Publication Report

Quality and Outcomes Framework

Prevalence, achievement, payment and exceptions data for Scotland, 2014/2015

Publication date – 13 October 2015

A National Statistics Publication for Scotland

Contents

Background

The Quality & Outcomes Framework (QOF) is one of the main sources of potential income for General Practices across the UK. It is a major part of the General Medical Services (GMS) contract, introduced on 1st April 2004. The QOF measures a General Practice's achievement against a set of evidence-based indicators designed to promote good practice. Payments are made to each General Practice on the basis of their level of achievement against those indicators.

This release provides information on 2014/15 QOF data. Included data are: an estimate of the percentage of the Scottish population recorded with selected health conditions; the number of points achieved by participating practices, the number of points achieved for individual QOF indicators and indicator groups; and the total QOF payments. QOF is an important source of data to estimate the percentage of people with particular chronic conditions.

Key points

- Hypertension was the most prevalent symptom in the clinical indicator group (13.9%). This figure is similar to previous years.

- The permanent retirement of number of indicators resulted in a reduction in total available QOF points from 923 to 659.

- The average QOF payment to a practice with a General Medical Services (GMS) contract for 2014/15 was £95,000. This is a significant decrease, down from £130,600 in 2013/14. To offset the loss in funding due to the removal of QOF points, additional payments were transferred to the core funding element of the contract.

- Nearly a quarter of the 819 GP practices with a GMS contract (196, 23.9%) scored the maximum number of QOF points. This increased from 9.0% in 2013/14.

- The average number of points achieved by the 819 GMS practices was 645.4 out of a maximum of 659 (97.9%). This is a similar level of achievement compared to 2013/14 (97.6%).

- Peripheral Arterial Disease (PAD) had the largest increase in achievement for a clinical indicator between 2013/14 and 2014/15. This increased from 96.0% to 98.5%, a difference of 2.5 percentage points.

Key Definitions

The Quality & Outcomes Framework (QOF)

This publication contains information on General Practices with a registered population in Scotland (representing 95% of all practices in Scotland). It does not include various specialist practices (such as practices offering only Out of Hours services and practices for patients with challenging behaviour). The publication includes details of practices' participation in QOF, prevalence of selected health conditions, practices' achievements against their selected indicators and the payments that are made to practices as a result of those achievements.

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 that indicator. This is more likely to happen in very small practices. Also, participation in the QOF is voluntary. 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. Therefore, while individual practices may not achieve full points for every QOF indicator because they have not been able to meet some or all of the requirements for that indicator, practices with lower points than others cannot automatically be regarded as being "worse".

The information contained in this publication will be of interest to individuals, organisations and groups with an interest in workload, quality improvement, epidemiology and other aspects of General Practice. Here are some examples of how the information on the QOF has been used.

- It has allowed General Practitioners (GPs), their patients and practice staff to compare their results with those for other practices, to reflect the workload for particular conditions and to assess and monitor particular conditions.
- NHS Boards and Community Health Partnerships use the results to see how the practices in their areas compare to others and use this information to support quality improvement work with practices.
- Government Health Departments and the British Medical Association use these data to negotiate future changes to QOF indicators and payment calculations.
- Academic researchers for research projects.
- Charities representing specific health conditions use QOF to raise awareness of specific conditions.

General Practice

QOF measures General Practice achievement against a set of evidence-based indicators designed to promote good practice. Payments are made to practices on the basis of their level of achievement against those indicators. However, a practice's overall QOF score will depend on what type of practice they are.

There are three types of General Practice:

- <u>GP run General Medical Services (GMS) contracted practices (also known as 17J practices).</u> Although QOF participation is voluntary for these practices, since QOF forms a significant part of a GMS practice's remuneration, participation by these practices in QOF is close to 100%.

- <u>GP run locally negotiated contracted practices (also known as 17C practices).</u> These contracts support flexible provision of services to support local needs. Where 17C practices do record data for QOF, they may not do so for all indicators where the indicator does not fit with their specific local requirements. This means that what may appear as a low QOF achievement may be due to only some indicators being used by that practice.

- <u>NHS Board run practices (also known as 2C practices).</u> These practices may offer only Out of Hours services, practices for patients with challenging behaviour, smaller practices or practices without a permanent GP. Like the 17C practices, what may appear as low QOF achievement for a 2C practice may be due to only some indicators being used.

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.

You can find out more about practice contract types in Appendix 1.

Prevalence

Prevalence is a measure of the frequency of a disease or health condition in a defined population at any particular point in time (for example, the number of people living in Scotland on the 1st April 2015 who have diabetes). 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.

Although the QOF can potentially be used to examine variations in the prevalence of individual diseases and health conditions, prevalence figures should be interpreted with caution. Prevalence rates are 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. These rates take no account of differences between practice populations in terms of their age or gender profiles, or other factors that influence the prevalence of health conditions. As one example, this could mean that a practice with an older population might appear to have higher prevalence rates for age-related conditions (e.g. cancer, stroke) than another practice with a younger population. Furthermore, although registers may be restricted (e.g. to only include persons over a specified age) the QOF prevalence rate is based on the total number of persons registered with the practice (the practice list size) at one point in time.

Further limitations include differences in prevalence figures from other sources because of coding or definitional issues and year-on-year changes in the size of QOF registers being influenced by various factors. Further information relating to use of QOF prevalence figures can be found here.

Number of points (achievement)

The QOF measures a General Practice's achievement against a scorecard of evidence-based indicators.

- In 2014/15 the QOF was restructured to span four domains: Clinical, Public Health, Quality and Safety, and Medicines Management. The number of points and indicators for the 2014/15 QOF dropped compared to 2013/14; practices could score up to a maximum of 659 points across 75 indicators.

- In 2013/14 the QOF spanned six domains: Clinical, Public Health, Quality, Medicines Management, Patient Experience and Additional Services; in this year, practices could score up to a maximum of 923 points across 124 indicators.

Four QOF domains in 2014/15

These cover the following areas:

- **Clinical (52 indicators):** this 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, asthma and Chronic Kidney Disease (CKD).

- **Public Health (12 indicators):** this domain was first included in QOF in April 2014 to reflect the part of QOF to be dedicated to evidence-based Public Health and primary prevention indicators. This domain was expanded in 2015 and has one indicator on blood pressure, three indicators on Cardiovascular Disease – Primary Prevention (CVD-PP), four indicators on smoking, three indicators on cervical screening, and one indicator on contraception.

- **Quality and Safety (8 indicators):** this domain comprises eight indicators on reviewing data/patients for outpatient referrals, emergency admissions and Anticipatory Care Plan (ACP) cohorts, and improvement indicators on patient safety.

- **Medicines Management (3 indicators):** this domain comprises three indicators about meetings with NHS Board prescribing advisers and medication reviews for patients.

Indicator Groups

Most health conditions or services are monitored using a combination of indicators, and together these indicators form an 'indicator group'. For example, the Peripheral Arterial Disease (PAD) group contains two indicators: the percentage of patients with PAD for whom the last blood pressure reading measured (in the preceding 15 months) is 150/90 mmHg or less; and the percentage of patients with PAD with a record in the preceding 15 months that aspirin or an alternative anti-platelet has been taken. A full description of the QOF indicators for 2014/15 can be found in the QOF 2014/15 Guidance for NHS Boards and GP Practices or in the List of individual QOF indicator descriptions Excel spreadsheet.

Note that some of the indicators changed QOF domains from 2013/14 to 2014/15. For example only one indicator was included under the Public Health domain in 2013/14 (blood pressure); in 2014/15 there are 12 indicators, the majority of which switched from the Clinical domain.

Methodology

Data
This release provides information on 2014/15 QOF data. Included data are: an estimate of the percentage of the Scottish population recorded with selected health conditions, the number of points achieved by participating practices, the number of points achieved for individual QOF indicators and indicator groups, and the total QOF payments.

Data were extracted from the QOF Calculator Database, the national IT system that supports the calculation of QOF achievements and payments, to give GP practices and NHS Boards objective evidence and feedback on the quality of care delivered to patients. Data covered 1st April 2014 to 31st March 2015 and were extracted on 29th June 2015. Local adjustments are made to these data via notifications from NHS Boards.

Reliability of QOF prevalence estimates
Registers are not primarily collected to collate statistics on how many people have a particular condition, but they do provide a useful source for estimates. New registers should be treated with caution in the first few years of reporting as they are still being established and validated. No new registers were established in 2014/15.

QOF registers give reliable estimates of prevalence for conditions which are managed mainly by the GP or practice nurse, but QOF registers are likely to underestimate prevalence for conditions where people do not always consult their doctor. For further information about the reliability of prevalence estimates for specific conditions see Appendix 3. For more specific information please refer to the Information for users of QOF register and prevalence data available on our website.

Comparability of QOF with other prevalence data
Scotland has a number of other data sources which are used to create estimates on the prevalence of health conditions:

- Data from the Scottish Health Survey in which adults and children are asked about their health.
- Surveys of specific diseases, for example, the annual Scottish Diabetes Survey which is extracted from the national diabetes IT system.

There are links to a range of condition specific outcomes which QOF can be compared to within our web page, which contains information for users of QOF register and prevalence data.

Comparability of QOF between years
QOF achievement data are not comparable from one year to the next due to changes in the list of indicators, changes in the points available and changes in the list of practices whose data are included in the QOF publication each year. This is particularly relevant for 2014/15 data, as the number of QOF points has decreased by around a third from 923 in 2013/14 to 659. By comparison, the number of QOF points decreased by only 8% from 2012/13 (1000 points) to 2013/14 (923 points). Although we strongly encourage users not to compare the data, if you wish to do so then we advise you to first check information about these changes on the revisions to QOF pages on the ISD website.

Comparability of QOF across individual practices
There may be other reasons for apparently lower levels of achievement against the QOF. These include the following:

- 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 cannot score any points against that indicator. This is more likely to happen in very small practices.

- Participation in the QOF is voluntary. 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

Comparability of QOF between the four UK nations
It is not possible to directly compare the QOF performance of the four nations of the United Kingdom. The only measure of QOF performance which is available across all four nations is the overall achievement for all practice types, but practice types score very differently due to differences in their contracts; 2C and 17C practices tend to score less than GMS practices. The ratio of practice types is not consistent across the UK and the different ratio in each of the home nations affects their overall average. From 2014/15 Scotland had a large number of indicators that have slightly different rules/definitions. These indicators are signified by (S) at the end of their reference code, an example is HF004(S).

Further data for other UK nations are available at these links:
- England
- Northern Ireland
- Wales

Geographies

NHS Board boundaries
2014 NHS Board boundaries, which came into effect from 1st April 2014, are used throughout this publication. Estimates by NHS Board in this publication are based on contractual boundaries rather than geographical boundaries (they are based on the location of the GP practice rather than the location of where people registered with the practice live). There are 14 NHS Boards in total.

Community Health Partnership boundaries
2012 Community Health Partnership (CHP) boundaries, which came into effect from 1st April 2012, are used throughout this publication. As with NHS Boards, estimates are based on contractual boundaries. There are 36 CHPs in total. CHPs ceased to exist when their functions were fully taken over by Health and Social Care Partnerships in April 2015. This is the last QOF publication for which CHPs will to be produced as a transfer to local council boundaries for the 2015/16 publication is anticipated.

Populations
In this document populations are taken from the number of patients registered at a General Practice, known as the practice list size. The list size is based on the Community Health Index (CHI) numbers registered for that practice and, at the time of this release, list size numbers are taken from the end of the 2014/15 financial year, 1st April 2015. These list size numbers should be treated with caution, particularly when comparing them to geography based population estimates (such as mid-year estimates), as the number of patients typically exceeds the population based estimate due to the following reasons:

- They include deceased individuals.

- They include people who have been given a CHI number but have since left the country to live for a period of time abroad (expats).

- They include overseas visitors who registered with a GP in Scotland or received screening services at a point in time.

- They include students who have moved from Scotland after their studies but who have not registered elsewhere in the UK.

- They include people who are residing in Scotland illegally but still access the health service; for example, international students whose student visas have expired but they remain in the country.

Changes to the publication
Several changes have been made to this document. The QOF prevalence rates are only presented for clinical indicators. Therefore, prevalence rates for CVD-PP and conditions associated with smoking are not presented, as their indicators changed from the Clinical to the Public Health domain.

Several other indicators have been retired and are therefore not presented in this publication. Achievement and exceptions data are no longer presented for the Patient Experience or Additional Services domains as they have been retired. See Appendix 5 for further details.

New tables and charts have been created to separate the Clinical (Table 3 and Chart 5) and Public Health (Table 4 and Chart 6) domains in terms of points achieved. This has been done as the Public Health indicator domain has grown significantly, from 15 points for one indicator in 2013/14 to 122 points for five indicators in 2014/15.

An extra section has been included in the Appendix to detail the number of retired QOF indicators and number of indicators that underwent wording or timeframe changes in 2014/15 (A5). This section details which indicator groups were retired altogether, which indicators within groups were changed and tabulates all changes that were made to the indicator wording or timeframe from 2013/14 to 2014/15 (Table A.5.1).

Results and Commentary

Participation

Numbers of General Practices by practice type participating in QOF are shown in Table 1. Only nine General Practices did not take part and, of those who submitted partial data, the vast majority were 17C practices.

Table 1. Numbers of General Practices participating in QOF, 2014/15[1]

Type of General Practice	Number in Scotland[1]	Took part in QOF	Submitted complete data	Submitted partial data
GMS (GP run)	825	823	819	4
17C (Locally negotiated)	118	117	52	65
2C (NHS Board run)	44	38	37	1
All practice types	987	978	908	70

1 – As at 31st March 2015

Chart 1. Percentage of General Practices in Scotland by practice type

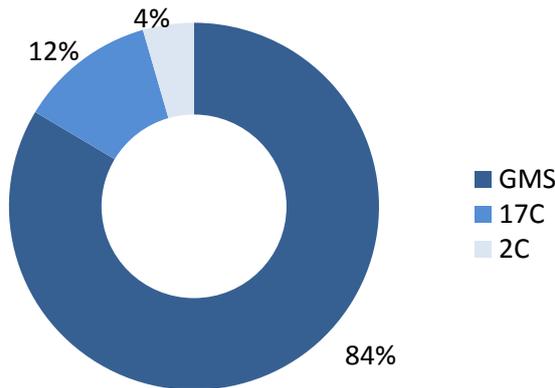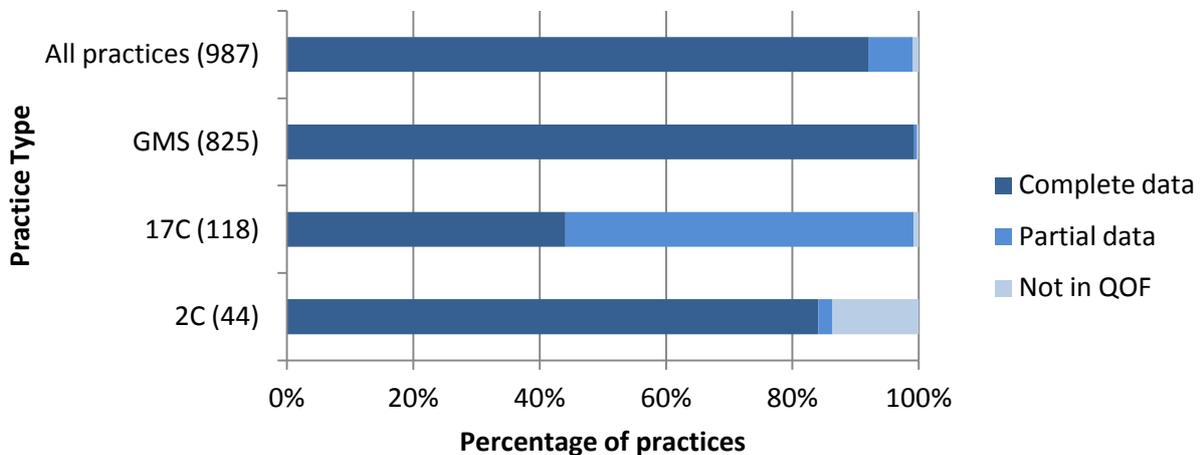**Chart 2. Percentage of practices which submitted complete data, partial data or did not participate in QOF by practice type**


10

All practices

Prevalence

Overall prevalence rates for health conditions drawn from the clinical domain of the QOF registers are shown in Chart 2. Hypertension has the highest overall prevalence at 13.9%, followed by depression and asthma (both 6.3%). There were only small changes in prevalence between 2013/14 and 2014/15. Depression shows the largest prevalence increase from 5.8% to 6.3%, while CHD dropped slightly from 4.3% to 4.1%.

Chart 3. QOF prevalence rates at 1st April 2015; all practice types[1,2,3]
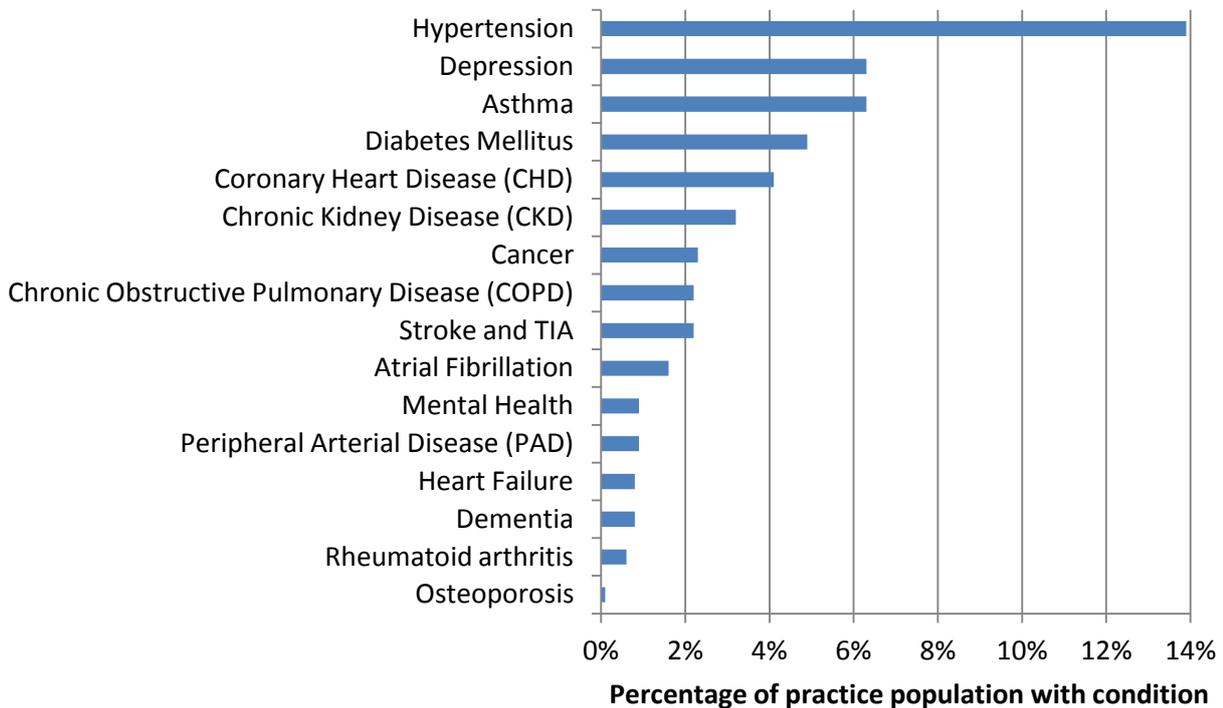
1. Registers are cumulative and include all patients with the condition since a given date, which vary for the different conditions, as opposed to those currently being treated for the condition.

2. Mental Health includes the following conditions: schizophrenia, bipolar affective disorder and other psychoses.

3. Extracted from QOF calculator on 29th June 2015

Further information on prevalence for NHS Boards, CHPs and practices can be found on the QOF pages on the ISD website.

GMS practices

Number of QOF points (achievement)

Amongst Scottish General Practices with a standard GMS contract type, the average number of QOF points achieved in 2014/15 was 645.4 (out of a maximum of 659) compared to 900.7 (out of a maximum of 923) in 2013/14. Nearly a quarter of GMS practices achieved the maximum of 659 points (23.9%). Over half of all GMS practices achieved at least 99% of all

available QOF points. A breakdown of GMS practice points achieved by domain is shown in Table 2, with the distribution of QOF points achieved by GMS practice shown in Chart 4. Over 90% of practices scored the maximum number of points for the Medicines Management and Quality and Safety domains.

Table 2. QOF points achieved by GMS practices, 2014/15[1]

	Points available	Average points achieved by GMS practice		Total number of GMS practices	GMS practices achieving maximum points		GMS practices achieving <90% of points	
		No.	%	No.	No.	%	No.	%
Total	659	645.4	97.9	819	196	23.9	35	4.3
Clinical Domain	403	396.0	98.3	819	278	33.9	24	2.9
Medicines Management Domain	23	22.7	98.7	819	792	96.7	27	3.3
Public Health Domain	122	119.1	97.6	819	436	53.2	51	6.2
Quality and Safety Domain	111	107.6	96.9	819	737	90.0	45	5.5

1 . As at 31st March 2015, extracted from QOF calculator on 29th June 2015

Chart 4. Distribution of QOF points achieved by GMS Practices, 2014/15
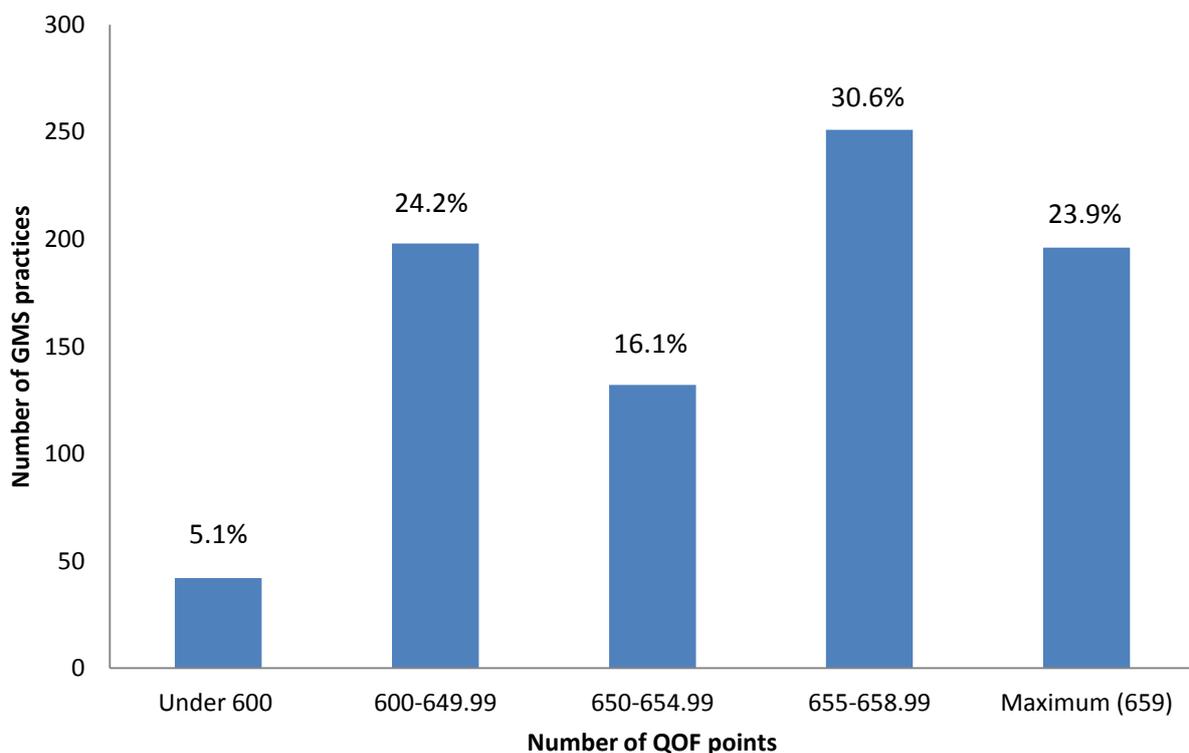
Further information on achievement for NHS Boards, CHPs and practices can be found on the QOF pages on the ISD website.

Number of points (achievement) within indicator groups

Most health conditions or services are monitored using a combination of indicators, and together these indicators form an indicator group. In total there are 24 indicator groups, of which, 17 are Clinical, five are Public Health, one is Quality and Safety, and one is Medicines Management. For practices with a GMS contract, 16 out of 17 Clinical indicators had an average achievement over 95% (see Chart 5).

Chart 5. QOF points achieved by GMS practices for each Clinical indicator group, 2014/15 (red line indicates 95%)[1]

Percentage of QOF points achieved
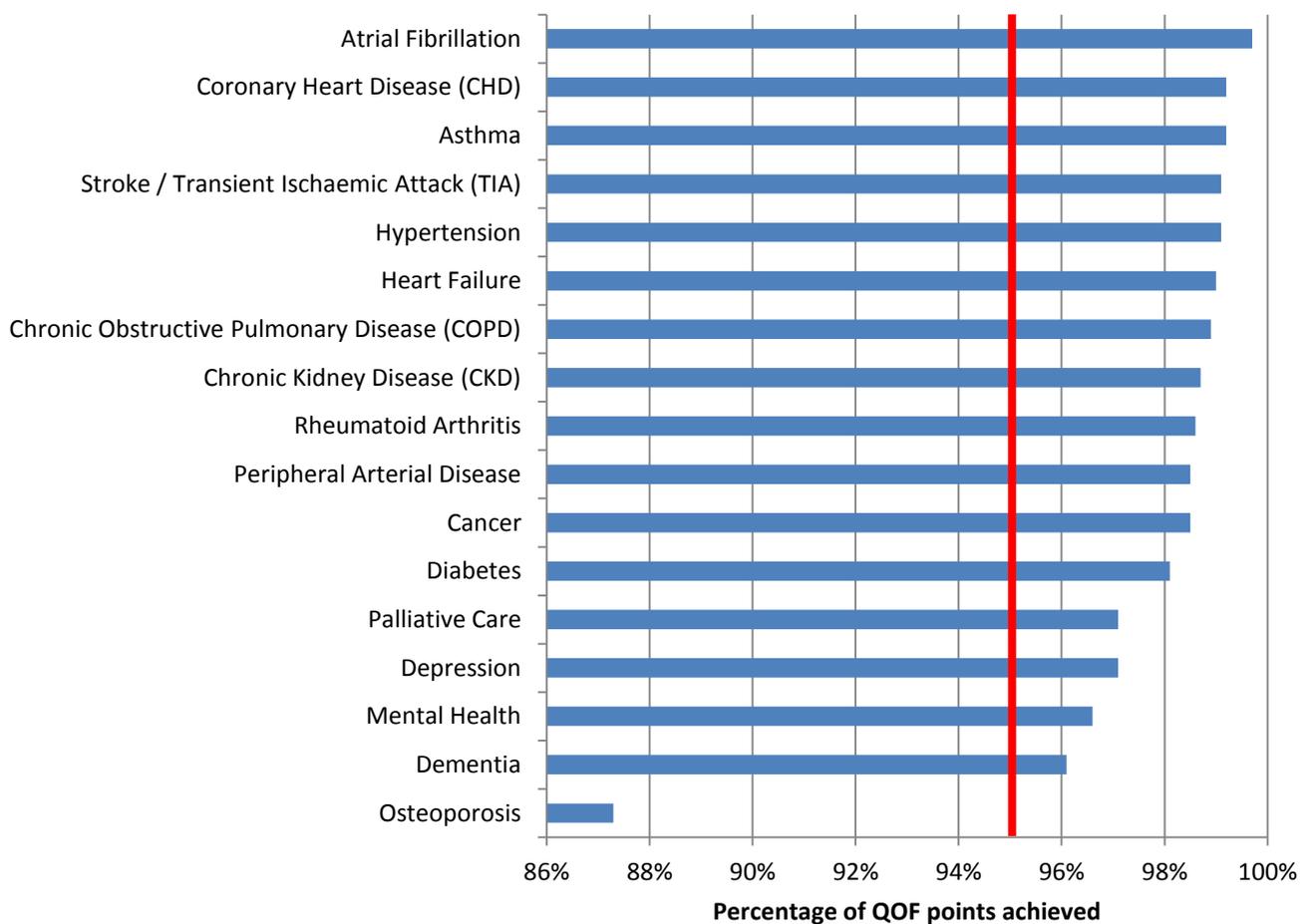
1 . As at 31st March 2015, extracted from QOF calculator on 29th June 2015

The Peripheral Arterial Disease (PAD) group indicator had the largest increase from 2013/14 to 2014/15, increasing from 96.0% to 98.5% (Table 3), a difference of 2.5%. The Osteoporosis indicator group had the largest decrease from 2013/14 to 2014/15, decreasing from 91.9% to 87.3%, a difference of 4.6%.

Table 3. QOF points achieved by GMS practices for each indicator group in the Clinical domain, 2014/15[1,2]

Clinical indicator group	Number of indicators	Number of points available	Average number of points achieved[1]	Average points achieved (%)[2]
Asthma	3	41	40.7	99.2%
Atrial Fibrillation	2	12	11.9	99.8%
Cancer	1	6	5.9	98.5%
Chronic Kidney Disease (CKD)	3	26	25.7	98.7%
Chronic Obstructive Pulmonary Disease (COPD)	4	25	24.7	98.9%
Coronary Heart Disease (CHD)	4	41	40.7	99.2%
Dementia	2	21	20.2	96.2%
Depression	1	10	9.7	97.1%
Diabetes	9	74	72.6	98.1%
Heart Failure	3	25	24.8	99.0%
Hypertension	1	55	54.5	99.1%
Mental Health	9	36	34.8	96.6%
Osteoporosis	2	6	5.2	87.3%
Palliative Care	1	3	2.9	97.1%
Peripheral Arterial Disease (PAD)	2	4	3.9	98.5%
Rheumatoid Arthritis	1	5	4.9	98.6%
Stroke /Transient Ischaemic Attack (TIA)	4	13	12.9	99.1%
Total	**52**	**403**	**396.0**	**98.3%**

1.   Average number of points achieved equals total points achieved in clinical indicator group across all GMS practices divided by number of practices

2.   Average points achieved (%) equals average points achieved divided by points available per practice and indicator group

For practices with a GMS contract, the CVD-PP and contraception indicators had an average achievement below 95% average (see Chart 6). The remaining three Public Health indicators (smoking, cervical screening and blood pressure) had an overall achievement against available points that was over the Public Health domain average of 97.6% (see Table 4).

Chart 6. QOF points achieved by GMS practices for each Public Health indicator group, 2014/15 (red line indicates 95%)[1]

1. As at 31st March 2015, extracted from QOF calculator on 29th June 2015
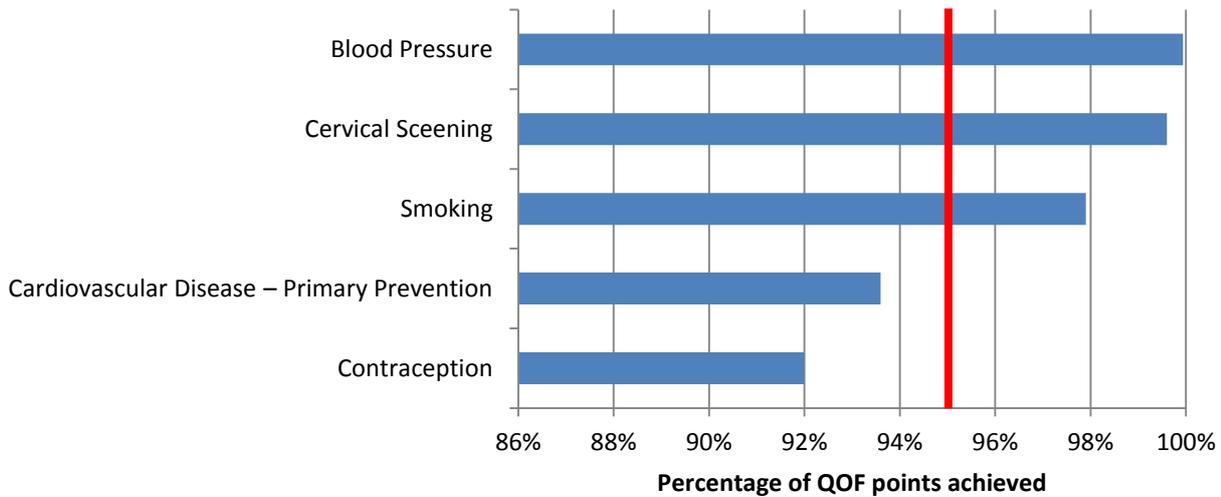
Table 4. QOF points achieved by GMS practices for each indicator group in the Public Health domain, 2014/15[1,2]

Public health indicator group	Number of indicators	Points available	Average points achieved[1]	Average points achieved (%)[2]
Blood Pressure	1	15	15.0	99.9%
Cardiovascular Disease – Primary Prevention (CVD-PP)	3	20	18.7	93.6%
Cervical Screening	3	20	19.9	99.6%
Contraception	1	3	2.8	92.0%
Smoking	4	64	62.7	97.9%
Total	**12**	**122**	**119.1**	**97.6%**

1. Average number of points achieved equals total points achieved in clinical indicator group across all GMS practices divided by number of practices

2. Average points achieved (%) equals average points achieved divided by points available per practice and indicator group

Further information on achievement for NHS Boards, CHPs and practices can be found on the QOF pages on the ISD website.

Payments

QOF payments for each practice are calculated based on the number of points achieved by the practice, the number of people registered at the practice and the prevalence of each condition in the practice as a proportion of the overall prevalence for Scotland. To put this in context, in 2013/14 QOF payments accounted for approximately £129million of the £740million spent on Primary Medical Services in Scotland.

The average QOF payment to a GMS practice (total payments made to all GMS practices divided by the total number of GMS practices) based on QOF points only for 2014/15 was £95,000 (Table 5). This is down from £142,000 in 2012/13 and down from £130,600 in 2013/14. This decrease was primarily due to changes in wording or timeframe definitions for certain indicators and a reduction in points from 923 to 659 resulting in a reduction in the funds paid through QOF. As part of the Scottish GMS contract 2014-15 it was agreed that 264 points were retired from the QOF. To offset funding lost through the removal of these QOF points, money was transferred to the core funding element of the contract. The transfer occurred based on an average GP practice QOF point achievement for the past three years. Guidance on the arrangements for post payment verification for the transferred points can be found in the NHS Circular PCA(M)09.

Table 5. QOF payments to practices, from 2010/11 to 2014/15

	2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Total QOF funding to all QOF practices[1]	£130million	£134million	£136million	£125million	£86million
Average payment per GMS practice	£132,600	£138,900	£142,000	£130,600	£95,000

1. Includes payment totals for all practices participating in QOF

More information about how QOF payments are calculated is in Appendix 4.

Exception reporting

There are occasions when General Practices are not able to treat or monitor patients in ways specified by the QOF indicators. The most common reason for this is that the patient has been diagnosed very recently and the treatment is not yet fully underway. Other reasons include a patient not attending their appointments or having only recently moved to the practice.

These patients are excluded from the QOF reporting using a system called 'exception reporting' so that General Practices are not penalised for patient characteristics beyond their reasonable control. When patients are 'exception reported' from an indicator they are not included in the calculation of a practice's achievement against that indicator.

Levels of exception reporting for Scotland as a whole varied considerably between the clinical indicators, ranging from 1.5% to 34.4%. For all indicators, exception reporting varied from 0.5% to 98.0%. In general, indicators with the lowest levels of exception reporting include those that involve recording information in the patient records (e.g. blood pressure measurement, recording smoking status), whereas the highest are seen in those that involve clinical treatments or clinically measurable outcomes (e.g. CVD-PP, diabetes). Further information on the numbers of patients excluded for 2014/2015 is available on the 2014/15 Exception Reporting webpage. The webpage also includes a Questions & Answers document which details the criteria for excluding patients, technical information on how the exclusions are calculated and commentary on observed exception reporting rates.

Glossary

17C practice

A practice run by GPs but has locally negotiated contracts for its services. This supports flexible provision of services to support local needs. You can read more about the different practice types and their participation in QOF on Page 4 and Appendix 1.

17J practice

See GMS practice.

2C practice

A practice which is run by an NHS Board rather than by GPs. These may be practices that offer only Out of Hours services, practices for patients with challenging behaviour, smaller practices or practices without a permanent GP. You can read more about the different practice types and their participation in QOF on Page 4 and Appendix 1.

Average

The average used throughout this publication is the arithmetic mean.

CHD

Coronary Heart Disease.

CHP

A Community Health Partnership (CHP) is a committee of the Health Board which develops local community health services, in partnership with their local authority partners. There are 36 CHPs in Scotland, covering 14 Health Boards and 32 local councils.

CKD

Chronic Kidney Disease.

COPD

Chronic Obstructive Pulmonary Disease.

CVD-PP

Cardiovascular Disease – Primary Prevention.

Domain

The four domains within QOF are: Clinical, Public Health, Quality and Safety, and Medicines Management. Each domain consists of a set of indicators, against which practices score points according to their level of achievement.

GMS practice (also known as a 17J practice)

A practice run by GPs that adheres to the nationally negotiated standard contract for General Practices. You can read more about the different practice types and their participation in QOF on Page 4 and Appendix 1.

Indicator

The QOF measures a General Practice's achievement against 75 evidence-based indicators. Most health conditions or services are monitored using several indicators, and these indicators together form an indicator group.

Indicator Group

There are a total of 24 indicator groups, which range from one to nine indicators, and from which a variety of QOF achievement points can be scored. For example, the indicator group Peripheral Arterial Disease (PAD) has two indicators: keeping a register of patients with PAD (two QOF achievement points) and percentage of these patients that are taking aspirin or antiplatelet drugs (two QOF achievement points). A total of four QOF achievement points can be gained for this group.

PAD

Peripheral Arterial Disease.

Prevalence

Prevalence is a measure of the frequency of a disease or health condition in a defined 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.

QOF

The Quality & Outcomes Framework (QOF) measures a General Practice's achievement against a set of evidence-based indicators. Payments are made to each General Practice on the basis of their achievements against those indicators.

QOF Calculator

The national QOF calculation database.

QOF Register

A QOF register is a list of patients registered with a practice. It 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.

List of Tables

Over 100 individual QOF files are available for 2014/15 containing data and supplementary reference information.

These files have been grouped into data table pages which you can access from the links below. Clicking on each link you will either take you to a single file or to a page where you can access the individual files

Data table page	Number of data files	Time period	File type & size(s)
Achievements data tables for Scotland and NHS Boards*	7	Year ending March 2015*	Excel [47kB – 339kB]
Achievements data for Community Health Partnerships (CHPs)*	7	Year ending March 2015*	Excel [45kB – 473kB]
Achievements data for practices – summaries*	4	Year ending March 2015*	Excel [573kB – 6.07MB]
Achievements data for practices - individual indicators*	36	Year ending March 2015*	Excel [333kB – 3.19MB]
Register and prevalence data for Scotland, NHS Boards and CHPs*	6	Year ending March 2015*	Excel [150kB – 1.60MB]
Prevalence trends for Scotland 2004/05 – 2014/15	1	2004/05 to 2014/15	Excel [62kB]
Scotland Performs – Dementia data for HEAT standard[1]	1	Year ending March 2015*	Excel [58kB]
Exception reporting in clinical indicators*	46	Year ending March 2015*	Excel [136kB – 1.47MB]

1. This provides information about NHSScotland performance against the Local Delivery Plan (LDP) Standards, which contribute towards delivery of the Scottish Government's Purpose and National Outcomes; and NHSScotland's Quality Ambitions.

Please note: When opening data files in Excel, you may need to select the option 'enable macro' 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/

Downloadable Tables and Charts included in this report

List of tables and charts in QOF 2014/15 Report and Summary

Contact

Dr Grant Aitken
Senior Information Analyst
Information Services
grant.aitken1@nhs.net
0131 275 7027

Ana Rodriguez
Principal Information Analyst
Information Services
ana.rodriguez@nhs.net
0131 275 6737

Catherine Thomson
Service Manager
Information Services
catherine.thomson@nhs.net
0131 275 7198

Tony Callaghan
Service Improvement Manager
Practitioner Services
tony.callaghan@nhs.net
0131 275 6121

Sally Richards
Deputy Financial Regional Manager
Practitioner Services
sallyrichards2@nhs.net
0131 275 7799

Further Information

Further information can be found on the ISD website

Rate this publication

Please provide feedback on this publication to help us improve our services.

Appendix

A1 – General Practice types and their participation in QOF

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 either a NHS organisation or a non-NHS organisation for the provision of NHS services. In practice, these Section 2C practices are run by the Boards themselves.

The majority (approximately 84%) of General Practices in Scotland have a GMS contract. The largest proportion of the remainder is made up of Section 17C (12%) Schemes, with a smaller number of services provided under section 2C (4%).

The GMS contract
The 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 Primary Care Contracting pages of the NHS Employers website.

The Quality & Outcomes Framework for practices with GMS contracts
The QOF, although fundamental to the 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, over 99% of 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 whether or not to participate in the QOF (see next page).

The Quality & Outcomes Framework 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.

A2 – Data completeness

Prevalence
All NHS Boards submitted complete prevalence data.

Achievement and Payment

Practices with 17C and 2C contracts support a different provision of services and may not record data on QOF when indicators do not fit their specific requirements. For this reason they are often removed from the achievement figures.

NHS Glasgow and Greater Clyde
No achievement data was published for 39 out of 40 practices with a 17C contract in NHS Greater Glasgow and Clyde as these practices are not carrying out the QOF. If their achievement figures were published it would give a false picture.

NHS Grampian
No achievement or payment data was published for any of the 13 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 so achievement will appear low against practices that measure achievement against all QOF indicators.

NHS Highland
Three GMS practices in NHS Highland do not have their achievement or payment data published.

NHS Lanarkshire
In NHS Lanarkshire, one 2C practice was set up for administrative reasons and should not be treated in the same way as other GMS/17C practices in terms of QOF achievement. Therefore achievement was not published for this practice.

NHS Lothian
Ten practices in NHS Lothian participated in a 17C redesign project (paid outside of QOF calculator) and received a QOF payment based on an achievement of 659 points. Another three NHS Lothian practices were new or restructured with their QOF achievement being based on the predecessor practices (two achieved a maximum of 659 points, another remained at its achieved points of 516 points but was adjusted to reflect a notional 3,500 population). One practice in NHS Lothian has a bespoke quality framework that is tailored to the needs of their registered patient population and received a QOF payment based on an achievement of 659 points.

For all of these 14 NHS Lothian practices, only data on detailed prevalence per indicator and the updated total points and total payments for each practice were published.

Further information on data completeness and the number of practices submitting QOF data in each board since 2009 is available on the QOF data completeness page of the ISD website

A3 – Reliability of QOF prevalence data by condition

The reliability for QOF register and prevalence data for each condition is discussed below.

Asthma
These data are reliable. However QOF registers only include patients who have received treatment during the previous 12 months so prevalence will differ from measures of how many people have ever been treated or who have minor symptoms that do not require medication.

Atrial Fibrillation
These data are reliable. Prevalence will depend on how thoroughly doctors search for the condition, as it may not be apparent to patients that they have it. Also, the condition is much more common in older age so practices with older populations will have higher prevalence.

Cancer
This is a register of everyone who has had a cancer diagnosis since 1 April 2003 (excluding skin cancer) and is still alive therefore it rises every year.

Coronary Heart Disease (CHD)
These data are reliable. The QOF prevalence represents the proportion of people who have ever had a diagnosis of CHD.

Chronic Kidney Disease (CKD)
These data are reliable though it should be noted that, as prevalence of CKD rises with age and, as QOF prevalence is not adjusted for age profile of practice, practices with older populations will have higher prevalence.

Chronic Obstructive Pulmonary Disease (COPD)
The QOF prevalence for COPD is an underestimate of the true figure. The QOF prevalence is somewhat arbitrary as there are people with poor lung function who do not consult their doctor even though they would meet diagnostic criteria for COPD.

Dementia
The prevalence figure may be an underestimate as the diagnosis is not always recorded if it is not the principal reason for consultation.

Depression
This measure is not seen as reliable because it is partly cumulative and will therefore rise each year. Individuals with resolved depression will only be taken off the register if this is recorded by the practice and this is not done in all cases.

Diabetes
This register is limited to those aged 17 and over with the diagnosis specified as type 1 or type 2, and excludes the very small number with other types and the larger number with type not recorded. The prevalence is calculated on the total practice population regardless of age, so will therefore be an underestimate.

Hypertension
These data are reliable.

Heart Failure
QOF prevalence is thought to be a slight underestimate of the true figure. A diagnosis of heart failure requires specialist confirmation and GPs may be reluctant to refer people who are housebound, suffering from other serious conditions, or for whom the heart failure is thought to be mild.

Mental Health
The mental health QOF register specifically counts people with schizophrenia, bipolar disorder and other psychoses. These data are reliable but may not compare with other measures of mental health prevalence due to differences in the conditions included.

Osteoporosis
The QOF prevalence for Osteoporosis is likely to be an underestimate of the true figure. The register is limited to those aged over 50 and patients may not consult their doctor even though they would meet diagnostic criteria for Osteoporosis.

Peripheral Arterial Disease (PAD)
New register in 2012/13 data should be treated with caution in the first few years of reporting as they are still being established and validated.

Rheumatoid Arthritis
New register in 2013/14 data should be treated with caution in the first few years of reporting as they are still being established and validated. The register is limited to people aged 16 and over with rheumatoid arthritis.

Stroke or Transient Ischaemic Attack (TIA)
This register includes all those who have ever had one of these conditions. As diagnosis of TIA may in practice be slightly subjective the QOF prevalence for this is seen as a slight underestimate.

For further information about the reliability of QOF prevalence estimates for specific conditions see our web page containing Information for users of QOF register and prevalence data. This page also contains links to more reliable prevalence data when these are available.

A4 – QOF payment calculation

The value of QOF points for the year 2014/15 is shown in the table below.

Table A4.1: QOF points and payments available to practices, 2014/15

Domain	Number of indicators	Total points available	Payment per point
Clinical	52	403	Variable
Public Health	12	122	£135.06
Quality and Safety	8	111	£135.06
Medicines Management	3	23	£135.06
Total	75	659	-

The following are also taken into account when calculating payments for each practice:

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. The initial calculated payment for clinical 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 5,241 patients for 2014/15).

More detail on this is given one our web page containing Information for users of QOF register and prevalence data. The rules for calculating QOF payments are explained in detail in the "General Medical Services Statement of Financial Entitlements", published by the Scottish Government.

A5 – Discontinued (Retired) and changed QOF indicators in 2014/15

A total of 46 indicators were retired in 2014/15, releasing 264 points. A further 43 indicators underwent changes to wording or timeframe.

Completely retired indicator groups

The following indicator groups were retired altogether:

Hypothyroidism (THY):
> **THY001:** The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine.
> **THY002:** The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months.

Epilepsy (EP):
> **EP001:** The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.
> **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.
> **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.

Learning Disability (LD):
> **LD001:** The contractor establishes and maintains a register of patients with learning disabilities.
> **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)

Child Health Surveillance (CSH):
> **CSH001:** Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with the NHS Scotland.

Maternity Services (MAT):
> **MAT001:** Antenatal care and screening are offered according to current local guidelines agreed with the NHS Scotland.

Obesity (OB):
> **OB001:** The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 12 months.

Patient Experience (PE):
> **PE001:** The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes. If the contractor routinely admits extras patients during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session such that the length of the booked appointments is not less than 10 minutes. If the extras patients are seen at the end of surgery, then it is not necessary to make this adjustment. For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes. Contractors that routinely operate a mixed economy of booked and open surgeries should ensure that the length of the booked appointments is not less than 10 minutes and the length of the open surgery appointments is not less than 8 minutes.

Partially retired indicator groups

The following indicators were retired in 2014/15. These full indicator groups were not retired as some indicators within that group remained.

Atrial Fibrillation (AF):

> **AF001:** The contractor establishes and maintains a register of patients with atrial fibrillation.
>
> **AF002:** The percentage of patients with atrial fibrillation for whom stroke risk has been assessed using the $CHADS_2$ risk stratification scoring system in the preceding 15 months (excluding those whose previous $CHADS_2$ score is greater than 1).

Secondary prevention of coronary heart disease (CHD):

> **CHD001:** The contractor establishes and maintains a register of patients with coronary heart disease.
>
> **CHD003(S):** The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.

Heart Failure (HF):

> **HF001:** The contractor establishes and maintains a register of patients with heart failure.

Hypertension (HYP):

> **HYP001:** The contractor establishes and maintains a register of patients with established hypertension.

Peripheral arterial disease (PAD):

> **PAD001:** The contractor establishes and maintains a register of patients with peripheral arterial disease.
>
> **PAD003:** The percentage of patients with peripheral arterial disease for whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less.

Stroke and transient ischaemic attack (STIA):

> **STIA001:** The contractor establishes and maintains a register of patients with stroke or TIA.
>
> **STIA004:** The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months.
>
> **STIA005:** The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less

Diabetes mellitus (DM):

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

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.
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.

Asthma (AST):
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.

Chronic obstructive pulmonary disease (COPD):
COPD001: The contractor establishes and maintains a register of patients with COPD.
COPD004(S): The percentage of patients with COPD with a record of FEV_1 in the preceding 12 months.

Dementia (DEM):
DEM001: The contractor establishes and maintains a register of patients diagnosed with dementia.

Mental Health (MH):
MH001: The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.

Cancer (CAN):
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'.

Chronic Kidney Disease (CKD):
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).

Osteoporosis: secondary prevention of fragility fractures (OST):
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.

Rheumatoid arthritis (RA):
RA001: The contractor establishes and maintains a register of ~~all~~ patients aged 16 or over with rheumatoid arthritis.
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.
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.

Palliative care (PC):
PC001: The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.

Smoking (SMOK):
SMOK001: The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months.

Cervical Screening (CS):
CS003: The contractor ensures there is a system for informing all women of the results of cervical screening tests.

Contraception (CON):

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.
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.

Wording or timeframe changes to indicators

A total of 44 indicators underwent a wording or timeframe change in 2014/15. These changes are detailed in Table A.5.1.

Table A.5.1: Changes to indicator wording or timeframe from 2013/14 to 2014/15

Indicator Name 2013/14	Indicator Name 2014/15	Change to wording or timeframe
AF003(S)	AF005(S)	In those patients with atrial fibrillation for whom there is a record of a CHADS$_2$ score of 1 (latest in the preceding **15** months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy.
CHD002	CHD002(S)	The percentage of patients with coronary heart disease for whom the last blood pressure reading (measured in the preceding **15** months) is 150/90 mmHg or less.
CHD004	CHD007(S)	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding **1 August** to 31 March.
CHD005	CHD005(S)	The percentage of patients with coronary heart disease with a record in the preceding **15** months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.
HYP002(S)	HYP006(S)	The percentage of patients with hypertension for whom the last blood pressure reading (measured in the preceding **12** months) is 150/90 mmHg or less.
PAD004	PAD004(S)	The percentage of patients with peripheral arterial disease with a record in the preceding **15** months that aspirin or an alternative anti-platelet is being taken.
STIA002	STIA008(S)	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April **2014**) 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 **the first TIA.**
STIA003	STIA003(S)	The percentage of patients with a history of stroke or TIA for whom the last blood pressure reading (measured in the preceding **15** months) is 150/90 mmHg or less.
STIA006	STIA009(S)	The percentage of patients with stroke or TIA who have had

		influenza immunisation in the preceding **1 August** to 31 March.
DM002	DM002(S)	The percentage of patients with diabetes, on the register, for whom the last blood pressure reading (measured in the preceding **15** months) is 150/90 mmHg or less.
DM003	DM003(S)	The percentage of patients with diabetes, on the register, for whom the last blood pressure reading (measured in the preceding **15** months) is 140/80 mmHg or less.
DM007	DM007(S)	The percentage of patients with diabetes, on the register, for whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding **15** months.
DM008	DM008(S)	The percentage of patients with diabetes, on the register, for whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding **15** months.
DM009	DM009(S)	The percentage of patients with diabetes, on the register, for whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding **15** months.
DM010(S)	DM018(S)	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 **August** to 31 March.
DM012	DM012(S)	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 **15** months.
AST003	AST003(S)	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding **15** months that includes an assessment of asthma control using the 3 RCP questions.
AST004	AST004(S)	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, for whom there is a record of smoking status in the preceding **15** months.
COPD003	COPD003(S)	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 **15** months.
COPD005	COPD005(S)	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding **15** months, with a record of oxygen saturation value within the preceding **15** months.
COPD006(S)	COPD007(S)	The percentage of patients with COPD who have had influenza immunisation in the preceding **1 August** to 31 March.
DEM002	DEM002(S)	The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding **15** months.

DEP002	DEP003	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 **2 weeks** after and not later than **8 weeks** after the date of diagnosis.
MH002	MH002(S)	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 **15** months), agreed between individuals, their family and/or carers as appropriate.
MH003	MH003(S)	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding **15** months.
MH004	MH004(S)	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 **15** months.
MH005	MH005(S)	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 **15** months.
MH006	MH006(S)	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding **15** months
MH007	MH007(S)	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding **15** months.
CAN002	CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within **6** months of the contractor receiving confirmation of the diagnosis.
CKD002	CKD002(S)	The percentage of patients on the CKD register for whom the last blood pressure reading (measured in the preceding **15** months) is 140/85 mmHg or less.
CKD004	CKD004(S)	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 **15** months.
OST003	OST005	The percentage of patients aged 75 or over with a **diagnosis of osteoporosis, with a record of a** fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent.
RA002	RA002(S)	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding **15** months.
CVD-PP001	CVD-PP001(S)	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 Board) of ≥20% in the preceding **15** months: the percentage who are currently treated with statins.
CVD-PP002	CVD-PP02(S)	The percentage of patients diagnosed with hypertension (diagnosed after on or after 1 April 2009) who are given lifestyle advice in the preceding **15** months for: **increasing physical activity,** smoking cessation, safe alcohol consumption and healthy diet.
CVD-PP003	CVD-PP03(S)	The percentage of patients diagnosed with hypertension (diagnosed after on or after 1 April 2009) who require lifestyle advice on increasing physical activity, as identified in CVD-PP002(S), in the preceding **15** months that are given advice utilising the Scottish Physical Activity Screening Questions (Scot-PASQ.)
BP001	BP001(S)	The percentage of patients aged **45** or over who have a record of blood pressure in the preceding 5 years.
QS005	QS005(S)	The contractor identifies a minimum of 30% of those patients from the list produced in indicator **QS004(S)** who would benefit from, and creates an Anticipatory Care Plan for them (the ACP must include poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patients review should be determined in light of their clinical and care needs. The contractor will be responsible for ensuring an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.
SMOK002	SMOK002(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 whose recorded smoking status in the preceding **15** months.
SMOK004	SMOK004(S)	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding **27** months.
SMOK005	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 treatment within the preceding **15** months.
MM003	MM003(S)	A medication review is recorded in the notes in the preceding **15** months for all patients being prescribed 4 or more repeat medicines. Standard 80 per cent.

A6 – Publication Metadata (including revisions details)

Metadata Indicator	Description
Publication title	Quality and Outcomes Framework: Prevalence, achievement, payment and exceptions data for Scotland, 2014/2015
Description	Information on estimates of the percentage of the Scottish population with selected health conditions; the number of points achieved by participating practices, the number of points achieved for individual QOF indicators and indicator groups; and the total QOF payments.
Theme	Health and Social Care
Topic	General Practice
Format	Excel workbooks, PDF files, Word files.
Data source(s)	QOF Calculator, plus notifications from NHS Boards of local adjustments to data
Date that data are acquired	Data extract taken on June 29th 2015. This was then validated and amended to reflect local adjustments, as notified by NHS Boards. Finalised data file available late August 2015.
Release date	13th October 2015
Frequency	Annual
Timeframe of data and timeliness	Data for the year ending March 2015. 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. QOF achievement data is not comparable from one year to the next due to changes in the list of indicators, changes in the points available and changes in the list of practices whose data are included in the QOF publication each year.
Revisions statement	All QOF data are finalised as part of the Payment Verification process prior to publication. There are no planned revisions to the data and the data are considered to be final. Any unplanned revisions or corrections will be managed in accordance with ISD's Statistical Revisions Policy.
Revisions relevant to this publication	None
Concepts and definitions	These are explained further in this document, in the Glossary and Appendix. Additional detail is given in footnotes to individual Excel workbooks

Relevance and key uses of the statistics	These statistics report on General Practices' achievement towards a set of evidence based indicators designed towards improvements in patient care in primary care. The information contained in this publication will be of interest to individuals, organisations and groups with an interest in workload, quality improvement, epidemiology and other aspects of General Practice. Here are some examples of how the information on the QOF has been used.
	• General Practitioners, their patients and practice staff to compare their results with those for other practices.
	• NHS Boards and Community Health Partnerships teams use the results to see how the practices in their areas compared to others and use this information to support quality improvement work with practices.
	• Government Health Departments and the British Medical Association (BMA) use this data to negotiate future changes to QOF indicators and payment calculations.
	• Academic researchers for research projects.
Accuracy	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 in the relevant section of the payment verification document - http://www.sehd.scot.nhs.uk/publications/DC20111020payverif.pdf
	Occasionally there may be technical or other problems with individual 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 for the Boards or Scotland. 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.
Completeness	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 95% of Scottish practices.
	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 can mean that 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. Details of practices omitted from the analysis are included in the footnotes where relevant.

	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.
	For more details on completeness please refer to – http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/Data-Completeness.asp
Comparability	The clinical information in the Scottish QOF is for the most part closely comparable with QOF clinical information for the other UK nations. Any variation between the nations is generally to be found in the fine details of definitions of indicators and rules. For example, the age range of women covered by the cervical screening indicators is not exactly the same for each nation. However, a number of other factors would need to be considered before any comparisons are made such as differences in the demographics of General Practices, the ratio of practice contract types and QOF remuneration between the nations. Links to QOF data for the other UK nations can be found in the ISD QOF pages.
	The QOF is specific to the UK and therefore the information shown here is not directly comparable with any apparent equivalents for other countries.
	QOF prevalence data for General Practices differs from those published by Practice Team Information (PTI). PTI is based on data collected from patient consultations within a small sample of Scottish practices (approximately 6%). More information on the comparability of QOF and PTI can be found in Practice Team Information (PTI) Statistics
	We strongly advise users not to use this data as PTI data is no longer collected. 2012/13 is the last year for which ISD will be able to publish annual PTI data. A new national GP information system known as the Scottish Primary Care Information Resource (SPIRE) is in development which will supersede and build on the data collected for PTI. SPIRE aims to include richer data from a greater number of practices and will help to inform public health surveillance, research and data linkage. Further benefits will see the creation of a mechanism to feedback data analysis to practices and an improved data extraction process. More information on SPIRE can be found in http://www.spire.scot.nhs.uk/
Accessibility	It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.
Coherence and clarity	Tables and charts are accessible via the ISD website at: http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/
Value type and unit of measurement	Numbers and percentages. Shown for individual practices, Community Health Partnerships, NHS Boards and Scotland
Disclosure	The ISD protocol on Statistical Disclosure Protocol is followed.

Official Statistics designation	National Statistics
UK Statistics Authority Assessment	Assessment has taken place and the subsequent report was published in June 2012 at http://www.statisticsauthority.gov.uk/assessment/assessment/assessment-reports/assessment-report-209---statistics-on-dental-and-ophthalmic-services-and-general-practice-in-scotland.pdf
Last published	30th September 2014
Next published	11th October 2016
Date of first publication	2005 (QOF data are published back to 2004/05, the first year for which the QOF existed)
Help email	nss.isdGeneralPractice@nhs.net
Date form completed	11th September 2015

A7 – 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

A8 – ISD and Official Statistics

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.