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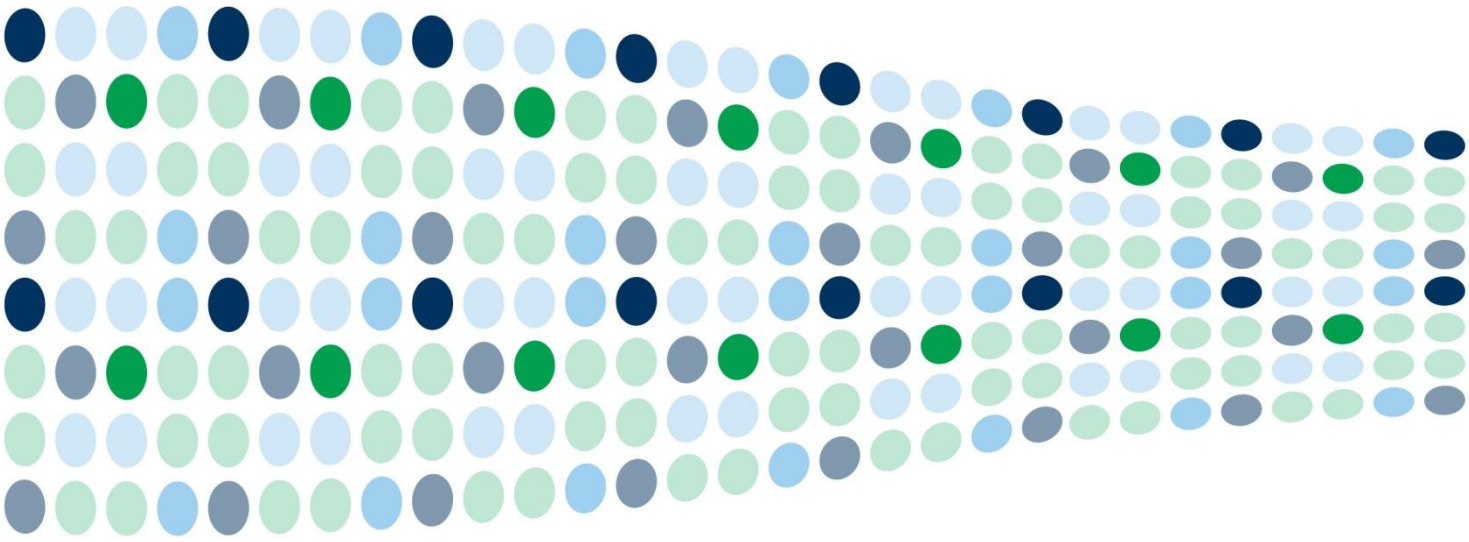
Quality and Outcomes Framework – Prevalence, Achievements and Exceptions Report

Technical Annex, 2013-14



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This publication may be of interest to General Practitioners, members of the public and other stakeholders to make local and national comparisons and gain a picture of GP service provision and service quality for participating practices in England.

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QOF Information

The Calculating Quality Reporting Service (CQRS)

In 2013/14, all the QOF data has been collected from practices by the General Practice Extraction Service (GPES)[1]. GPES is a centrally managed primary care data extraction service that extracts information from GP IT systems for a range of purposes at a national level. GPES flows data to the Calculating Quality Reporting Service (CQRS)[2].

CQRS has been used to calculate payments for GP practices across England for the 2013/14 financial year. The service calculates achievement and payments on quality services, including the Quality and Outcomes Framework (QOF), as well as Enhanced Services (ESs) and some other clinical services (e.g. new immunisations).

The QOF bulletin covers three types of data for England:

- Data relating to QOF achievement.
- Recorded prevalence information based on QOF clinical registers.
- Data relating to QOF clinical indicator exceptions.

Data coverage – QOF achievement data

QOF achievement data are presented for general practices in England which made an end-of-year submission to CQRS. QOF achievement figures were extracted on the 25th July so include all adjustments made on CQRS up to the 24th July.

Note that the number of practices covered by the QOF publication changes each year.

QOF achievement data for PMS practices

Personal Medical Services (PMS) practices are able to negotiate local contracts with their commissioning organisations for the provision of all services. PMS practices may also participate in the QOF, and they may either follow the national QOF framework or enter into local QOF arrangements. PMS practices with local contractual arrangements are included in the published QOF information, and in the figures presented in the bulletin.

Where PMS practices use the national QOF, their achievement (in terms of the 900 QOF points available) is subject to a deduction (approximately 100 points) before QOF points are turned into QOF payments. This is because many PMS practices already have a chronic disease management allowance, a sustained quality allowance and a cervical cytology payment included in their baseline payments. GMS practices do not receive such payments, but receive similar payments through the QOF. To ensure comparability between GMS and PMS practices, the QOF deduction for PMS practices ensures that they do not receive the same payments twice. Because the bulletin covers QOF achievement and not payments, all QOF achievement shown is based on QOF points prior to PMS deductions. This is to allow comparability in levels of achievement – so that where GMS and PMS practices have maximum QOF achievement, both are regarded as having achieved the maximum 900 points.

[1] http://www.hscic.gov.uk/gpes
[2] http://systems.hscic.gov.uk/cqrs

QOF prevalence data

Prevalence information is provided for all practices that were in the QOF achievement dataset. CQRS uses clinical registers to make prevalence adjustments in calculating practices' QOF payments, but the national publication of QOF information shows only raw recorded prevalence.

The number of patients on clinical registers can be used to calculate disease prevalence, expressing the number of patients on each register as a percentage of the number of patients on practices' lists. Therefore 'raw prevalence' for a clinical area is defined as:

*Raw prevalence = (number on clinical register / number on practice list) * 100*

Seven clinical areas and 5 public health areas of the QOF are based on registers that relate to specific age groups. These are:

Chronic kidney disease 18+

Depression 18+

Diabetes mellitus 17+

Epilepsy 18+

Learning disabilities 18+

Osteoporosis 50+

Rheumatoid arthritis 16+

Blood pressure 40+

Obesity 16+

Smoking 15+

Contraception <55

Cervical Screening 25-64

Because 'prevalence rates' based on registers as a percentage of total list size would underestimate prevalence for any of the above that have a prevalence rate, alternative calculations, based on appropriate age-banded list size information, have been used to derive more precise prevalence rates for these.

The clinical registers used to calculate prevalence were those submitted to CQRS at the same time as achievement submissions (i.e. end of year submissions). From 2009 onwards, 'National Prevalence Day' was moved to 31 March – so for the purpose of prevalence adjustments to QOF payments, prevalence is calculated on the same basis as disease registers for indicator denominators. (In years prior to 2008/09 'National Prevalence Day' for prevalence adjustments was 14 February.)

Practice list sizes

The QOF information published by the Health and Social Care Information Centre (HSCIC) includes practice list sizes supplied to CQRS from the National Health Applications and Infrastructure services (NHAIS)[3], as at 1st January of the reporting year. These figures are

[3] http://systems.hscic.gov.uk/ssd/prodserv/vaprodopenexe

used in CQRS for list size adjustments in QOF payment calculations. In the context of this publication, these list sizes are used as the basis for the calculation of raw clinical prevalence.

The sum of the practice list sizes for the practices included in the QOF publication are estimated to represent over 99.0 per cent of registered patients in England (based on registration data from Exeter extract).

Level of detail

There is no patient-specific data in CQRS because this is not required to support the QOF. For example, GPES captures aggregate information for each practice on patients with coronary heart disease and on patients with diabetes, but it is not possible to identify or analyse information about individual patients. It is not possible, for example, to identify the number of patients with both of these diseases.

QOF exception reporting

Patient exception reporting applies to those indicators in the QOF where level of achievement is determined by the percentage of patients receiving the specified level of care.

The GMS contract Statement of Financial Entitlements (SFE)[4] includes the following:

'The QOF includes the concept of exception reporting. This has been introduced to allow 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.

The following criteria have been agreed for exception reporting:

A) patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months

B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty

C) patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels

D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal

E) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contraindication or have experienced an adverse reaction

F) where a patient has not tolerated medication

G) where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records

H) where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease

[4] https://www.gov.uk/government/publications/the-statement-of-financial-entitlements-amendment-directions-2012

I) where an investigative service or secondary care service is unavailable.
In the case of exception reporting on criteria A and B this would apply to the disease register and these patients would be subtracted from the denominator for all other indicators. For example, in a practice with 100 patients on the CHD disease register, in which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95. This would apply to all relevant indicators in the CHD set.

In addition, practices may exception-report patients relating to single indicators, for example a patient who has heart failure due to left ventricular dysfunction (LVD) but who is intolerant of ACE inhibitors could be exception-reported. This would again be done by removing the patient from the denominator.

Practices should report the number of exceptions for each indicator set and individual indicator. Exception codes have been added to systems by suppliers. Practices will not be expected to report why individual patients were exception-reported. Practices may be called on to justify why they have excepted patients from the QOF and this should be identifiable in the clinical record.'

Definitions

Definitional background

There is a distinction between:

- Numbers of patients on disease registers for QOF indicator groups (disease areas).
- Numbers of patients relevant to specific indicators within these indicator groups.
- Numbers of patients relevant to specific indicators who are included in the indicator denominator when measuring QOF achievement.

Registers

Registers relate to each of the indicator groups within the QOF. Not all conditions have a register e.g. Blood pressure is a count of those who have had their blood pressure taken so is not a register. The information systems which underpin the QOF hold the numbers of patients on each of these registers, for each participating practice. For example, there is a register count for all people diagnosed with coronary heart disease at each practice.

Indicator denominators, exclusions and exceptions

Indicator ***denominators*** are the numbers of patients from the appropriate disease register who are counted for QOF achievement against a specific QOF indicator. (The indicator numerator is the number of those in the denominator who meet the specific indicator success criteria.)

Differences between an indicator denominator and the number on a register can be due to indicator definition. Some indicators refer to subsets of patients on a disease register, for example they may refer only to patients who smoke. Patients who are on the disease register, but not included in the indicator denominator for definitional reasons, are referred to here as ***exclusions***.

Where differences between an indicator denominator and the number on a register are not due to indicator definition, this is due to ***exceptions***. Exceptions relate to patients who are on the disease register, and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the SFE[5] exception criteria.

The normal relationship between registers, denominators, exclusions and exceptions is therefore:

Register = Denominator + Exclusions + Exceptions

QOF measures

QOF achievement

Reference to ‘QOF achievement’ often refers to the percentage of available QOF points achieved. So if a practice achieves the full 900 QOF points it has achieved 100 per cent of the points available and may be said to have 100 per cent achievement across the whole QOF.

[5] Statement of Financial Entitlement - see page 6

The level of achievement for certain elements of the QOF can be expressed in the same way. A practice achieving all clinical QOF points available, can be said to have 100 per cent clinical achievement even though it may not have 100 per cent achievement overall.

Practices achieve the maximum QOF points for most indicators (especially clinical indicators) when they have delivered the maximum threshold to achieve the points available.

For many indicators a practice must provide a certain level of clinical care to 90 per cent of patients on a particular clinical register to achieve the maximum points.

Underlying achievement (net of exceptions)

Underlying achievement (net of exceptions) data are provided in the spreadsheets associated with the report. Since a practice can deliver the required care to fewer than 100 per cent of its patients (often around 90 per cent) to achieve the full (100 per cent) points available, there is an important distinction between percentage achievement in terms of QOF points available and the underlying achievement (net of exceptions) for specific indicators.

Underlying achievement (net of exceptions) presents the indicator numerator as a percentage of the denominator as is calculated thus;

$$\text{Underlying achievement (net of exceptions)} = \frac{\text{Indicator Numerator}}{(\text{Indicator Denominator})}$$

Percentage of patients receiving the intervention

Underlying achievement (net of exceptions) does not account for all patients covered by indicator, as it takes no account of “exceptions” (patients to whom the indicator applies, but who are not included in the indicator denominator according to agreed exception criteria). *Percentage of patients receiving the intervention*, gives a more accurate indication of the rate of the provision of interventions as the denominator for this measure covers all patients to whom the indicator applies, regardless of exception status (i.e. indicator exceptions and indicator denominator). This measure is calculated as follows;

$$\text{Percent of patients receiving intervention} = \frac{\text{Indicator Numerator}}{(\text{Indicator Exceptions} + \text{Indicator Denominator})}$$

Percentage of patients receiving the intervention **figures are not covered in the main report bulletin, they are presented in the indicator specific spreadsheets at national, Region, Area Team, CCG and practice level, where they are presented alongside achievement and exceptions data.**

Points achieved as a per cent of QOF points available

In recognition of the fact that it is not always possible for practices to achieve all of the points in the QOF, the HSCIC has produced a further measure of practice achievement. This measure takes account of instances where practices cannot achieve points because they have no patients pertinent to an indicator.

For example, in 2013/14 there were 900 points available in the QOF. 77 of these points were allocated to Hypertension indicators. If a practice does not have any patients on their Hypertension register (i.e. no patients meeting the QOF definition for established hypertension), then they would be unable to achieve any of the points allocated to the Hypertension indicators. Therefore, even if the practice achieved all the other points

available they would only be able to reach 91.4 per cent points achievement (823 points achieved / 900 points available).

In these circumstances, the standard 'points achievement' measure can be misrepresentative and may result in a practice's achievement apparently declining from one year to the next where they have patients on a register in one year but none in the next year.

To represent practice points achievement more fairly, the HSCIC calculates adjusted maximum points achievable for each practice, effectively removing points from the calculation denominator where **both** of the following conditions apply:

- the practice does not have any patients in the indicator denominator.
- the practice has reported no exceptions for the indicator denominator

In essence, the indicator denominator plus indicator exceptions must equal zero. This ensures we are not adjusting maximum points achievable where there are patients on the relevant disease register (exceptions are included in the disease register, but not in the relevant denominator), who have not received the interventions.

For the example outlined previously, for a practice with no patients on their hypertension register the practices maximum **points available** would be 823 (900 points minus the 'unachievable' 77 Hypertension points). In this case, the difference between the practices **'points achievement'** and **'points achieved as a per cent of QOF points available'** would be as follows;

Points achievement	= (Points achievement / All QOF points) x 100
	= (823 / 900) x 100 = 91.4 per cent
Points achieved as per cent of points available	= (Point achievement / QOF points available) x 100
	= (823 / 823) x 100 = 100 per cent

Points achieved as a per cent of QOF points available **are not covered in the main report bulletin, they are presented at practice level in the practice domain summary spreadsheet, alongside the *Points achievement* data.**

Effective exception rates

Exception reporting rates presented in this bulletin are referred to as 'effective exception rates'. For each indicator in the clinical domain, the effective exception rate is calculated as follows:

*[Number of Exceptions / (Number of Exceptions + Indicator Denominator)] * 100*

Therefore the recorded number of exceptions is expressed as a percentage of the number of patients on a disease register who were qualified to be part of the indicator denominator – i.e. were not counted as *exclusions* for definitional reasons.

Source data

CQRS is primarily a system to support QOF payments, and exception reporting is recorded as part of that process. CQRS was not designed to deliver specific management information

about exception reporting, but does allow summary information on the levels of exception reporting to be generated. This information is the basis for this publication.

Number of practices included in exceptions data

A small number of practices which participate in the QOF make manual submissions to CQRS or are otherwise unable to make an electronic submission of exceptions data. For this small number of practices, no exceptions data are available. However, in order to maintain consistency with the report annexes, which are based on aggregated data from individual practices, they are included in the overall exception calculations.

This has the impact of slightly reducing the exception rates (because there are no *indicator exceptions* for these practices in the calculation numerator, but their *indicator denominator* data are included in the calculation denominator). The impact of this is minimal with an impact of less than 0.01 of a percentage point on the national level exception rate. At Area Team level (where only seven of 25 are affected), the biggest impact is less than 0.05 of a percentage point of overall exception rates.

Notes on the data

Practices using CQRS were able to amend disease register figures and measures of QOF achievement (numerators and denominators for indicators) following the financial year end, prior to agreement of QOF achievement with their Area Teams (ATs) for payment. However, information captured by CQRS relating to exceptions and exclusions can not be amended on the CQRS system. Where amendments to registers or indicator denominators occurred, the relationship between disease register, indicator denominator, exclusions and exceptions could be affected – and there could be a difference between effective exception rates computed using CQRS data and 'actual rates' that would have been computed if exception and exclusion counts had been amended in line with changes to registers and denominators.

CQRS does not allow a presentation of exceptions broken down by each of the nine Statement of Financial Entitlements (SFE) exception criteria outlined above. There are four reasons for this:

- CQRS uses an internal set of exception ID codes that do not map directly into the nine exception reporting criteria in the SFE; rather, these exception ID codes relate to exception reporting coding 'clusters' within QOF business rules, often specific to individual QOF indicators.
- CQRS reporting functionality does not make a distinction between exception reporting and definitional exclusions – both types of omission from indicator denominators are included on reports available to CQRS users.
- Any individual patient can be associated with more than one of the exception criteria, but only one such reason needs to be identified in order to exception-report a patient from inclusion in the indicator denominator. Only the first reason identified by the system is therefore captured, and no information is captured for other potential reasons.
- Testing of data extraction to CQRS in line QOF business rules around patient exceptions is primarily focused on ensuring that data values used for achievement calculations are accurate for payment purposes; ie that patients are not included in indicator denominators where appropriate in terms of the business rules. Therefore any testing of the order of sequencing (ie the order whereby systems check for different exception codes or criteria) is secondary. Different GP clinical information

systems **may** follow different sequencing without this impacting on payment accuracy.

QOF prevalence

Notes on QOF prevalence

It is important to emphasise that QOF registers are constructed to underpin indicators on quality of care, and they do not necessarily equate to prevalence as may be defined by epidemiologists. For example, prevalence figures based on QOF registers may differ from prevalence figures from other sources because of coding or definitional issues. It is difficult to interpret year-on-year changes in the size of QOF registers, for example a gradual rise in QOF prevalence could be due partly to epidemiological factors (such as an ageing population) or due partly to increased case finding. Other factors in interpreting information on specific registers include:

- Some clinical areas have 'resolution codes' to reflect the nature of diseases. Others, such as the cancer register, do not
- To be on the asthma register, patients need a diagnosis of asthma and a prescription for an asthma drug within the year
- Seven clinical areas of the QOF are based on registers that relate to specific age groups. Osteoporosis registers are based on patients aged 50+; diabetes registers are based on patients aged 17+; chronic kidney disease, depression, epilepsy and learning disabilities registers are based on patients aged 18+; and obesity registers are based on patients aged 16+. Because 'prevalence rates' based on registers as a percentage of total list size would underestimate prevalence for these seven clinical areas, alternative calculations, based on appropriate age-banded list size information, were used to derive more accurate prevalence rates for these seven clinical areas
- Many patients are likely to suffer from co-morbidity, i.e. diagnosed with more than one of the clinical conditions included in the QOF clinical domain. Robust analysis of co-morbidity is not possible using QOF data because QOF information is collected at an aggregate level for each practice; there is no patient-specific data within CQRS. For example, CQRS captures aggregated information for each practice on patients with coronary heart disease and on patients with diabetes, but it is not possible to identify or analyse patients with both of those diseases.
- To be included in the obesity register a patient must be 16 or over and have a record of a BMI of 30 or higher in the previous 12 months. This requirement results in the prevalence of obesity in QOF being much lower than the prevalence found in the Health Survey for England and other surveys.
- The QOF register for 'cardiovascular disease – primary prevention' does not count the number of patients with cardiovascular disease. Rather, this is a register of patients with a new diagnosis of hypertension, excluding those with pre-existing CHD, diabetes and stroke/TIA
- The QOF register for 'Osteoporosis – secondary prevention of fragility fractures' is a register of patients aged over 50 with a record of a fragility fracture since April 2012. Patients aged 50-74 must have the diagnosis of osteoporosis confirmed by a DXA scan; for patients aged 75 and over the DXA confirmation is not required

Age specific list sizes and prevalence rates

Age-banded practice list sizes, relating to the final quarter of the reporting year (January to March), are obtained from the HSCIC reference data service for the practices included in the QOF prevalence dataset. List size figures for this period are usually available for the majority of practices (over 99 per cent) in the QOF prevalence dataset. The list size figures for this period are the most appropriate for using a basis for prevalence measures, as disease registers are taken as at 31 March each year ('prevalence day')

The HSCIC data gives ages by single year. These provide the:

- Number on each practice list aged 16+ (for obesity and rheumatoid arthritis)
- Number on each practice list aged 17+ (for diabetes)
- Number on each practice list aged 18+ (for depression, epilepsy, chronic kidney disease and learning disabilities)
- Number on each practice list aged 50+ (for osteoporosis)

These numbers were then used to calculate:

- The percentage of each practice list who were aged 16+ (for obesity and rheumatoid arthritis)
- The percentage of each practice list who were aged 17+ (for diabetes)
- The percentage of each practice list who were aged 18+ (for depression, epilepsy, chronic kidney disease and learning disabilities)
- The percentage of each practice list who were aged 50+ (for osteoporosis)

These percentages were then applied (if the data was missing or zero then data for these practices was omitted) to the total list sizes in the QOF dataset to give:

- The number on each QOF patient list aged 16+ (for obesity and rheumatoid arthritis)
- The number on each QOF patient list aged 17+ (for diabetes)
- The number on each QOF patient list aged 18+ (for depression, epilepsy, chronic kidney disease and learning disabilities)
- The number on each QOF patient list aged 50+ (for osteoporosis)

These numbers then became the denominators for calculation of prevalence rates for the seven clinical areas whose registers are age-specific.

Depression prevalence rates

Note that Depression prevalence rates for 2008/09, as shown in the Quality and Outcomes Framework Achievement and prevalence report 2008/09, were calculated using the whole practice list size (rather than the age specific 18+ list size). These data have not subsequently been recalculated and therefore rates for 2008/09 are inconsistent and in effect are artificially suppressed compared with subsequent years.

Caveats concerning QOF achievement and prevalence data

The CQRS system was established as a mechanism to support the calculation of practice QOF payments. It is not a totally comprehensive source of data on quality of care in general practice, but it is potentially a rich and valuable source of information for healthcare organisations, analysts and researchers, providing the limitations of the data are acknowledged.

Levels of QOF achievement will be related to a variety of local circumstances, and should be interpreted in the context of those circumstances. Users of the published QOF data should be particularly careful in undertaking comparative analysis.

The following points have been raised by local healthcare organisations in consultation with the Health and Social Care Information Centre:

- The ranking of practices on the basis of QOF points achieved, either overall or with respect to areas within the QOF, may be inappropriate. QOF points do not reflect practice workload issues (for example around list sizes and disease prevalence) – that is why practices' QOF payments include adjustments for such factors.
- Comparative analysis of practice-level or CCG-level QOF achievement (or prevalence) may also be inappropriate without taking account of the underlying social and demographic characteristics of the populations concerned. The delivery of services may be related, for example, to population age/sex, ethnicity or deprivation characteristics that are not included in QOF data collection processes.
- Information on QOF achievement, as represented by QOF points, should also be interpreted with respect to local circumstances around general practice infrastructure. In undertaking comparative or explanatory analysis, users of the data should be aware of any effect of the numbers of partners (including single handed practices), local recruitment and staffing issues, issues around practice premises, and local IT issues.
- Users of the data should be aware that different types of practice may serve different communities. Comparative analysis should therefore take account of local circumstances, such as numbers on practice lists of student populations, drug users, homeless populations and asylum seekers.
- Analysis of co-morbidity (patients with more than one disease) is not possible using QOF data. QOF information is collected at an aggregate level for each practice. There is no patient-specific data within QOF data. For example, CQRS captures aggregated information for each practice on patients with coronary heart disease and on patients with asthma, but it is not possible to identify or analyse patients with both of these diseases.
- Underlying all this is the fact that the information held within CQRS, and the source for the published tables, is dependent on diagnosis and recording (case finding) within practices using practices' clinical information systems.
- Measuring the quality of care is not a simple process. Within the clinical domain, the QOF does not cover every clinical condition, and only describes some aspects of the care for the clinical areas that are included. However, the QOF does provide valuable information (for example on prevalence, cholesterol levels and blood pressure) on a

scale unavailable before 2004/05, and provides a measure of improvement in the delivery of care.

Caveats concerning QOF exceptions data

An important aim of the Quality and Outcomes Framework is to encourage appropriate and high quality clinical care for key long-term conditions. Potentially, exception reporting could influence the level of financial reward to practices.

The availability of high level information on exception reporting provides an indication of the variations in exception rates that are found between specific indicators, and between NHS organisational areas.

It is important to emphasise some of the limitations of the available data, as described previously in this document. These include practices missing from the analysis; the derivation of exception counts; and the potential for amendments to indicator denominators not mirrored by changes to counts of exceptions.

Additionally, care should be taken to interpret high level analysis in the context of local primary care service delivery, notably in terms of the numbers of patients associated with relatively high or low exception rates. Clinical commissioning groups will have access to more detailed local information, and knowledge of local circumstances, to enable unusual levels of exception reporting to be investigated further.

QOF formulae

FORMULAE USED IN THE QOF

PLEASE NOTE: Data for 2012-13 is included in the spreadsheets for comparability. However, the sum of the registers, achievement scores or exception counts for 2012-13 practices are not equal to the sum of the same measures at higher levels (CCGs, Area Teams or Region and Nation) for the same year.
This is because practices which are not participating in QOF this year have been removed from practice level spreadsheets, but the CCG, Area Team, Region and England totals are shown as they were published last year.

Measure	Formula
prevalence rate (per cent)	register / full list size x 100
age-specific prevalence rate (per cent)	register / age-related list size x 100
achievement score (per cent)	achievement points / 900 x 100
adjusted achievement score (shown for total only) where practices have one or more register with no patients (per cent)	achievement points / maximum points possible x 100
achievement score (individual indicators) (per cent)	numerator / (denominator + exceptions) x 100
achievement score net of exceptions (per cent)	numerator / denominator x 100
axception rate (per cent)	exceptions / (denominator + exceptions) x 100
year-on-year change (per cent)	((this year per cent / last year per cent) - 1) x 100

QOF indicators 2013/14

Condition / Measure	Indicator Code	Indicator Description
Asthma	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
	AST002	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis
	AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23
	AST004	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months
Atrial fibrillation	AF001	The contractor establishes and maintains a register of patients with atrial fibrillation
	AF002	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the $CHADS_2$ risk stratification scoring system in the preceding 12 months (excluding those whose previous $CHADS_2$ score is greater than 1), NICE 2011 menu ID: NM24
	AF003	In those patients with atrial fibrillation in whom there is a record of a $CHADS_2$ score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy, NICE 2011 menu ID: NM45
	AF004	In those patients with atrial fibrillation whose latest record of a $CHADS_2$ score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46
Cancer	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'
	CAN002	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis, NICE 2012 menu ID: NM62
Chronic kidney disease	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)
	CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
	CKD003	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB
	CKD004	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 12 months

Chronic obstructive pulmonary disease (COPD)	COPD001	The contractor establishes and maintains a register of patients with COPD
	COPD002	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register
	COPD003	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 12 months
	COPD004	The percentage of patients with COPD with a record of FEV1 in the preceding 12 months
	COPD005	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months, NICE 2012 menu ID: NM63
	COPD006	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
Dementia	DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia
	DEM002	The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months
	DEM003	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register, NICE 2010 menu ID: NM09
Depression	DEP001	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded, NICE 2012 menu ID: NM49
	DEP002	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 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50
Diabetes mellitus	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, NICE 2011 menu ID: NM41
	DM002	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2010 menu ID: NM01
	DM003	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02

	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, NICE 2012 menu ID: NM59
	DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)
	DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14
	DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months
	DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
	DM010	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March
	DM011	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
	DM012	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 12 months, NICE 2010 menu ID: NM13
	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, NICE 2011 menu ID: NM28
	DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27
	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, NICE 2012 menu ID: NM51
	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, NICE 2012 menu ID: NM52
Epilepsy	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, NICE 2010 menu ID: NM03
Heart failure	HF001	The contractor establishes and maintains a register of patients with heart failure
	HF002	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register
	HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB
	HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure
Hypertension	HYP001	The contractor establishes and maintains a register of patients with established hypertension
	HYP002	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less
	HYP003	The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less, NICE 2012 menu ID: NM53
	HYP004	The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months, NICE 2011 menu ID: NM36
	HYP005	The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months, NICE 2011 menu ID: NM37
Hypothyroidism	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
Learning disability	LD001	The contractor establishes and maintains a register of patients aged 18 or over 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), NICE 2010 menu ID: NM04
Mental health	MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy

	MH002	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 12 months, agreed between individuals, their family and/or carers as appropriate
	MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17
	MH004	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 12 months, NICE 2010 menu ID: NM18
	MH005	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 12 months, NICE 2011 menu ID: NM42
	MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months, NICE 2010 menu ID: NM16
	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months, NICE 2010 menu ID: NM15
	MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years, NICE 2010 menu ID: NM20
	MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, NICE 2010 menu ID: NM21
	MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months, NICE 2010 menu ID: NM22
Osteoporosis: secondary prevention of fragility fractures	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 Although the register indicator OST001 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers. NICE 2011 menu ID: NM29
	OST002	The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent, NICE 2011 menu ID: NM30
	OST003	The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent, NICE 2011 menu ID: NM31
Palliative care	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age

	PC002	The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed
Peripheral arterial disease	PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease, NICE 2011 menu ID: NM32
	PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2011 menu ID: NM34
	PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less, NICE 2011 menu ID: NM35
	PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken, NICE 2011 menu ID: NM33
Rheumatoid arthritis	RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis, NICE 2012 menu ID: NM55
	RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months, NICE 2012 menu ID: NM58
	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, NICE 2012 menu ID: NM56
	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, NICE 2012 menu ID: NM57
Secondary prevention of coronary heart disease	CHD001	The contractor establishes and maintains a register of patients with coronary heart disease
	CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
	CHD003	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
	CHD004	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March
	CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken
	CHD006	The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin, NICE 2010 menu ID: NM07
Stroke and transient ischaemic attack	STIA001	The contractor establishes and maintains a register of patients with stroke or TIA

	STIA002	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) 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 TIA
	STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
	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 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, NICE 2012 menu ID: NM60
	STIA006	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March
	STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken
Blood pressure	BP001	The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years, NICE 2012 menu ID: NM61
Cardiovascular disease - primary prevention	CVD-PP001	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 CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins, NICE 2011 menu ID: NM26
	CVD-PP002	The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
Obesity	OB001	The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 12 months
Smoking	SMOK001	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months
	SMOK002	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 notes record smoking status in the preceding 12 months, NICE 2011 menu ID: NM38
	SMOK003	The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
	SMOK004	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 24 months, NICE 2011 menu ID: NM40

	SMOK005	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 12 months, NICE 2011 menu ID: NM39
Cervical screening	CS001	The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates
	CS002	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years
	CS003	The contractor ensures there is a system for informing all women of the results of cervical screening tests
	CS004	The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years
Child health surveillance	CHS001	Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with the NHS CB
Maternity services	MAT001	Antenatal care and screening are offered according to current local guidelines agreed with the NHS CB
Contraception	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
	CON003	The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription
Quality and Productivity	QP001	The contractor reviews data on secondary care outpatient referrals, for patients on the contractor's registered list, provided by the NHS CB
	QP002	The contractor participates in an external peer review with other contractors who are members of the same clinical commissioning group to compare its secondary care outpatient referral data with that of the other contractors. The contractor agrees with the group areas for commissioning or service design improvements
	QP003	The contractor engages with the development of and follows 3 care pathways, agreed with the NHS CB, for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals

	QP004	The contractor reviews data on emergency admissions, for patients on the contractor's registered list, provided by the NHS CB
	QP005	The contractor participates in an external peer review with other contractors who are members of the same clinical commissioning group to compare its data on emergency admissions with that of the other contractors. The contractor agrees with the group areas for commissioning or service design improvements
	QP006	The contractor engages with the development of and follows 3 care pathways, agreed with the NHS CB (unless in individual cases they justify clinical reasons for not doing this), in the management and treatment of patients in aiming to avoid emergency admissions
	QP007	The contractor reviews data on accident and emergency attendances, for patients on the contractor's registered list, provided by the NHS CB. The review will include consideration of whether access to clinicians in the contractor's premises is appropriate, in light of the patterns on accident and emergency attendance
	QP008	The contractor participates in an external peer review with other contractors who are members of the same clinical commissioning group to compare its data on accident and emergency attendances with that of the other contractors. The contractor agrees an improvement plan with the group. The review should include, if appropriate, proposals for improvement to access arrangements in the contractor's premises in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements
	QP009	The contractor implements the improvement plan that aims to reduce avoidable accident and emergency attendances
Patient Experience	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 extra patients during booked surgeries, then the average booked consultation length should allow for the average number of extra patients seen in a surgery session such that the length of booked appointments is not less than 10 minutes. If the extra 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 booked appointments is not less than 10 minutes and the length of open surgery appointments is not less than 8 minutes.

QOF links

QOF online database:

http://www.qof.hscic.gov.uk/

NHS Employers (for QOF guidance):

http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework

GMS contract Statement of Financial Entitlements:

https://www.gov.uk/government/publications/the-statement-of-financial-entitlements-amendment-directions-2012

Primary Care Commissioning:

http://www.pcc-cic.org.uk/article/qof-business-rules-v25.0

GPES:

http://www.hscic.gov.uk/gpes

CQRS:

http://systems.hscic.gov.uk/cqrs

QOF Publications in other UK countries

Scotland:

http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework//

Wales:

http://wales.gov.uk/statistics-and-research/general-medical-services-contract/?lang=en

Northern Ireland:

http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof.htm

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