

National Quality and Outcomes Framework  
Exception Reporting Statistics for England  
2006/07

A key feature of the Quality and Outcomes Framework is the encouragement of appropriate and high quality clinical care for patients with chronic diseases. The availability of high level information on exception reporting enables an analysis of the indicators most likely to be subject to exception reporting. It enables a description of the variations in exception reporting rates that are found between specific indicators, and between NHS organisational areas. Exception reporting information was available for the second time in 2006/07, enabling comparison with the previous year for the first time. The Quality and Outcomes Framework was revised in 2006/07, and introduced additional clinical areas.

In 2006/07:

- The overall effective exception rate for England was 5.83%.
- There is variation between indicators. In general, the lowest exception rates relate to indicators that measure a process, and the highest exception rates relate to indicators that measure outcomes.
- At practice level 460 practices (5.5%) had overall exception rates higher than 10%.

Contents:

1. Introduction and Background
  2. Exception Reporting 2006/07
  3. Summary
  4. More Information
- Annex: QOF Indicator Definitions

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# 1. Introduction and Background

## 1.1 Overview of the QOF

The national Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. Participation by practices in the QOF is voluntary, though participation rates are very high, with most Personal Medical Services (PMS) practices also taking part.

For participating practices, the QOF measures practice achievement against a range of evidence-based clinical indicators and against a range of indicators covering practice organisation and management. Practices score points according to their levels of achievement against these indicators, and practice payments are calculated from points achieved.

QOF achievement statistics for 2004/05, 2005/06 and 2006/07 have been published by the Information Centre for health and social care, and may be found on the Information Centre's web site at [www.ic.nhs.uk](http://www.ic.nhs.uk).

From April 2006 a revised QOF was introduced, including new clinical areas and revising some clinical indicators. The revised QOF continued to measure achievement against a set of evidence-based indicators, but allowed a possible maximum score of 1,000 points. The reduction from the previous maximum of 1,050 points was due to the reallocation of resources associated with the 'access bonus' (previously 50 QOF points) to become part of an 'access directed enhanced service'.

The revised QOF measures achievement against 135 indicators and one measure of depth of care, known as holistic care. Practices score points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

Full details of the revision to the QOF are available from the NHS Employers' web site: [www.nhsemployers.org/primary/primary-890.cfm](http://www.nhsemployers.org/primary/primary-890.cfm)

Details of the GMS contract can be found on the Department of Health website (see section 4 of this bulletin).

## 1.2 Contents of the QOF

The QOF contains four main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement:

The **Clinical Domain** consists of 80 indicators across 19 clinical areas:

- Coronary heart disease (10 indicators)
- Heart failure (3)
- Stroke and transient ischaemic attack (8)
- Hypertension (3)
- Diabetes mellitus (16)
- Chronic obstructive pulmonary disease (5)
- Epilepsy (4)
- Hypothyroidism (2)
- Cancer (2)
- Palliative care (2)
- Mental Health (6)
- Asthma (4)
- Dementia (2)
- Depression (2)
- Chronic kidney disease (4)
- Atrial fibrillation (3)
- Obesity (1)
- Learning disabilities (1)
- Smoking (2)

Indicators in the clinical domain are worth up to a maximum of 655 points (65.5% of the total).

The **Organisational Domain** consists of 43 indicators across five organisational areas:

- Records and information (12 indicators)
- Information for patients (4)
- Education and training (8)
- Practice management (10)
- Medicines management (9)

Indicators in the organisational domain are worth up to 181 points (18.1% of the total).

The **Patient Experience Domain** consists of four indicators that relate to length of consultations and to patient surveys. These indicators are worth up to 108 points (10.8% of the total).

The **Additional Services Domain** consists of eight indicators across four service areas:

- Cervical screening (4 indicators)
- Child health surveillance (1)
- Maternity services (1)

- Contraceptive services (2)

Additional services indicators are worth up to 36 points (3.6% of the total).

The QOF also rewards practices with a **holistic care payment**, based on achievement across the clinical domain. This is worth up to 20 points (2.0% of the total).

### 1.3 QOF Exception Reporting

Patient exception reporting applies to those indicators in the clinical domain of the QOF where level of achievement is determined by the percentage of patients receiving the designated level of care. Exception reporting also applies to one cervical screening indicator in the additional services domain.

The GMS Statement of Financial Entitlements (SFE)<sup>1</sup> 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*

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<sup>1</sup> GMS Statement of Financial Entitlements, Annex D Quality and Outcomes Framework Guidance, available from [www.dh.gov.uk](http://www.dh.gov.uk)

*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*

*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.*

## **1.4 Definitional Background**

Exception reporting criteria are applied to individual QOF indicators within the chronic disease indicator groups, and to one cervical screening indicator within the additional services domain.

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.

### 1.4.1 Registers

Registers relate to each of the indicator groups within the clinical domain of the QOF. In 2006/07, there were 19 registers relating to clinical indicator groups, and these are listed in section 1.2 above.

Information systems underpinning the QOF hold, for each participating practice, the numbers of patients on each of these registers. For example, there is a register count for all people on each practice list who are diagnosed with CHD.

### 1.4.2 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 exception criteria.

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

$$\text{Register} = \text{Denominator} + \text{Exclusions} + \text{Exceptions}$$

### 1.5 Effective Exception Rates

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

$$[\text{Number of Exceptions} / (\text{Number of Exceptions} + \text{Indicator Denominator})] * 100$$

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 – ie, were not counted as *exclusions* for definitional reasons.

## **1.6 Source Data**

The source for this bulletin was an extract of data from QMAS (the national IT system delivered by Connecting for Health that supports the QOF payment process).

QMAS is primarily a system to support QOF payments, and exception reporting is recorded as part of that process. QMAS 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.

## **1.7 Number of Practices Included**

Exception reporting information was compiled for 8,331 of the 8,372 practices included in published QOF achievement statistics for 2006/07 in England. Exception information was not submitted to QMAS for practices that made manual submissions to QMAS instead of automatic submissions from practice clinical systems, or where the version of the QMAS software installed on practice systems did not support the submission of information on exception reporting.

## **1.8 Derivation of Exception Numbers**

For each practice-indicator combination, numbers of exceptions were derived as follows:

- Where QMAS recorded a number of exceptions for a practice and indicator (including zero exceptions) this figure was used.
- Where QMAS did not record a number of exceptions for a practice-indicator combination, but did record a number of exclusions, the number of exceptions was taken to be zero.
- Where QMAS did not record a number of exceptions, nor a number of exclusions, for a practice-indicator combination, but where the practice was known to be capable of submitting exception information to QMAS (by virtue of such information being submitted for other indicators), the number of exceptions was taken to be zero.

For some indicators the number of exceptions was recorded for almost all practices, and almost no inferred zeros were derived. For other indicators a zero exception count was derived for a large number of practices.



## 1.9 Notes on the Data

Practices using QMAS were able to amend disease register figures and measures of QOF achievement (numerators and denominators for indicators) following the financial year end (2006/07), prior to agreement of QOF achievement with their primary care trusts (PCTs) for payment. However, information captured by QMAS relating to exceptions and exclusions could not be amended on the QMAS 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 QMAS 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.

Therefore, although the exception reporting rates presented are the best available figures, this bulletin does not present effective exception rates by individual GP practice.

Additionally, the potential for publishing exception reporting data is limited because QMAS does not allow a presentation of exceptions broken down by each of the nine SFE exception criteria outlined above. There are two reasons for this:

- Any individual patient can be associated with more than one of the exception criteria, but only one such reason needs to be identified by the QMAS system in order to except this patient from inclusion in the indicator denominator.
- The testing of patient exceptions on national QOF systems (such as QMAS) is primarily focused on ensuring that data values used for achievement calculations are accurate for payment purposes. 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.

## 2. Exception Reporting 2006/07

### 2.1 Exception Reporting by Indicator Group

Table 1 shows effective exception rates for the 16 areas of the clinical domain, and for cervical screening. The exception rates shown are based on the sum of exceptions and the sum of denominators for all indicators within these indicator groups. (Note that 2006/07 exception reporting information is not available for three areas of the clinical domain – obesity, learning disabilities and palliative care – because indicators for these three areas refer only to the existence of clinical registers.)

Indicator Group	Total Number of Exceptions 2006/07	Sum of Denominators 2006/07	Effective Exception Rate 2006/07	Effective Exception Rate 2005/06
Mental health	123,613	721,504	14.63%	5.39%
Ch. Kidney Disease	489,902	2,940,966	14.28%	-
Heart failure	27,794	223,295	11.07%	8.16% (LVD)
COPD	269,519	2,620,054	9.33%	7.03%
CHD	1,186,262	12,447,795	8.70%	7.38%
Stroke	404,490	4,501,501	8.24%	7.53%
Epilepsy	77,849	881,068	8.12%	8.05%
Atrial fibrillation	64,059	741,697	7.95%	-
Dementia	15,349	196,325	7.25%	-
Diabetes (DM)	1,734,887	25,649,834	6.34%	6.01%
Cervical screening	752,239	12,328,311	5.75%	4.60%
Asthma	186,227	3,273,339	5.38%	7.40%
Depression	198,550	3,718,026	5.07%	-
Cancer	5,336	139,728	3.68%	8.87%
Hypertension (BP)	380,669	12,960,450	2.85%	2.46%
Hypothyroidism	8,010	1,351,843	0.59%	0.59%
Smoking	65,605	12,069,984	0.54%	-
<b>All Indicator Groups</b>	<b>5,990,360</b>	<b>96,765,720</b>	<b>5.83%</b>	<b>5.55%</b>

**Table 1: Exception rates by indicator group, 2006/07**

Table 1 shows that the overall effective exception rate for England, across all indicator groups, was 5.83%. (Note that the numbers of exceptions and the sum of the denominators refer to patient records associated with indicators, not individual patients. Individual patients can occur in more than one indicator group, and can occur more than once in any specific indicator group when associated with more than one indicator.)

Note also that any comparison with figures for 2005/06 will be affected by changes in the sets of QOF indicators for 2006/07. For example, there was

an increase in the overall exception rate for mental health indicators, and this was in part be due to the inclusion of two new mental health indicators (MH07 and MH09) in the QOF for 2006/07. Both of these new indicators measured achievement in respect of intermediate outcomes, and the exception rate for MH09 was among the highest ten (see Table 2, below).

## 2.2 Exception Reporting by Indicator

There is exception reporting information for 62 individual indicators across 16 areas of the clinical domain, and one indicator for cervical screening within the additional services domain (see Annex).

Effective exception rates were calculated for each individual indicator at a national level. The 10 indicators with the highest exception rates are shown in Table 2. The 10 indicators with the lowest rates are shown in Table 3.

Indicator	Total Number of Exceptions 2006/07	Sum of Denominators 2006/07	Effective Exception Rate 2006/07	Effective Exception Rate 2005/06
CKD03	377,333	893,914	29.68%	-
CHD10	525,687	1,362,568	27.84%	24.87%
AF02	24,576	92,899	20.92%	-
ASTHMA08	23,516	91,859	20.38%	-
HF02	8,942	35,300	20.21%	-
STROKE11	9,873	44,423	18.18%	-
DEP02	84,273	398,493	17.46%	-
MH06	62,082	295,033	17.38%	-
EPILEPSY08	53,336	266,313	16.69%	-
MH09	52,669	304,466	14.75%	-

**Table 2: Exception rates by indicator (highest ten), 2006/07**

Indicator	Total Number of Exceptions 2006/07	Sum of Denominators 2006/07	Effective Exception Rate 2006/07	Effective Exception Rate 2005/06
DM16	52,685	1,898,522	2.70%	2.84%
DM22	44,088	1,907,124	2.26%	-
STROKE05	17,391	840,903	2.03%	2.25%
DM11	28,650	1,922,551	1.47%	1.52%
CHD05	22,167	1,866,301	1.17%	1.24%
BP04	65,876	6,604,535	0.99%	0.94%
SMOKE02	15,111	1,671,448	0.90%	-
CKD02	9,865	1,261,275	0.78%	-
THYROID02	8,010	1,351,843	0.59%	0.59%
SMOKE01	50,494	10,398,536	0.48%	-

**Table 3: Exception rates by indicator (lowest ten), 2006/07**

In general, the lowest exception rates relate to indicators that measure a process (such as such as recording smoking status or recording blood pressure). Five of the ten indicators with the lowest exception rates relate to the recording of blood pressure.

The highest exception rates relate to indicators that measure outcome or action in respect of a diagnosis. For example, relatively high exception rates were found for the three new indicators that measured objective clinical outcomes. Of these, the indicator CKD03 (the percentage of patients on the chronic kidney disease register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less) had the highest exception rate of any individual indicator (29.7%).

Table 2 shows that only one of the indicators with the highest 10 exception rates was part of the QOF indicator set for 2005/06. The other 9 indicators were new indicators for 2006/07, either replacements for old indicators or indicators for new clinical areas. A summary of the variation that is found between new and old indicators, and between process and outcome indicators is presented in Table 4. The exception rate for all outcome indicators combined (intermediate and objective outcomes) was 7.43%.

	<b>Intermediate Outcome Indicators</b>	<b>Objective Outcome Indicators</b>	<b>Process Indicators</b>	<b>All Indicators</b>
Old Indicators	7.17%	6.62%	4.34%	5.97%
Replacement Indicators	6.79%	12.33%	3.89%	7.91%
New Indicators	5.83%	29.68%	0.52%	4.30%
<b>All Indicators</b>	<b>6.85%</b>	<b>8.57%</b>	<b>3.18%</b>	<b>5.83%</b>

**Table 4: Exception rates by indicator type, 2006/07**

Old indicators – code existed in 2005/06 QOF; replacement indicators – new code, replacing an indicator code in the 2005/06 QOF; new indicators – code new to 2006/07 QOF (ie new clinical area or two new MH codes).

## 2.3 Exception Reporting at SHA Level

Around the overall national exception rate of 5.83%, geographical variation is found in overall exceptions rates (across all indicators) at strategic health authority (SHA) level. Table 5 shows that at SHA level the overall exception rate ranges from 5.51% (North East SHA and West Midlands SHA) to 6.24% (London SHA). The average rate across the 10 SHAs is 5.81%.

SHA Name	Total Number of Exceptions	Sum of Denominators	Effective Exception Rate 2006/07
North East	321,266	5,510,204	5.51%
North West	901,561	14,013,876	6.04%
Yorkshire and Humber	606,594	10,201,751	5.61%
East Midlands	503,925	8,430,398	5.64%
West Midlands	630,721	10,809,120	5.51%
East of England	607,538	10,280,706	5.58%
London	862,113	12,955,416	6.24%
South East Coast	488,407	7,766,412	5.92%
South Central	451,656	6,883,148	6.16%
South West	616,579	9,914,689	5.85%
<b>All SHAs</b>	<b>5,990,360</b>	<b>96,765,720</b>	<b>5.83%</b>

**Table 5: Effective exception rates by SHA, 2006/07**

However, individual SHAs do not tend to be associated with relatively low or high exception rates for all indicator groups – there is variation, whereby individual SHAs may have relatively high exception rates for one indicator group, and relatively low exception rates for another. This is illustrated in Table 6 with reference to three indicator groups (asthma, CHD and diabetes), where the rank order of each SHA is shown (rank=1 denotes the highest exception rate for that indicator group). Here, for example, North East SHA has the highest exception rate for asthma, but the lowest for CHD and diabetes, while London SHA has the highest rate for diabetes and the lowest rate for asthma.

Potentially, greater variation may be observed at the level of individual indicator.

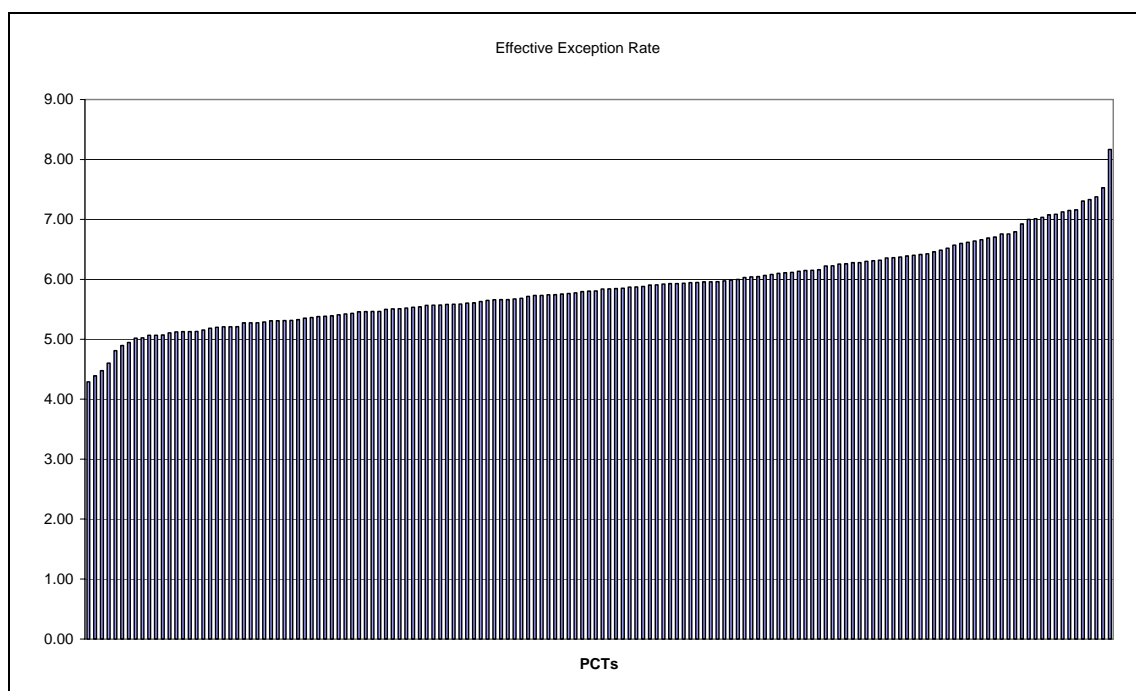
SHA Name	Asthma Effective Exception Rate	Asthma Rank	CHD Effective Exception Rate	CHD Rank	Diabetes Effective Exception Rate	Diabetes Rank
East Midlands	5.39	6	8.37	8	6.15	7
East of England	4.72	8	8.60	6	6.19	5
London	4.20	10	9.10	2	7.16	1
North East	7.54	1	7.80	10	5.49	10
North West	6.53	2	9.18	1	6.36	4
South Central	5.70	3	8.89	4	6.86	2
South East Coast	5.59	4	9.05	3	6.77	3
South West	5.50	5	8.86	5	6.18	6
West Midlands	4.67	9	8.50	7	5.91	8
Yorks. and Humber	5.16	7	8.27	9	5.75	9

**Table 6: Illustrative exception rates and rank order by SHA, 2006/07**

## 2.4 Exception Reporting at PCT Level

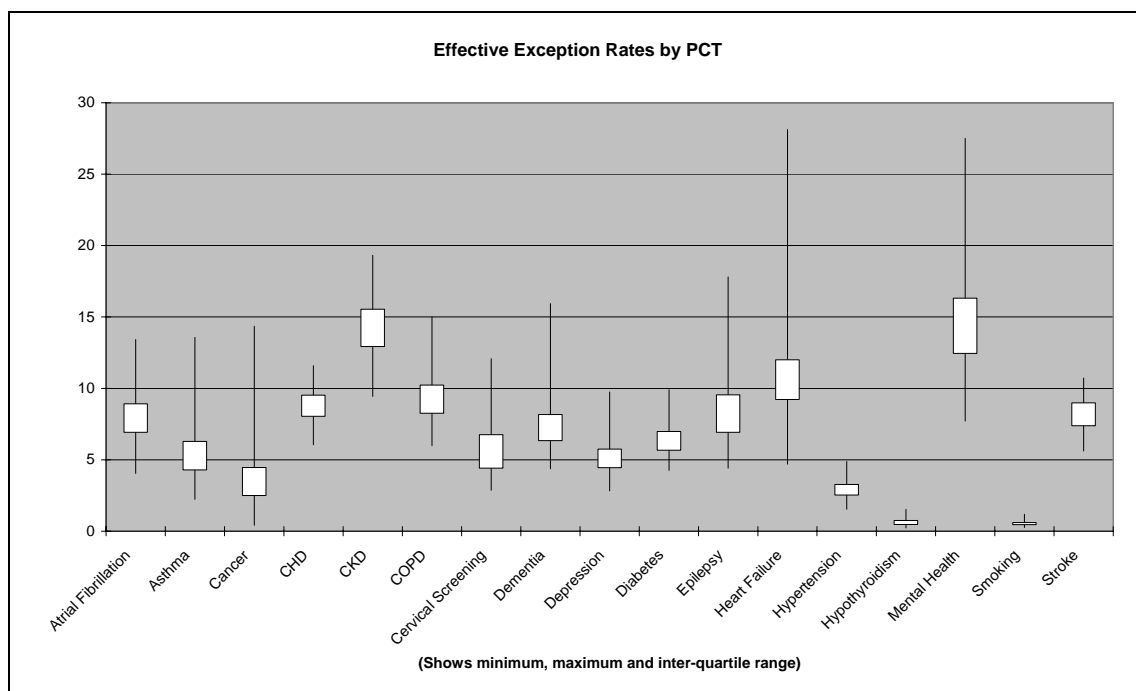
Around the overall national exception rate of 5.83%, geographical variation is found in overall exceptions rates (across all indicators) at primary care trust (PCT) level.

Figure 1 shows the distribution of exception rates for the 152 PCTs. The lowest overall exception rate at PCT level is 4.29%, and the highest is 8.17%. The average rate across the 152 PCTs is 5.88%



**Figure 1: Overall effective exception rates by PCT, 2006/07**

Figure 2 shows the range of exception rates by PCT and indicator group, presenting minimum and maximum values for PCTs, and inter-quartile ranges.



**Figure 2: Exceptions rates by PCT and indicator group – minimum, maximum and inter-quartile ranges, 2006/07**

PCTs will be able to use local information on exception reporting to determine where they lie within these ranges. For example, PCTs may examine how their overall rates reflect differences at practice level and at indicator level, and the extent to which relatively high or low rates are due to small numbers of patients.

## 2.5 Exception Reporting at Practice Level

The calculated effective exception rates at individual practice level show that:

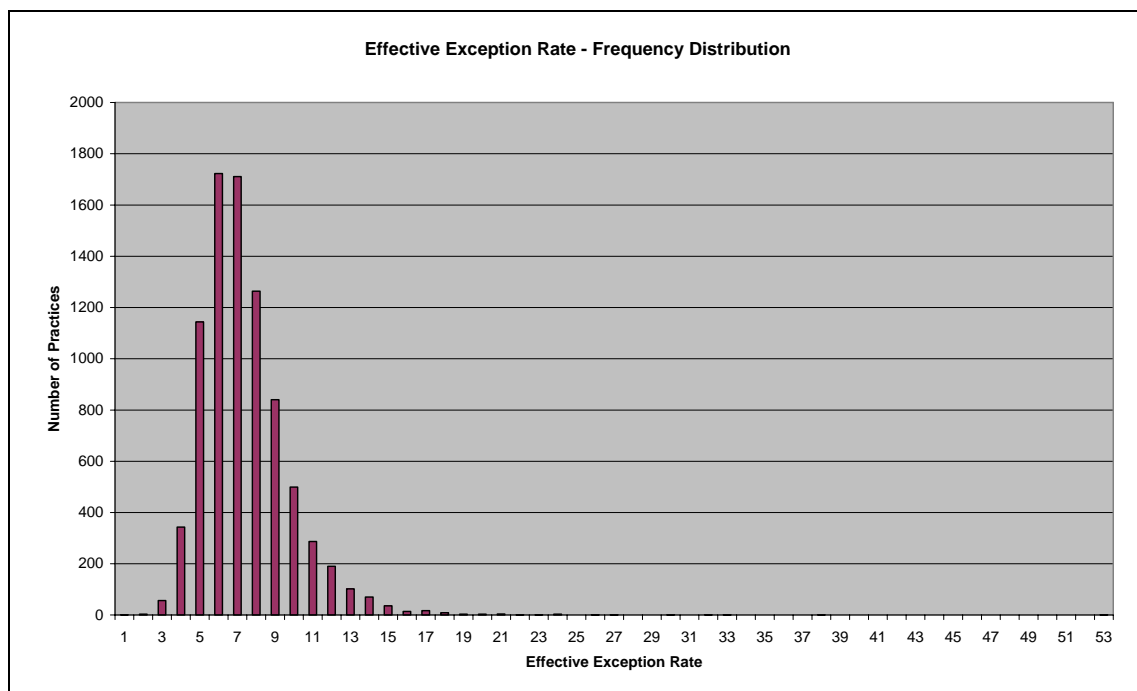
- The overall exception rate, across all indicators, ranges from zero percent to 51.58%. Unusually high or low exception rates at practice level can be due to very small numbers of patients.
- The average rate across the 8,331 practices is 5.91%
- There were 48 practices (0.6%) with overall exception rates higher than 15%.
- There were 460 practices (5.5%) with overall exception rates higher than 10%.
- There were 3,270 practices (39.3%) with overall exception rates lower than 5%.
- Four practices had overall exception rates lower than 1%.

It is important to emphasise some of the limitations of the available data, as described in section 1 above. 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.

Care should be taken not to draw false inferences from headline figures of exception rates calculated at practice level. For example, rates which appear to be very high (especially at individual indicator level) may simply be a function of very small numbers of patients. Similarly, very low (or zero) rates at indicator level could also result from very small numbers of patients.

Figure 3 presents a frequency distribution of effective exception rates by practice.



**Figure 3: Frequency distribution of overall effective exception rates by practice, 2006/07**

Table 7 provides a summary of descriptive statistics of 2006/07 practice level exception rates, shown alongside statistics for 2005/06. Because of the changes to the QOF in 2006/07, direct comparison of summary statistics for 2006/07 and 2005/06 is not appropriate. The 2005/06 statistics are provided here for reference only.



	<b>2006/07</b>	<b>2005/06</b>
Mean	5.91	5.64
Median	5.49	5.18
Standard Deviation	2.42	2.44
Range	51.58	27.90
Minimum	0.00	0.00
Maximum	51.58	27.90
10th Centile	3.47	3.15
25th Centile	4.35	4.03
75th Centile	7.01	6.72
90th Centile	8.78	8.63
Count (number of practices)	8,331	8,241

**Table 7: Effective exception rates at practice level, 2006/07 and 2005/06 – descriptive statistics**

### **3. Summary**

A key feature of the Quality and Outcomes Framework is to encourage appropriate and high quality clinical care in respect of key chronic diseases. Potentially, exception reporting could influence the level of financial reward to practices.

The availability of high level information on exception reporting in respect of QOF achievement has enabled analysis of the indicators most likely to be subject to exception reporting. It has provided an indication of the variations in exception rates that are found between specific indicators, and between NHS organisational areas.

Care should be taken to interpret this 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. Primary care trusts will have access to more detailed local information, and knowledge of local circumstances, to enable unusual levels of exception reporting to be investigated more closely.

## 4. More Information

QOF achievement information:

[www.ic.nhs.uk](http://www.ic.nhs.uk)

Primary Care Contracting – DH and GPC exception reporting guidance:

[http://www.pcc.nhs.uk/uploads/QOF/october\\_06/qof212\\_exception\\_reporting\\_guidance\\_final.pdf](http://www.pcc.nhs.uk/uploads/QOF/october_06/qof212_exception_reporting_guidance_final.pdf)

Primary Care Contracting – Q&A on exception reporting:

<http://www.primarycarecontracting.nhs.uk/qanda.php?cat=qua&subcat=exc>

GMS Statement of Financial Entitlements (3 August 2007):

[http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Primarycarecontracting/GMS/DH\\_4133079](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Primarycarecontracting/GMS/DH_4133079)

Department of Health: Primary Care Contracting and QOF:

<http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Primarycarecontracting/index.htm>

Department of Health: General Medical Services Contract:

<http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Primarycarecontracting/GMS/index.htm>

Connecting for Health QMAS pages:

<http://www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/qmas>

NHS Employers - Primary Care Contracting

<http://www.nhsemployers.org/primary/index.cfm>

NHS Employers - GMS Contract:

<http://www.nhsemployers.org/primary/primary-886.cfm>

NHS Employers - QOF, including 2006/07 revisions and guidance:

<http://www.nhsemployers.org/primary/primary-890.cfm>

NHS Primary Care Contracting:

<http://www.primarycarecontracting.nhs.uk/16.php>

British Medical Association - GMS Contract:

<http://www.bma.org.uk/ap.nsf/Content/Hubthenewgmscontract>

### QOF Publications in other UK countries

Scotland: <http://www.isdscotland.org>

Wales: <http://www.wales.nhs.uk>

Northern Ireland: <http://www.dhsspsni.gov.uk>

## Annex – QOF Indicator Definitions

Indicator Code	Indicator Description
<b>Coronary Heart Disease</b>	
CHD01	The practice can produce a register of patients with coronary heart disease
CHD02	The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment
CHD05	The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months
CHD06	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less
CHD07	The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months
CHD08	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less
CHD09	The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)
CHD10	The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)
CHD11	The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or angiotensin II antagonist
CHD12	The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March
<b>Heart Failure</b>	
HF01	The practice can produce a register of patients with heart failure
HF02	The percentage of patients with a diagnosis of heart failure (diagnosed after the 1st April 2006) which has been confirmed by an echocardiogram or by specialist assessment
HF03	The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (unless a contraindication or side effects are recorded)
<b>Stroke and TIA</b>	
STROKE01	The practice can produce a register of patients with Stroke or TIA
STROKE05	The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months
STROKE06	The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less
STROKE07	The percentage of patients with TIA or stroke who have a record of total cholesterol in the previous 15 months
STROKE08	The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less
STROKE10	The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March

STROKE11	The percentage of new patients with a stroke who have been referred for further investigation
STROKE12	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)
<b>Hypertension</b>	
BP01	The practice can produce a register of patients with established hypertension
BP04	The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months
BP05	The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less
<b>Diabetes Mellitus</b>	
DM19	The practice can produce a register of all patients aged 17 years and over with diabetes mellitus. which specifies whether the patient has Type 1 or Type 2 diabetes
DM02	The percentage of patients with diabetes whose notes record BMI in the previous 15 months
DM05	The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months
DM07	The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months
DM09	The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months
DM10	The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months
DM11	The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months
DM12	The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less
DM13	The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)
DM15	The percentage of patients with diabetes with proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)
DM16	The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months
DM17	The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less
DM18	The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March
DM20	The percentage of patients with diabetes in whom the last HbA1C is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months
DM21	The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months
DM22	The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months
<b>Chronic Obstructive Pulmonary Disease</b>	
COPD01	The practice can produce a register of patients with COPD

COPD08	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
COPD09	The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing
COPD10	The percentage of patients with COPD with a record of FeV1 in the previous 15 months
COPD11	The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months
<b>Epilepsy</b>	
EPILEPSY05	The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy
EPILEPSY06	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months
EPILEPSY07	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of medication review involving the patient or carer in the previous 15 months
EPILEPSY08	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months
<b>Hypothyroidism</b>	
THYROI01	The practice can produce a register of patients with hypothyroidism
THYROI02	The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months
<b>Cancer</b>	
CANCER01	The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'
CANCER03	The percentage of patients with cancer, diagnosed within the last 18 months, who have a patient review recorded as occurring at 6 months after the practice has received confirmation of the diagnosis
<b>Palliative Care</b>	
PC01	The practice has a complete register of all patients in need of palliative/supportive care
PC02	The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed
<b>Mental Health</b>	
MH08	The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses
MH04	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the previous 15 months
MH05	The percentage of patients on lithium therapy with a record of lithium levels in a therapeutic range within the previous 6 months
MH06	The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate
MH07	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non attendance

MH09	The percentage of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months. In the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status
<b>Asthma</b>	
ASTHMA01	The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months
ASTHMA03	The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months
ASTHMA06	The percentage of patients with asthma who have had an asthma review in the previous 15 months
ASTHMA08	The percentage of patients aged eight and over diagnosed as having asthma from 1st April 2006 with measures of variability or reversibility
<b>Dementia</b>	
DEM01	The practice can produce a register of patients diagnosed with dementia
DEM02	The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months
<b>Depression</b>	
DEP01	The percentage of patients with diabetes and/or heart disease for whom case finding for depression has been undertaken on one occasion during the previous 15 months using the two standard screening questions
DEP02	In those patients with a new diagnosis of depression, recorded between the preceding 1 April and 31st March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care
<b>Chronic Kidney Disease</b>	
CKD01	The practice can produce a register of patients aged 18 years and over with CKD. (US National Kidney Foundation: Stage 3-5 CKD)
CKD02	The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months
CKD03	The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less
CKD04	The percentage of patients on the CKD register with hypertension, who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)
<b>Atrial Fibrillation</b>	
AF01	The practice can produce a register of patients with atrial fibrillation
AF02	The percentage of patients with atrial fibrillation diagnosed from 1st April 2006 with ECG or specialist confirmed diagnosis
AF03	The percentage of patients with atrial fibrillation who are currently treated with anti-coagulant drug therapy or an anti-platelet drug therapy
<b>Obesity</b>	
OBESITY01	The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the last 15 months
<b>Learning Disabilities</b>	
LD01	The practice can produce a register of patients with learning disabilities

<b>Smoking</b>	
SMOKE01	The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months (except those who have never smoked where smoking status need only be recorded once since diagnosis)
SMOKE02	The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months
<b>Cervical Screening</b> (part of Additional Services domain of QOF)	
CS01	The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years.