

Publication Report



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

Achievement, prevalence
and exception reporting data 2009/10

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About ISD

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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

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Introduction

The Quality & Outcomes Framework (QOF) is part of the new 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 2009/10 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 for the previous five years (2004/05 to 2008/09).

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 86% of practices in Scotland had a GMS contract at the end of the 2009/10 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 2009/10. Exception reporting allows practices to pursue the quality improvement agenda and not be penalised where, for example, patients do not attend for review, or where 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. For illustration here, 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 section below on 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

- GMS practices in Scotland achieved an average of 972.2 QOF points in 2009/10 out of a possible maximum 1000. On face value this is very similar to the 972.0 average for 2008/09. However, within this there were noticeable increases in achievements in some indicators such as two relating to patient experience, offset by relatively lower achievement against newly introduced QOF indicators.
- The largest increase in achievement against available points between 2008/09 and 2009/10 occurred in the patient experience indicators, PE07 and PE08. For PE07 (access to a GP or nurse within 48 hours) the achievement increased from 87.1% to 98.0% of available points and for PE08 (ability to book an appointment in advance) the increase was from 61.5% to 80.2%.
- The average QOF payment to a GMS practice for 2009/10 was £130,778. This is up slightly from £129,434 in 2008/09.

Results and Commentary

Overall achievements

Amongst Scottish general practices with a standard GMS contract type, the average total number of QOF points achieved in 2009/10 was 972.2 (out of a maximum 1000). 96.8% of GMS practices had a total achievement of at least 900 QOF points and 85.4% of practices had an achievement of at least 950 QOF points. Overall, the average number of points achieved in 2009/10 appears to show little change from the average for 2008/09, which was 972.0 points. However, any comparisons made between achievements or payments in 2009/10 and the previous year should acknowledge that there have been changes to the QOF for 2009/10. The QOF was not designed to be static. Each year it is subject to formal review and as a result new indicators can be introduced and existing indicators can be dropped or redefined. For 2009/10, new indicators were introduced and some existing ones were revised. Achievement tends to be lower for newly introduced indicators whilst achievement for established indicators tends to increase year upon year, therefore increases in some areas are offset by relatively less high achievement against newly introduced indicators. More detail on the changes to QOF indicators for 2009/10 is given in Appendix A1 of this report and on the [primary care contracting pages](#) of the NHS Employers website. A separate page on ISD's website gives more detail on [Revisions to the QOF for 2009/10 and earlier years](#).

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 by decision of 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, 26 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 85.6% on average. This is down from 95.6% for the depression indicator group in 2008/09, but reflects the fact that for 2009/10 a new indicator, DEP03, was introduced. This new 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 new DEP03 indicator in its first year of inclusion in the QOF.

Amongst GMS practices, the patient experience indicator group had the largest overall increase in the percentage of available QOF points achieved between 2008/09 and 2009/10, although the total increase appears relatively small at Scotland level and is more noticeable when looking at results for individual practices and/or individual patient experience indicators. The overall percentage of available points achieved for the patient experience indicators rose from 88.9% in 2008/09 to 91.9% in 2009/10. This increase is mainly down to improvements in achievement for two indicators around access to practices, PE07 and PE08:

- PE08 in particular showed improvement between the two years (up from 61.5% of available points to 80.2%). 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 and so the observed increase in achievement has been comparatively less pronounced (from 87.1% of points in 2008/09 to 98.0% of points in 2009/10).

It should also be noted that two patient experience indicators were removed from the QOF for 2009/10, therefore the percentage achievement for the patient experience indicator group is not based on the same indicator set or number of available points as was the case in 2008/09. The indicators removed were PE02 and PE06; more information on these changes is given in Appendix A1 of this report and on the [primary care contracting pages](#) of the NHS Employers website.

PE07 and PE08 indicator achievement is based for each practice on results of the GP Patient Experience Survey. The results of this survey were published earlier in 2010 on the Scottish Government website at <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPAccessSurveyResults> and also on the Better Together Scotland website at http://www.bettertogetherscotland.com/bettertogetherscotland/CCC_FirstPage.jsp

Payments

The average QOF payment to a GMS practice for 2009/10 was £130,778. This is up slightly from £129,434 in 2008/09. Total QOF funding to practices in Scotland for the 2009/10 year was approximately £129 million, compared to roughly £128 million in 2008/09. QOF payments are part of a total of around £700 million invested annually in Primary Medical Services across Scotland.

The rules for calculating QOF payments were changed for 2009/10. The changes apply to the clinical domain of the QOF (the indicators that relate to particular health conditions such as CHD or diabetes). The changes in the payment calculation rules have had relatively little impact on the overall totals, with average payment per practice in 2009/10 being fairly similar to the average for 2008/09. However, the nature of the rule changes is one of a number of reasons that changes to payments for some individual practices can be quite pronounced, even if their QOF achievements appear to be similar in each year.

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](#)). A very brief summary of the changes to the clinical indicator payment rules in 2009/10 is also given on our web page containing [Information for users of QOF register and prevalence data](#).

In addition to QOF funding for 2009/10, 295 practices in Scotland received an easement payment in relation to their QOF achievements for 2009/10. In autumn/winter 2009/10, general practices across Scotland participated in the campaign to vaccinate patients against the H1N1 strain of influenza (also known as "swine flu"). This was additional work for practices over and above the usual annual seasonal flu vaccination programme. Part of the UK agreement for the H1N1 vaccination programme was that if a practice achieved a certain level of H1N1 vaccination uptake amongst patients at particular risk of complications from flu, that practice would be entitled to concessions (easements) on the two QOF indicators relating to patient access (PE7 and PE8) if they had not achieved full points for those two indicators. The total value of the easement payments was approximately £539,000 (this is over and above the normal QOF payment totals reported above). More information on the easement arrangements is provided in Appendix A1 of this publication.

Prevalence

Overview

Prevalence is a measure of the burden 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.

Scotland level prevalence rates of health conditions included in the QOF were initially published in June 2010. These initial figures were based on practice register submissions as used to support QOF payment calculations. However, this publication contains prevalence information by Board and Community Health Partnership (CHP) and for individual practices. The initial rates for Scotland are now supplemented with rates based on finalised practice QOF register data from a higher number of practice returns. This means that some of the prevalence rates provided in this release may differ from those published in June.

Any comparison of QOF-reported prevalence rates between years should be treated with caution (see notes on interpretation of QOF prevalence figures, below). However, reported QOF prevalence rates for Scotland changed little between 2008/09 and 2009/10. The main change in reported prevalence rates was for 'new diagnosis of depression'. The overall QOF-reported crude prevalence rate (for all practices) of 'new diagnosis of depression' increased from 7.7% to 8.6%. However, this increase was expected. The register for 'new diagnosis of depression' is often in effect cumulative since it measures all diagnoses of depression recorded in a practice clinical IT system (excepting those subsequently recorded as being resolved) .

Previously published prevalence figures for 2008/09 have been updated to include data from 8 practices in NHS Grampian with 17C contracts. This is to bring the prevalence data for 2008/09 in line with data from previous years, as well as data for 2009/10, which include these practices. The revision has an effect of increasing the reported counts of patients on each QOF register within NHS Grampian and Scotland but has very little effect on the prevalence rates as derived from these registers. This group of practices is not included in the tables showing practice QOF achievements, however, as each of these practices uses just a subset of the GMS QOF indicators in their own quality work. As outlined above in the commentary on overall achievements, the QOF is part of the GMS contract (the main contract type for general practices) and as such, practices with other contract types may choose not to use the QOF at all, or only use parts of it.

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 include only persons over a specific age. However, the QOF prevalence rates use as their denominator the total (all ages) number of patients registered to 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, patients need to be aged 17 or over and 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 are difficult to interpret for various reasons including:- changes in epidemiological factors (such as an ageing population); improvements in case finding by practices; changes over time in the definition of the registers.

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 can 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 also incorporates a range of information on QOF exception reporting in Scotland for 2009/10. 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 [2009/10 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 5% 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 only 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 2C practices do record data for QOF indicators, they may only 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. For 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 (£126.76 in 2009/10) 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 pounds are 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. For 2009/10 indicators measuring achievement against primary prevention of cardiovascular disease were added. This, combined with small changes to existing indicator areas, means that there are now 86 indicators in 20 areas.
COPD:	Chronic Obstructive Pulmonary Disease
CVD:	Cardiovascular Disease
Denominator:	The indicator 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 86% 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 (QMAS) 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
QOF:	Quality & Outcomes Framework
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 recency of diagnosis.

TIA:

Transient Ischaemic Attack

List of data table pages

Data table page	Number of data files	Time period	File type & size(s)
Achievements data tables at Scotland and NHS Board Level *	6	Year ending March 2010*	Excel [29kb – 380kb]
Achievements data at Community Health Partnership (CHP) level *	5	Year ending March 2010*	Excel [37kb - 890kb]
Achievements data at practice level – summaries *	22	Year ending March 2010*	Excel [231kb - 285kb]
Achievements data practice level - individual indicators *	37	Year ending March 2010*	Excel [0.2mb – 5.7mb]
Register and prevalence data at Scotland, NHS Board and CHP level *	5	Year ending March 2010*	Excel [0.2mb – 1.3mb]
Scotland Performs - Dementia data for HEAT target	1	Year ending March 2010	Excel [38kb]
Exception reporting in clinical indicators *	36	Year ending March 2010*	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 on this topic can be found on the [General Practice: QOF area of 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 86%) 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, 2009/10

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 2009/10, 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 – 2008/09) 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, 2009/10

Domain	Number of indicators	Total points available	Pounds per point
Clinical	86	697	Variable
Organisational	36	167.5	£126.76
Patient Experience	3	91.5	£126.76
Additional Services	9	44	£126.76
Total	134	1000	

Notes:

1. £126.76 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 5150 patients for 2009/10). No further adjustments are done to the payments for additional services beyond those in note 3 above.

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, as outlined in two of our web pages: [Summary of available clinical domain points, by year](#) and [Revisions to the QOF, by year](#).
- 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 2009/10 comprises indicators on cervical screening, child health surveillance, maternity services and sexual health. The sexual health group replaced a group of contraceptive services indicators used from 2004/05 to 2008/09.

Summary of available clinical domain points, 2009/10

The proportion of the QOF that is taken up by clinical indicators has increased since it was first introduced in 2004/05. In 2009/10, 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 2009/10. This and equivalent information for previous QOF years (2004/05 – 2008/09) 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 2009/10 is given below, whilst changes for previous years are summarised on our web page [Revisions to the QOF, by year](#).

Points available to practices 2009/10, 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

Revisions to the QOF, 2009/10

Out of the maximum 1,000 QOF points available to each practice in 2008/09, 72 were re-allocated for 2009/10. These 72 points were removed from indicators in the following groups: Patient Experience, Smoking, Hypertension, Coronary Heart Disease, Atrial Fibrillation and Contraceptive Services.

Of these 72 points, 23 were allocated to two new indicator groups for 2009/10. These are:

- Sexual Health (10 points), which replaces Contraceptive Services and is designed to improve advice and choice on contraceptive methods
- Primary Prevention of Cardiovascular Disease (13 points), which is designed to help to prevent the development of cardiovascular disease in people diagnosed with high blood pressure.

In addition to these new indicator groups, 49 points were re-allocated within existing indicator groups, either for re-defined or completely new indicators. The groups are Heart Failure, Chronic Kidney Disease, Depression, Diabetes and Chronic Obstructive Pulmonary Disease (COPD). These changes are designed, amongst other things, to reduce early cessation of treatment for depression and improve drug treatment for people with heart failure.

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](#).

Easements to practice QOF payments for 2009/10

Introduction

In addition to QOF funding for 2009/10, 295 practices in Scotland received an easement payment in relation to their QOF achievements for 2009/10. In autumn/winter 2009/10, general practices across Scotland participated in the campaign to vaccinate patients against the H1N1 strain of influenza (also known as "swine flu"). This was additional work for practices over and above the usual annual seasonal flu vaccination programme. Part of the UK agreement for the H1N1 vaccination programme was that if a practice achieved a certain level of H1N1 vaccination uptake amongst patients at particular risk of complications from flu, that practice would be entitled to concessions (easements) on the two QOF indicators relating to patient access (PE7 and PE8) if they had not achieved full points for those two indicators. The total value of the easement payments was approximately £539,000 (this is over and above the normal QOF payment totals reported above). This section of Appendix A1 contains a summary of the easement arrangements and a downloadable [Excel file of 2009/10 easement figures for practices and NHS Boards in Scotland](#).

When did easements apply?

Practices were eligible to receive a QOF easement payment for 2009/10 if BOTH of the following conditions were met:-

1. They vaccinated (for H1N1) more than 50.7% of their patients who were in clinical risk groups and were between 6 months and 64 years of age
2. They did not achieve full points for either or both of the following QOF indicators relating to patient access:
 - PE7 (The percentage of patients who, through the 2009 GP patient experience survey, indicated that they were able to access a doctor or nurse at the practice within 48 hours)
 - PE8 (The percentage of patients who, through the same survey, indicated that they were able to make an appointment with practices in advance)

QOF easement payments were paid to eligible practices by final agreement with each NHS Board. It was not automatic that a potentially eligible practice would receive the easement payment. For example, NHS Board run practices with 2C contract types may have recorded H1N1 vaccination data for management information purposes and have achieved fewer than full points for PE7 and/or PE8 but not been "paid" under QOF easement arrangements as in these cases the easement amounts were for information only.

How did the easements work?

The two QOF indicators PE7 and PE8 have their points (and therefore payments) awarded on a sliding scale. What this means is that two percentages are set in relation to each indicator:

- a minimum percentage of patients (lower threshold), which represents the start of the scale (i.e. with a value of zero points); and
- a maximum percentage of patients (upper threshold), which is the lowest percentage of eligible patients for whom the particular indicator outcome must be recorded in order to qualify for all the points available for that indicator.

Where practice achievements fall below the minimum percentage, no points are scored. Where they lie on or above the maximum percentage, full points are scored. For percentages between the minimum and maximum values designated for the indicator, the number of points achieved is calculated in a linear way, based on where the observed percentage lies relative to the lower and upper thresholds.

For 2009/10, where practices met the eligibility criteria for easement payments, the lower and upper thresholds for PE7 and/or PE8 were reduced and the points and associated payment recalculated. The payment for these indicators made under normal QOF rules was subtracted from the recalculated value, and the difference was paid to practices as their H1N1 QOF easement payment.

For 2009/10 the original and eased thresholds for PE7 and PE8 were as follows:-

PE7	uneased	eased	PE8	uneased	eased
Lower threshold	70	50	Lower threshold	60	40
Upper threshold	90	80	Upper threshold	90	80
Maximum points	23.5	23.5	Maximum points	35	35

Example H1N1 QOF points easement calculation:

Practice A exceeded the minimum H1N1 vaccination uptake, had a maximum score for the QOF indicator PE7 but did not achieve full points for PE8. The PE8 results showed that 70% of patients indicated that they had been able to book an appointment in advance.

Under the usual QOF rules the points for PE8 were calculated as follows:-

$$((70 - 60) / (90 - 60)) \times 35 = (10 / 30) \times 35 = 11.67$$

Where

70 = the practice % for the indicator

60 = the lower threshold

90 = the upper threshold

35 = maximum number of points available for the indicator

Under the easement rules, the points for PE8 were recalculated as follows:-

$$((70 - 40) / (80 - 40)) \times 35 = (30 / 40) \times 35 = 26.25$$

The difference between the uneased and eased points for PE8 was 14.58 and the corresponding easement payment was based on this difference of 14.58 points.

Where to get more information on the H1N1 easement arrangements

More information on the H1N1 QOF easements is available in the following documents:-

- [H1N1 vaccination programme: guidance on GP practice eligibility for QOF PE7/8 easement \(NHS Circular PCA\(M\)\(2010\)4\)](#)
- [The Primary Medical Services \(Directed Enhanced Services - Pandemic Influenza \(H1N1\) vaccinations scheme\) \(Scotland\) Directions 2009 \(NHS Circular PCA\(M\)\(2009\)13\)](#)
- [The General Medical Services Statement of Financial Entitlements for 2009/10 \(NHS Circular PCA\(M\)\(2009\)15\)](#)

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 2009/10](#) published by the Scottish Government
- In the [Quality and Outcomes Framework Guidance for GMS Contract 2009/10](#)
- 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](#)
- 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, "QMAS" (which stands for Quality and Outcomes Framework Management and Analysis System). During the latter part of each financial year, QMAS 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 by the QMAS database. 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 (23rd July 2010 in the case of the 2009/10 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 2009/10
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)	QMAS database, plus notifications from NHS Boards of local adjustments to data
Date that data is acquired	Data extract taken in July 2010. This was then validated and amended to reflect local adjustments, as notified by NHS Boards. Finalised data file available late August 2010.
Release date	28 September 2010
Frequency	Annual
Timeframe of data and timeliness	Data for the year ending March 2010. 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	QOF data are collected as part of practices' contractual agreements and are subject to payment verification processes both prior to and after payment. Therefore, overall, QOF figures have a good degree of accuracy. However, from time to time there may be

	<p>technical or other problems with individual practice data submissions which can mean that the finely detailed data here may under-count 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.</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 99% of Scottish practices. However, 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</p>

	the information shown here is not directly comparable with any apparent equivalents for other countries.
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 measure	Numbers and percentages. Shown for individual practices, Community Health Partnerships, NHS Boards and Scotland
Disclosure	The ISD protocol on Statistical Disclosure Protocol is followed. A copy of this protocol is available at: http://www.isdscotland.org/isdscotland/About-ISD/About-Our-Statistics/
Official Statistics designation	National Statistics
UK Statistics Authority Assessment	Awaiting assessment by UK Statistics Authority
Last published	29 September 2009
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Help e-mail	nss.isdGeneralPractice@nhs.net
Date form completed	May 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)

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