scotland for the 2010/11 year was approximately £130 million, compared to roughly £129 million in 2009/10. QOF payments are part of a total of around £682 million invested annually in Primary Medical Services across Scotland.

The rules for calculating QOF payments are explained in detail in the "General Medical Services Statement of Financial Entitlements" documents published by the Scottish Government (links to these are provided in the Links section of ISD's [QOF web pages](#)).

## Prevalence

### Overview

Prevalence is a measure of the frequency of a disease or health condition in a defined population at a particular point in time (and is different to incidence, which is a measure of the number of newly diagnosed cases in a defined population during a particular time period). Data on the prevalence of specific diseases or health conditions are an important element of the QOF and are of interest to many people.

Prevalence data within the QOF are collected in the form of practice "registers". A QOF register may count patients with one specific disease or condition, or it may include multiple conditions. There may also be other criteria for inclusion on a QOF register, such as age or time of diagnosis.

This publication contains prevalence information at Scotland, Board, Community Health Partnership (CHP) and individual practice level.

Reported QOF prevalence rates for Scotland changed little between 2009/10 and 2010/11. It should be noted that any comparison of QOF-reported prevalence rates between 2009/10 and 2010/11 should be treated with caution because of the difference in the number of practices with valid prevalence data in each year – see 'Missing Data' section above for more details. More caveats to comparing prevalence data across years are described in the 'Notes on interpretation of QOF prevalence figures', below.

The main change in reported prevalence rates was for 'obesity' which increased from 7.0% to 7.7% from 2009/10 to 2010/11. These figures are far lower than the generally accepted rates (for example the 2009 Scottish Health Survey reported that 26.8% of men and 26.4% of women aged over 16 years were obese). Since many of those who are obese are not recorded on practice registers, the increase in the QOF prevalence of obesity for 2010/11 is likely to be due to improvements in the ascertainment of obesity within practices rather than any real increase.

The overall QOF-reported crude prevalence rate (for all practices) of 'new diagnosis of depression' increased from 8.6% to 9.0%. However, this increase was expected. The register for 'new diagnosis of depression' is cumulative since it measures all diagnoses of depression recorded in a practice clinical IT system (excepting those subsequently recorded as being resolved).

The QOF prevalence rate for dementia rose from 0.6% to 0.7% between 2009/10 and 2010/11. QOF dementia register data are the primary source used to measure the dementia HEAT target. The target is to increase the number of people with a diagnosis of dementia to 39,578 by March 2011. The performance measure used for this target is the number of people with a diagnosis of dementia on QOF dementia registers and other equivalent sources. This figure was 35,816 in 2009/10 and increased to 40,195 in 2010/11, an increase of 12.2 percent.

Further information on HEAT targets can be found on the Scotland Performs section of the Scottish Government website at <http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance>

## Notes on interpretation of QOF prevalence figures

QOF prevalence data should be used and interpreted with caution. The main points to note are as follows:-

- QOF prevalence rates are "raw" or "crude" rates per 100 registered patients - which means that they are not adjusted to account for differences between practice populations in their age or gender profiles, or other factors that influence the prevalence of health conditions (such as deprivation). A QOF prevalence rate is simply the total number of patients on the register, expressed as a proportion or percentage of the total number of patients registered with the practice (the practice list size) at one point in time. This means, for example, that an apparently higher prevalence of age-related conditions such as cancer or stroke in a particular practice might simply be due to it having an older patient age profile.
- Some QOF registers are restricted to persons over a specific age. However, the QOF prevalence rates use as their denominator the total (all ages) number of patients registered with the practice at one point in time. Diabetes registers are based on patients aged 17 and over; epilepsy, chronic kidney disease and learning disabilities registers are based on patients aged 18 and over; and obesity registers are based on patients aged 16 and over. This means that for these conditions the QOF-reported prevalence will appear lower than would be the case if the age restriction was also applied to the population denominator.
- Prevalence figures based on QOF registers may also differ from prevalence figures from other sources because of coding or definitional issues. For example, to be on the QOF diabetes register the type of diabetes (type 1 or type 2) must be specified by the practice. If the type is not specified the patient will not be counted in the register. Information on diabetes as reported elsewhere may not be subject to these restrictions.
- Year-on-year changes in the size of QOF registers may be influenced by various factors including:- demographic changes (such as an ageing population); improvements in case finding by practices; changes over time in the definition of the registers; and changes in the number of practices, and therefore the population, that the registers are drawn from.

These points are addressed in more detail within our web page containing [Information for users of QOF register and prevalence data](#).

## Choice of QOF prevalence data tables

In this publication, two types of data tables are available showing QOF prevalence information for Scotland, by Board and by Community Health Partnership (CHP). These are

1. for GMS practices only and
2. for practices with any contract type

The QOF is part of the GMS contract and so practices with other contract types are not automatically expected to take part in it. Non-GMS practices also vary considerably in the extent to which they use parts or all of the QOF and so sometimes individual practices have data available for individual QOF registers and sometimes they do not. Either version of the data files is valid for QOF-reported prevalence rates, but non-specialist users of this information may prefer to select the all contract types versions of the files since they give larger and more complete counts of patients on QOF registers.

## Exception Reporting

This publication incorporates a range of information on QOF exception reporting in Scotland for 2010/11. An introduction to this technical sub-topic of the QOF, how the data are presented, and some commentary on the figures, is provided within a separate Questions & Answers document prepared to accompany these statistics. This document, the results graphs and data tables are all available on our web page [2010/11 Exception Reporting](#).

## Glossary

### 2C practice:

In general terms, this is most likely to mean that the practice is run by the NHS Board (rather than by GPs and/or other partners, as is the case for practices with 17C or 17J contract types). With effect from 1st April 2004, The Primary Medical Services (Scotland) Act 2004 amended The National Health Service (Scotland) Act 1978 by placing a duty on NHS Boards to provide or secure 'primary medical services' for their populations. NHS Boards can do so by making arrangements with 17C and/or 17J practices (see below). Additionally they can arrange for services to be provided directly (this is known as 'direct provision') or via another organisation (this is known as a 'Health Board Primary Medical Services' contract). These additional options are included under Section 2C of the 1978 Act. Approximately 4% of Scottish general practices are of "Section 2C type".

2C practices may use part of, or all of, the standard GMS QOF as a measurement tool when conducting their own quality and outcomes work. Where 2C practices do record data for QOF indicators, they may record data for some of the indicators and not others. This means that what might appear to be a "low" QOF achievement for some of these practices may simply reflect only some of the QOF indicators being used in this practice.

### 17C practice:

A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances. Section 17C is in respect of The National Health Service (Scotland) Act 1978, as amended under The Primary Medical Services (Scotland) Act 2004. Approximately 9% of Scottish general practices operate under a "Section 17C" contract.

17C practices may use part of, or all of, the standard GMS QOF as a measurement tool when conducting their own quality and outcomes work. Where 17C practices do record data for QOF indicators, they may record data for some of the indicators and not others. This means that what might appear to be a "low" QOF achievement for some of these practices may simply reflect only some of the QOF indicators being used in this practice.

Additional services domain:	Comprises indicators on cervical screening, child health surveillance, maternity services and, until 2008/09, contraceptive services. In 2009/10 the contraceptive services indicators were replaced with new sexual health indicators.
Adjusted Disease Prevalence Factor (ADPF):	During calculation of QOF payments, the baseline number of pounds per point (£127.28 in 2010/11) is adjusted up or down within each clinical domain area according to each practice's prevalence for that disease or condition, relative to the estimated national prevalence. The amount by which the payment is adjusted up or down is known as the Adjusted Disease Prevalence Factor (ADPF).
CHD:	Coronary Heart Disease
CKD:	Chronic Kidney Disease
Clinical Domain:	The clinical domain is the largest element of the QOF. Within it are a series of indicators relating to processes and outcomes in relation to a range of health conditions such as diabetes, COPD and Coronary Heart Disease. The clinical indicator set has been subject to a series of changes, as outlined in our most recent QOF publication, available via our general practice publications page. In 2004/05 and 2005/06 the domain comprised 76 indicators in 10 areas. From 2006/07 to 2008/09 the domain comprised of 80 indicators in 19 areas. Indicators included asthma, atrial fibrillation, cancer, coronary heart disease, COPD, chronic kidney disease, dementia, depression, diabetes, epilepsy, heart failure, hypertension, hypothyroidism, mental health, palliative care, conditions assessed for smoking, stroke, learning disabilities and obesity. In 2009/10 indicators measuring achievement against primary prevention of cardiovascular disease were added as well as there being some small changes to existing indicator areas. As a result of these changes, for 2009/10 and 2010/11 there are 86 indicators in 20 areas.
COPD:	Chronic Obstructive Pulmonary Disease
CVD:	Cardiovascular Disease
Denominator:	The indicator denominator is the total number of patients who could have achieved a quality target (while the numerator is the count of those who actually did). The denominator (where applicable) counts the number of patients in the practice who were included in the measurement of that particular QOF indicator. Denominators for clinical indicators are subsets of the

relevant registers, with some patients excluded due to the indicator definition, and some patients exception reported on the basis of defined criteria.

- Domain: There are 4 domains within the QOF; Additional Services, Clinical, Organisational and Patient Experience. Each domain consists of a set of indicators, against which practices score points according to their level of achievement.
- Exceptions/Exception reporting: Patients who are on the disease register, and fall within the indicator definition, but are not included in the calculation of a practice's achievement against that indicator. Reasons why a patient might be exception reported include - the treatment not being clinically appropriate for the patient, the patient not attending for treatment, the patient refusing to have the treatment, or the patient only having been diagnosed/registered with the practice very recently.
- Exception rate: The number of patients exception-reported as a percentage of the number of people eligible to be included in the indicator denominator. This is calculated as:  $\text{exceptions}/(\text{exceptions}+\text{denominator}) \times 100$ .
- Exclusions: Patients who are included on a particular register, but for who for definitional reasons, cannot be included in a specific QOF indicator denominator. For example, an indicator may refer only to patients of a specific age group, patients with a specific status (such as those who smoke), or patients with a specific length of diagnosis.
- Exclusion rate: The number of patients excluded from the indicator, as a percentage of the number of people eligible to be included in the indicator denominator. This is calculated as:  $\text{exclusions}/(\text{exclusions}+\text{exceptions}+\text{denominator}) \times 100$ .
- GMS practice (17J practice): A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract. Within this, there is some local flexibility for GPs to opt out of certain services (such as additional services) or opt in to the provision of other services (such as enhanced services). Section 17J is in respect of The National Health Service (Scotland) Act 1978, as amended under The Primary Medical Services (Scotland) Act 2004. This is the main, generic type of contract for general practices in Scotland. Approximately 87% of Scottish general practices operate under a new GMS contract. The new GMS contract was introduced on 1st April 2004. The QOF is a voluntary, but nonetheless major part of the new GMS contract.

Holistic care points:	In the first four years of the QOF (2004/05 to 2007/08 inclusive) holistic points were awarded to practices according to the consistency with which they had achieved across the clinical domain. Holistic care points were dropped from the QOF from 2008/09 onwards and the points redistributed to other/new indicators.
Incidence:	a measure of the number of newly diagnosed cases within a particular time period
LVD:	Left Ventricular Dysfunction
National Prevalence Day:	The national prevalence estimate used in the payment calculations is based on prevalence data recorded in the payment calculation system (QOF Calculator for 2010/11, QMAS in previous years) as at a date referred to in the QOF as 'National Prevalence Day'.
Numerator:	An indicator numerator counts the number of patients in the indicator denominator for whom the indicator success criteria were met. For example, in an indicator relating to influenza vaccinations for patients with particular conditions, it counts the number of vaccinations given to patients with that particular condition.
Organisational domain:	Comprises indicators on records & information, patient communication, education & training, practice management and medicines management.
Patient experience domain:	Comprises indicators such as patient experiences when trying to make an appointment with the practice.
Prevalence:	A measure of the burden of a disease in a population at a particular point in time. When reported through QOF, prevalence is calculated as the total number of patients on the disease register, expressed as a proportion or percentage of the total number of patients registered with the practice.
PP-CVD:	Primary Prevention of Cardiovascular Disease
QMAS:	Quality and Outcomes Framework Management and Analysis System: the national QOF calculation database in use between 2004/05 and 2009/10
QOF:	Quality & Outcomes Framework
QOF Calculator:	The national QOF calculation database in place from 2010/11
Register:	A 'register' of patients in a practice for inclusion in a specific clinical indicator group. A register may count

patients with one specific disease or condition, or it may include multiple conditions. There may also be other criteria for inclusion on a register, such as age or date of diagnosis.

TIA:

Transient Ischaemic Attack

## List of Tables

Data table page	Number of data files	Time period	File type & size(s)
<a href="#">Achievements data tables at Scotland and NHS Board Level</a> *	6	Year ending March 2011*	Excel [28kb – 380kb]
<a href="#">Achievements data at Community Health Partnership (CHP) level</a> *	5	Year ending March 2011*	Excel [35kb - 800kb]
<a href="#">Achievements data at practice level – summaries</a> *	22	Year ending March 2011*	Excel [231kb - 285kb]
<a href="#">Achievements data practice level - individual indicators</a> *	37	Year ending March 2011*	Excel [0.2mb – 5.7mb]
<a href="#">Register and prevalence data at Scotland, NHS Board and CHP level</a> *	5	Year ending March 2011*	Excel [0.2mb – 1.3mb]
<a href="#">Scotland Performs - Dementia data for HEAT target</a>	1	Year ending March 2011	Excel [38kb]
<a href="#">Exception reporting in clinical indicators</a> *	36	Year ending March 2011*	Excel [43kb – 4.3mb]

Apart from the “Scotland Performs” dementia figures, data files are not listed individually in the table above due to the large number of individual files involved (over 100, plus a range of further Excel and PDF files containing supplementary reference information). Instead, six of the seven links provided in the table above lead to web pages from which individual data files may be accessed.

Please note that for some of the data files you may need to allow Excel to “enable macros” in order for the files to open and work correctly.

\*Where data table page names and time periods are marked with an asterisk (\*), this indicates that equivalent tables for earlier years are also available on the QOF area of ISD’s website. To access these earlier data tables and other information related to the QOF, go to <http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/>

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## Further Information

Further information can be found on the [ISD website](#)

## Appendix

### A1 – Background Information

#### Primary Medical Services, the new GMS contract, and QOF

Below is a brief summary of the wider context for the Quality & Outcomes Framework. It is essential that published QOF results are interpreted carefully in the context of the contracting arrangements of individual practices. In particular, practices with contract types "17C" and "2C" may only use some of the QOF indicators and thus may not appear to achieve as many points as other practices who use all of the QOF indicators.

#### Primary Medical Services

With effect from 1st April 2004, The [Primary Medical Services \(Scotland\) Act 2004](#) amended The National Health Service (Scotland) Act 1978 by placing a duty on NHS Boards to provide or secure 'primary medical services' for their populations. NHS Boards can do so by providing services directly (this is known as 'direct provision' Section 2C of the 1978 Act) or by making arrangements (by 'contract' or 'agreement') with a range of 'providers' through:

- a 'GMS' (General Medical Services - Section 17J of the 1978 Act) contract - nationally negotiated with some local flexibility for GPs to 'opt out' of certain services or 'opt in' to the provision of other services
- a 'Section 17C' (formerly known as 'Personal Medical Services' or 'PMS') agreement - locally negotiated agreements which are more flexible in accordance with local circumstances
- a 'Health Board Primary Medical Services' contract (Section 2C of the 1978 Act) - the NHS Board can, in certain circumstances, make arrangements with, for example, a non-NHS organisation for the provision of NHS services.

Within the in-hours period (i.e. the hours when practices are normally open to patients), the majority (approximately 87%) of general practices in Scotland have a new GMS contract. The largest proportion of the remainder is made up of Section 17C Schemes, with a small number of services provided under 'direct provision'. In the out of hours period (e.g. night-times), 'direct provision' (section 2C) is the predominant model.

#### The new GMS contract

The new GMS contract, implemented throughout the United Kingdom since 1st April 2004, was the product of negotiations between the British Medical Association's (BMA's) General Practitioners Committee and the NHS confederation. The new contract was introduced to support the ongoing development of primary care, and to give greater flexibility in how general practices deliver patient care, and are paid. A fundamental component of the new GMS contract is a system of financial incentives for delivering clinical and organisational quality - the Quality & Outcomes Framework (QOF). Further information on the QOF and the new GMS contract is available via the [nGMS contract pages](#) of the NHS Scotland Pay Modernisation website and on the [Primary Care Contracting](#) pages of the NHS Employers website.

### **The Quality & Outcomes Framework for practices with new GMS contracts**

The QOF, although fundamental to the new GMS contract, is nonetheless a voluntary part of it; general practices can aspire to achieve all, part, or none of the points available in QOF. Whilst, to date, most GMS practices in Scotland have participated fully in the QOF, it is important to note that for some practices it may be impossible to achieve all the points available in the framework. For example, some of the clinical indicators relate to very specific subgroups of patients, and if the practice does not have any patients in that particular subgroup, they cannot score any points against the relevant indicator(s). This means that it is not necessarily possible for all practices to achieve a full 'score' against the QOF.

Additionally, practices with section 2C or 17C agreements may choose to participate in the QOF (see below).

### **Quality & Outcomes Framework data for practices with 17C or 2C agreements**

Section 17C or 2C schemes include quality and outcomes as part of their locally negotiated agreements, and in many cases, they opt to use part or all of the new GMS QOF as a measurement tool. However, it is possible to tailor the quality and outcomes requirements of a Section 17C or 2C agreement in accordance with local circumstances - such as the needs of a particular group of patients - and, again, subject to local agreement. Such practices might use quality measures that, although rigorous and appropriate, are not identical to those used in the GMS QOF. Therefore, although 17C/2C practices may record full QOF data if they wish, they may deliberately use only part of the QOF, or may not use it at all.

This means that practices with contract types '17C' and '2C' may sometimes not appear to achieve as many points as other practices who use all of the QOF indicators.

## Summary of available QOF points and pounds, 2010/11

The QOF measures a general practice's achievement against a scorecard of evidence-based indicators. These indicators span four domains: clinical, organisational, patient experience and additional services. In 2010/11, practices could score up to a maximum of 1,000 points across 134 indicators. The distribution of these points between the four domains is shown in the table below. This and equivalent information for previous QOF years (2004/05 – 2009/10) is also available on our web page [Summary of available QOF points and pounds, by domain and year](#).

### QOF points and payments available to practices, 2010/11

Domain	Number of indicators	Total points available	Pounds per point
Clinical	86	697	Variable
Organisational	36	167.5	£127.28
Patient Experience	3	91.5	£127.28
Additional Services	9	44	Variable
Total	134	1000	

Notes:

1. £127.28 per point is inclusive of employers' superannuation payments.
2. Within the Clinical domain, the baseline payment per point is adjusted up or down for each practice according to an "Adjusted Disease Prevalence Factor" (ADPF) value derived from the QOF register applicable to each individual indicator. More detail on this is given on our web page containing [Information for users of QOF register and prevalence data](#).
3. Within the additional services domain, the baseline payment per point is adjusted up or down for each practice according to the number of patients within the target population for each additional service type, relative to the national average target population size for that additional service.
4. The initial calculated payment for clinical, organisational and patient experience domains, as well as the additional payment point areas, are added together to give the total "raw" payment for the practice. This "raw" payment is then adjusted up or down according to the list size of the practice (i.e. the number of patients registered) relative to the national average size (set at 5170 patients for 2010/11).

**The four QOF domains cover the following areas:**

- The clinical domain is the largest element of the QOF. Within it are a series of indicators relating to processes and outcomes in relation to a range of health conditions such as diabetes, COPD and Coronary Heart Disease. The clinical indicator set has been subject to a series of changes over the years, as outlined in two of our web pages: [Summary of available clinical domain points, by year](#) and [Revisions to the QOF, by year](#). There have, however, been no changes in the indicator set between 2009/10 and 2010/11.
- The organisational domain comprises indicators on records & information, patient communication, education & training, practice management and medicines management.
- The patient experience domain comprises indicators on patient survey, patient access and consultation length.
- The additional services domain for 2010/11 comprises indicators on cervical screening, child health surveillance, maternity services and sexual health.

## Summary of available clinical domain points, 2010/11

The proportion of the QOF that is taken up by clinical indicators has increased since it was first introduced in 2004/05. In 2010/11, 697 of 1,000 points available were in the clinical domain. The table below shows how the clinical domain points were split between clinical indicator groups in 2010/11. This and equivalent information for previous QOF years (2004/05 – 2009/10) is also available on our web page [Summary of available clinical domain points, by year](#). Further information on the changes to the clinical domain and other parts of the QOF for previous years are summarised on our web page [Revisions to the QOF, by year](#).

### Points available to practices 2010/11, by clinical indicator group

Clinical indicator area	Number of indicators	Total points available
Asthma	4	45
Atrial Fibrillation	3	27
Cancer	2	11
CHD (Coronary Heart Disease)	10	87
CKD (Chronic Kidney Disease)	5	38
COPD	5	30
Cardiovascular Disease - Primary Prevention	2	13
Dementia	2	20
Depression	3	53
Diabetes Mellitus	17	100
Epilepsy	4	15
Heart Failure	4	29
Hypertension	3	81
Hypothyroidism	2	7
Learning Disabilities	1	4
Mental Health	6	39
Obesity	1	8
Palliative Care	2	6
Conditions assessed for smoking	2	60
Stroke & Transient Ischaemic Attack	8	24
Total	86	697

## Key stages in the QOF process

This section provides a summary of the key stages in the QOF process. Further details can be found:

- within the [General Medical Services Statement of Financial Entitlements for 2010/11](#) published by the Scottish Government
- In the [Quality and Outcomes Framework Guidance for GMS Contract 2009/10](#) (this remains unchanged for 2010/11).
- on the NHS Scotland Pay Modernisation website, within chapter 3 of the document [Implementing the nGMS contract in Scotland](#)

The QOF reflects a voluntary cycle of continuous quality improvement in standards of patient care. This requires practices and NHS Boards to:

- plan - work out how many of the QOF points available it is realistic to aspire to, and specific ways to deliver care using the available resources
- act - deliver high quality services and record achievement on practice systems
- assess - calculate QOF points and payments
- learn - reflect on how quality of care and points scores could be improved for the next year

Key stages in the annual QOF process are:

- Monthly aspiration payments to practices. These payments provide in-year financial support against likely QOF achievements. Where a practice has not previously participated in the QOF (as was the case for all practices in 2004/05), aspiration levels were based on assessments by practices (with approval required from NHS Boards) as to how many of the available QOF points it can realistically achieve. For subsequent years, aspiration payments are based on likely practice achievements against the QOF based on previous performance; more details on how this is done are available within the following documents, all published by the Scottish Government:
  - [General Medical Services Statement of Financial Entitlements for 2006 onwards](#)
  - [General Medical Services Statement of Financial Entitlements for 2007](#)
  - [General Medical Services Statement of Financial Entitlements for 2008](#)
  - [General Medical Services Statement of Financial Entitlements for 2009](#)
  - [General Medical Services Statement of Financial Entitlements for 2009/10](#)
  - [General Medical Services Statement of Financial Entitlements for 2010/11](#)
- Delivery of high quality primary care services and recording of information to support QOF assessment. Through the year, practices enter information to support the ongoing care of patients into their practice clinical systems. Information not directly required for clinical care, but required to support the QOF (e.g. the organisational and patient experience domains), is input manually to the national QOF calculation database, "QOF Calculator". During the latter part of each financial year, QOF Calculator receives aggregated data from the practice clinical systems, in order to calculate achievement points and payments. Each practice has a responsibility to ensure that its QOF data are properly recorded.
- Calculation and sign-off of achievement points and payments. Achievement points and payments are calculated automatically within QOF Calculator. Details of how all the calculations are made, with worked examples, are provided in chapter 3 of the

document [Implementing the nGMS contract in Scotland](#). Practices and NHS Boards review what has been calculated, with NHS Boards required to confirm and sign-off all achievement payments before they are made. In many instances in the first years of the QOF, sign-off was completed within the April following the QOF year (end of year QOF reports are as at 31st March). However, the process of sign-off can be complicated and time-consuming so increasingly NHS Boards have taken extra time as allowed in published Statements of Financial Entitlements, to verify and sign-off practice data by the end of June in each year. During the process of data verification, parts of the data for some practices may need amendment to give an accurate reflection of their achievements before the final points and payments are agreed and signed off. Even after the main sign-off period, elements of data for some practices remain under discussion, and there are formal mechanisms in place for addressing such issues as they arise.

The payments published within these web pages are the total QOF payments for the year, which include both aspiration payments and additional payments required once final achievement against the QOF is assessed.

The data published within these web pages include achievements for all practices whose points and payments were formally signed off (or otherwise indicated by NHS Boards as being finalised) by the dates indicated alongside the relevant tables (18th July 2011 in the case of the 2010/11 data). Details may still be subject to subsequent revision locally.

## A2 – Publication Metadata (including revisions details)

Metadata Indicator	Description
Publication title	Quality & Outcomes Framework (QOF) of the new GMS contract. Achievement, prevalence and exception reporting data 2010/11
Description	Information on QOF points achieved, total QOF payments, QOF register and prevalence information, and exception reporting data.
Theme	Health and Social Care
Topic	General Practice
Format	Excel workbooks, PDF files, one Word file.
Data source(s)	QOF Calculator, plus notifications from NHS Boards of local adjustments to data
Date that data are acquired	Data extract taken on July 18 <sup>th</sup> 2011. This was then validated and amended to reflect local adjustments, as notified by NHS Boards. Finalised data file available late August 2011.
Release date	27 <sup>th</sup> September 2011
Frequency	Annual
Timeframe of data and timeliness	Data for the year ending March 2011. Normal timeliness for this publication. Practices and NHS Boards sign off the QOF data for payment during the period April to June each year therefore a final national dataset is not available prior to July. Further work to validate the data for publication is done during July and August.
Continuity of data	Continues directly on from earlier publications of data from 2004/05 onwards
Revisions statement	These data are not subject to planned major revisions. There may be minor revisions to already published statistics in future editions of this publication in the event that any underlying errors in the data sources are found and corrected.
Revisions relevant to this publication	None
Concepts and definitions	These are explained further in this document, in the Glossary and Appendix A1. Additional detail is given in footnotes to individual Excel workbooks
Relevance and key uses of the statistics	Making information publicly available for planning, provision of services, research.
Accuracy	<p>QOF data are collected as part of practices' contractual agreements and are subject to payment verification processes, carried out by the respective NHS Board for each practice, both prior to and after payment. Therefore, the data presented will have an excellent degree of accuracy since they represent figures corresponding to verified practice payment. Any non-verified data are removed from analysis and it is up to the individual boards to inform ISD of these. More details on the QOF payment verification process can be found here <a href="http://www.sehd.scot.nhs.uk/publications/DC20111020payverif.pdf#page=19">http://www.sehd.scot.nhs.uk/publications/DC20111020payverif.pdf#page=19</a></p> <p>Occasionally there may be technical or other problems with individual</p>

	<p>practice data submissions which can mean that the finely detailed data here may undercount or over-count the numbers of patients falling into a particular category. This may in turn have an impact on the accuracy of the aggregate information presented, although typically the impact will be small at Board or Scotland level. Any erroneous data will be removed from analysis wherever possible, after either notification of a known problem from the NHS Board or through cross-checks on the data carried out by ISD, but it may be that a small amount are missed.</p>
Completeness	<p>Virtually all general practices in Scotland collect at least some QOF data. Summary tables such as those showing total payments and achievements include data from around 98% of Scottish practices.</p> <p>In 2010/11 there were problems with data submissions from a number of practices in NHS Lothian and NHS Highland meaning that indicator level and prevalence data are available from fewer practices than in previous years. Also, as in previous years, individual practices (particularly those that do not operate under a standard GMS contract) vary in the extent to which they collect data for all of the individual QOF indicators. Furthermore, issues with the accuracy of data submissions for a small number of practices in each year can mean that the data for these practices are excluded from the publication (for example if there were technical problems with the data submission process). This means that there are variations in the numbers of practices included in individual data tables. Information on the numbers of practices included in each analysis is given in the data tables.</p> <p>As individual data tables are based on data from varying numbers of practices (and variations may exist from year to year as well as between individual tables for the same year) direct comparisons of counts of patients in particular groups may not always be possible. However, direct comparisons of percentages or rates can be made for equivalent registers, indicators or indicator groups.</p>
Comparability	<p>Scottish QOF information is for the most part closely comparable with QOF information for the other UK countries. Any variations between the countries are generally in terms of the fine details of indicator or rules definitions. For example the age range of women covered by the cervical screening indicators is not exactly the same for every individual country.</p> <p>The QOF is specific to the UK and therefore the information shown here is not directly comparable with any apparent equivalents for other countries.</p>
Accessibility	<p>It is the policy of ISD Scotland to make its web sites and products accessible according to <a href="#">published guidelines</a>.</p>
Coherence and clarity	<p>Tables and charts are accessible via the ISD website at: <a href="http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/">http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/</a></p>
Value type and unit of measurement	<p>Numbers and percentages. Shown for individual practices, Community Health Partnerships, NHS Boards and Scotland</p>
Disclosure	<p>The <a href="#">ISD protocol on Statistical Disclosure Protocol</a> is followed.</p>
Official Statistics	<p>National Statistics</p>

designation	
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Help email	<a href="mailto:nss.isdGeneralPractice@nhs.net">nss.isdGeneralPractice@nhs.net</a>
Date form completed	10 September 2011

## **A3 – Early Access details (including Pre-Release Access)**

### **Pre-Release Access**

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

#### **Standard Pre-Release Access:**

Scottish Government Health Department  
NHS Board Chief Executives  
NHS Board Communication leads

#### **Extended Pre-Release Access**

Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

Scottish Government Health Department (Analytical Services Division)

#### **Early Access for Quality Assurance**

These statistics will also have been made available to those who needed access to help quality assure the publication:

NHS Board Primary Care Leads and QOF Leads / QOF payment verification staff