Quality and Outcomes Framework
Achievement, prevalence and exceptions data, 2012/13

Frequently asked questions

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What is 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.

Background and QOF guidance can be found on the NHS Employers’ web site:
http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx

Detailed QOF guidance document (covering 2012/13 QOF):

Where does the data come from / what is QMAS?
QOF information published by the Health and Social Care Information Centre (HSCIC) is from the Quality Management Analysis System (QMAS), a national IT system developed by NHS Connecting for Health. QMAS uses data from general practices to calculate individual practices’ QOF achievement.

QMAS calculates practice achievement against national indicators. It gives general practices and commissioning organisations objective evidence and feedback on the quality of care delivered to patients.

What is in QOF? What are ’domains’?
The QOF has 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.

QOF indicators are described in detail in the 2012/13 guidance document:
The following is a summary of the QOF domains for 2012/13:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator Group</th>
<th>Number of Indicators</th>
<th>Number of Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td>Atrial Fibrillation (AF)</td>
<td></td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Cardiovascular Disease - Primary Prevention (PP)</td>
<td></td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td></td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td></td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>Dementia (DEM)</td>
<td></td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>Depression (DEP)</td>
<td></td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Diabetes Mellitus (DM)</td>
<td></td>
<td>15</td>
<td>88</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Heart Failure (HF)</td>
<td></td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Hypertension (BP)</td>
<td></td>
<td>3</td>
<td>69</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Learning Disabilities (LD)</td>
<td></td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Mental Health (MH)</td>
<td></td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Obesity (OB)</td>
<td></td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Osteoporosis : secondary prevention of fragility fractures (OST)</td>
<td></td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Palliative Care (PC)</td>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Peripheral Arterial Disease (PAD)</td>
<td></td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Secondary prevention of coronary heart disease (CHD)</td>
<td></td>
<td>7</td>
<td>69</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>4</td>
<td>73</td>
</tr>
<tr>
<td>Stroke and Transient Ischaemic Attack (TIA)</td>
<td></td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td><strong>Clinical Total</strong></td>
<td></td>
<td><strong>96</strong></td>
<td><strong>669</strong></td>
</tr>
<tr>
<td>Education and Training</td>
<td></td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Information for Patients</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Medicines Management</td>
<td></td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Practice Management</td>
<td></td>
<td>7</td>
<td>13.5</td>
</tr>
<tr>
<td>Quality and Productivity</td>
<td></td>
<td>9</td>
<td>99.5</td>
</tr>
<tr>
<td>Records and Information</td>
<td></td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td><strong>Organisational Total</strong></td>
<td></td>
<td><strong>42</strong></td>
<td><strong>254</strong></td>
</tr>
<tr>
<td>Length of Consultations</td>
<td></td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td><strong>Patient Experience Total</strong></td>
<td></td>
<td><strong>1</strong></td>
<td><strong>33</strong></td>
</tr>
<tr>
<td>Cervical Screening</td>
<td></td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Child Health Surveillance (CHS)</td>
<td></td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Maternity Services (MAT)</td>
<td></td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td><strong>Additional Services Total</strong></td>
<td></td>
<td><strong>9</strong></td>
<td><strong>44</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>148</strong></td>
<td><strong>1,000</strong></td>
</tr>
</tbody>
</table>
Thus the QOF is a voluntary process for all practices in the UK and as part of this annual reward & incentive programme, QOF awards achievement points for:

- Clinical care, mainly in terms of managing some of the most common chronic diseases e.g. asthma, diabetes.
- How well the practice is organised.
- How patients view their experience at the surgery.
- The quality of extra services offered, such as child health and maternity services.

**How do QMAS / QOF data relate to GP practice payments?**

Through the QOF, general practices are rewarded financially for aspects of the quality of care they provide. QMAS ensures consistency in the calculation of quality achievement and disease prevalence, and is linked to payment systems.

This means that payment rules underpinning the new GMS contract are implemented consistently across all systems and all practices in England.

For 2012/13 practices were paid, on average, £133.76 for each point they achieved.

Users of data derived from QMAS should recognise that QMAS was established as a mechanism to support the calculation of practice QOF payments. QOF does not provide a comprehensive source of data on quality of care in general practice, but it is potentially a rich and valuable source of such information, providing the limitations of the data are acknowledged.

**What is in the latest QOF publication?**

The information published by the HSCIC relates to general practices in England.

The latest available information is for 2012/13, and is based on data for the period April 2012 to March 2013. The data were extracted from the national QMAS system at the end of June 2013 in order to include adjustments agreed between practices and Area Teams up to the end of June 2013.

This publication covers three types of data for England: data relating to QOF achievement, disease prevalence and exception reporting.

The 2012/13 QOF publication consists of:

- A statistical bulletin.
- A set of spreadsheets of QOF data at England, NHS Region, Area Team, CCG and practice level.
- An online database that allows searches for individual practices, and which presents QOF results graphically.

**Where can I find QOF data for previous years?**

On the HSCIC web site you can find QOF information for the years 2004/05 to 2011/12:

http://www.hscic.gov.uk/qof
Can I have QOF indicator information for years prior to 2004/05?
The Quality and Outcomes Framework was introduced in 2004/05. No QOF indicator information is available for previous years.

How is 2012/13 QOF different from previous years?
The QOF was introduced in 2004/05, with an indicator set that remained the same in 2005/06. In 2004/05 and 2005/06 practices were able to achieve a maximum QOF score of 1,050 points.

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.

Some changes were made at the start of 2008/09, with the most significant change being the introduction of two new indicators within the Patient Experience domain. The new indicators, PE7 and PE8, are derived from the results of the national GP Patient Survey, and reward practices for providing 48 hour appointments (PE7) and advanced booking (PE8). These two new indicators are worth a total of 58.5 QOF points, and their introduction coincided with the removal of some indicators (or points associated with indicators), so that the maximum QOF score remained at 1,000 points.

Further changes to the QOF were made at the start of 2009/10, and remained in force in 2011/12. These included the introduction of new indicators in the existing heart failure, chronic kidney disease, depression and diabetes clinical indicator sets; the introduction of two new indicators under a new cardio-vascular disease (primary prevention) clinical indicator set; the removal of some patient experience indicators; changes to contraception indicators within the Additional Services domain of the QOF; and various changes to the points values of some QOF indicators. Overall, the maximum QOF score remained at 1,000 points.

Changes to the QOF at the start of 2011/12 included the introduction of new indicators in the epilepsy, learning disability and dementia clinical indicator sets; the introduction of a new set of indicators measuring quality and productivity, 12 indicators across a range of sets were retired, 22 indicators were replaced, either due to changes to indicator wording or coding/business logic changes, five indicators had changes to point values or thresholds. Overall, the maximum QOF score remained at 1,000 points.

Changes to the QOF at the start of 2012/13 included the retirement of seven indicators (including five from the Quality and Productivity area), releasing 45 points to fund new and replacement indicators; the introduction of nine new NICE recommended clinical indicators, including two new clinical areas (PAD and Osteoporosis) and additional smoking indicators; the introduction of three new organisational indicators for improving Quality and Productivity which focus on accident and emergency attendances; sixteen other indicators were replaced, either due to changes to indicator wording or coding/business logic changes or to changes to point values or thresholds. Overall, the maximum QOF score remained at 1,000 points.

What are QOF business rules? Where can I find them?
QOF data are captured from GP practice systems according to coded 'business rules', produced by the HSCIC. The business rules are reviewed twice each year to take account of
new clinical codes. QOF business rules are published on the Primary Care Commissioning web site:
http://www.pcc-cic.org.uk/article/qof-business-rules-v25.0

What is QOF exception reporting?
‘Exception reporting’ refers to the potential removal of individual patients from calculations of practice achievement for specific clinical indicators.

Some exception reporting is applied automatically by the IT system, for example in respect of patients who are recently registered with a practice, or who are recently diagnosed with a condition. Other exception reporting is based on information entered into the clinical system by the GP. Practices may ‘exception-report’ (ie omit) specific patients from data collected to calculate QOF achievement scores within clinical areas. For example, patients on a specific clinical register can be excluded from individual QOF indicators if a patient is unsuitable for treatment, is newly registered with the practice, is newly diagnosed with a condition, or in the event of informed dissent. The GMS contract sets out valid exception reporting criteria.

Where can I find information on QOF exception reporting?

Exception reporting information as part of the QOF publication is available at:
http://www.hscic.gov.uk/qof

Why are exception reporting figures published by the Health and Social Care Information Centre (HSCIC) different from the figures in QMAS reports?

QMAS presents counts of exception-reported patients, which roughly equates to the number of people on a disease register who are not included in an indicator denominator.

For the HSCIC QOF publication there is a distinction between patients who are actually exception-reported, and those whose non-inclusion in an indicator denominator is for definitional reasons. Definitional 'exclusions' are treated as exception reporting by QMAS, and the 'excluded' patients are show in exception reporting counts. QMAS does this because it is primarily a system to support payments, and its function in respect of exception reporting is to ensure the right patients are not included in indicator denominators.

To give an example, CHD13 is about patients on the CHD register who have newly diagnosed angina:

If the CHD register is 100, and if only 10 of those patients have newly diagnosed angina, and if two of those patients are subject to actual exception reporting, then the relevant figures would be:

CHD Register = 100
CHD13 Denominator = 8
CHD Exception Count = 2
CHD Definitional Exclusions = 90
However, QMAS would show this as 92 exception-reported patients because there is no concept of exclusions within QMAS – they are all exceptions.

For publication the HSCIC looked at the underlying exception reporting ID codes within the QMAS tables, and assigned the notion of ‘definitional exclusions’ to some codes. These are not included in our published exception counts and rates.

Published exception reporting figures therefore do not include counts of definitional exclusions, since these cannot make up part of the indicator denominator.

**How many practices are in the QOF achievement data? Are all practices included?**

QOF achievement for 2012/13 was published for 8,020 general practices in England. These practices made an end-of-year submission to QMAS. QOF achievement figures include data automatically extracted from general practice systems by the QMAS system in March 2013, and data adjustments for the year 2012/13 submitted between April and July 2013.

The sum of the practice list sizes for the practices included in the QOF publication represents over 99 per cent of registered patients in England (based on registration data from the ePACT system of the Prescription Pricing Division of the NHS Business Services Authority, January to March 2013).

**Are Personal Medical Services (PMS) practices in the QOF dataset?**

Personal Medical Services (PMS) practices are able to negotiate local contracts with their PCTs 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 2012/13 QOF information.

**Do QOF achievement scores shown for PMS practices incorporate a PMS deduction?**

Where PMS practices use the national QOF, their 2012/13 achievement (in terms of the 1,000 QOF points available) is subject to a deduction of 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 this publication 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 1,000 points.
Please provide a link to guidance on the points deduction from QOF for PMS practices

There is a PMS quality points offset to account for the fact that the average PMS practice will already have received the PMS Baseline contract price of £13,050.

For 2012/13 divide the fixed sum of £13,050 by the pounds per point for that year which was £133.76 to give a quality points offset of 97.56.

The relevant guidance is in the Sustaining Innovation guidance, available from the Department of Health web site. Please refer to section 4.3 on page 32 of this document:


The document in context may be found here:


What does 100 per cent achievement mean? What is ‘underlying achievement (net of exceptions)?

Reference to 100 per cent achievement often refers to the percentage of available QOF points achieved. So if a practice achieves the full 1,000 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.

The level of achievement for certain elements of the QOF can be expressed in the same way. A practice achieving all 669 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.

It can therefore deliver the required care to fewer than 100 per cent of its patients (90 per cent in this case) to achieve the full (100 per cent) points available. Therefore there is an important distinction between percentage achievement in terms of QOF points available and the underlying achievement (net of exceptions) for specific indicators, the latter representing the indicator numerator as a percentage of the denominator.

What is ‘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;

\[
\text{Percent of patients receiving intervention} = \frac{\text{IndicatorNumerator}}{\left(\text{IndicatorExceptions} + \text{IndicatorDenominator}\right)}
\]
As an example; a practice has 100 patients on the CHD register, and 10 patients are exception reported from CHD09, making a denominator for CHD09 of 90 patients. The practice delivers the CHD09 intervention to 80 patients. The difference in figures for **underlying achievement (net of exceptions)** and **percent of patients receiving the intervention** is seen below.

Underlying achievement (net of exceptions) \(= \frac{\text{Numerator}}{\text{Denominator}} \times 100\)

\[= \frac{80}{90} \times 100 = 88.9\text{ per cent}\]

Percent of patients receiving intervention \(= \frac{\text{Numerator}}{\text{Exceptions + Denominator}} \times 100\)

\[= \frac{80}{10 + 90} \times 100 = 80.0\text{ per cent}\]

**Are all practices supposed to reach, or try to reach, 100 per cent QOF achievement?**

Not necessarily. The achievement of full points may not be possible or desirable for some practices. Participation in the QOF is voluntary, and practices may aspire to achieve all, some, or none of the points available. It is important to note that for some practices it may be impossible to achieve all of the points available in the QOF.

For example, some clinical indicators relate to specific subgroups of patients, and if the practice does not have any such patients it cannot score points against the relevant indicators. A practice that exclusively serves a student population, for instance, may not have patients on some of the clinical registers that are covered by the QOF, and although its QOF points total would be less than 1,000 (or 100 per cent), it may be providing all the appropriate care in respect of the clinical registers that it does hold.

In addition, practices with personal medical services contracts may include quality and outcomes as part of their locally negotiated agreements, and in may opt to use part or all of the new GMS QOF as a measurement tool. This is an extremely important consideration when undertaking any comparative analysis of QOF achievement.

**What is ‘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 2012/13 there were 1,000 points available in the QOF. 69 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 93.1 per cent points achievement (931 points achieved / 1,000 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 931 (1,000 points minus the ‘unachievable’ 69 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.

\[
\text{Points achievement} = \frac{\text{Points achievement}}{\text{All QOF points}} \times 100 = \frac{931}{1,000} \times 100 = 93.1\text{ per cent}
\]

\[
\text{Points achieved as per cent of points available} = \frac{\text{Points achievement}}{\text{QOF points available}} \times 100 = \frac{931}{931} \times 100 = 100\text{ per cent}
\]

Due to the complexities of calculating and presenting the ‘points achieved as a per cent of QOF points available’ figures, we only provide these figures for total points, not for any domain or group totals.

**What disease prevalence information is available from QOF?**

Prevalence information for 2012/13 is presented in the publication for the 8,020 practices that were in the QOF achievement dataset. For 21 of the 22 areas of the clinical domain, QMAS captures the number of patients on the clinical register for each practice. (The register for smoking indicators, is based on subsets of other clinical registers.)

The number of patients on the clinical registers can be used to calculate measures of disease prevalence, expressing the number of patients on each register as a percentage of the number of patients on practices’ lists. (But see the next FAQ.)

**What prevalence figures are shown and how are they calculated?**

The clinical registers used to calculate prevalence were those submitted to QMAS at the same time as achievement submissions (ie 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 previous years ‘National Prevalence Day’ for prevalence adjustments was 14 February.)

Seven clinical areas within the QOF (diabetes, epilepsy, chronic kidney disease, obesity, learning disabilities and osteoporosis) are based on clinical registers that relate to specific age groups:

- Obesity registers are based on patients aged 16 and over.
- Diabetes registers are based on patients aged 17 and over.
- Epilepsy, chronic kidney disease, depression and learning disabilities registers are based on patients aged 18 and over.
- Osteoporosis registers are based on patients aged 50 and over

For 2012/13 the HSCIC has produced prevalence rates for these seven conditions based on estimates of appropriate age-banded list size information. For example, diabetes registers were expressed as a percentage of an estimate of patients on practices lists aged 17+. These estimates were produced to help researchers or information users who require more precise prevalence rates for these seven clinical areas.

### Why are there two QOF registers for depression?

There are two QOF registers associated with the Depression indicator group. These relate to the Depression 1 and Depression 2 indicators.

For Depression 1, the register figures do not represent numbers of people with depression, but represent people on the diabetes and/or CHD registers to whom the Depression 1 indicator relates.

For Depression 2, the register figures relate to all patients on practice lists aged 18+ who have a current diagnosis of depression. It is important to note that the Depression 2 indicator denominator is based only on a subset of this register, i.e. those who are recently diagnosed.

Note that although the Depression 2 indicator definition does not refer to patient age, the QOF business rules define this register to include only patients who are aged 18 and over.

### What do smoking prevalence figures mean? How do I get a count of the numbers of patients who smoke?

The register underpinning the QOF Smoking indicators is not a register, or count, of people who smoke. QOF provides no information on numbers of smokers and non-smokers.

The QOF Smoking register is a count of the number of people on a practice list who have one of the following conditions: CHD, stroke/TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses. QOF Smoking indicators are defined in respect of this set of patients.
Do prevalence figures differ from prevalence figures published elsewhere?

Differences may occur because QOF registers 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.

Care should be taken to understand definitional differences, for example when comparing QOF prevalence with expected prevalence rates using public health models.

For example, to be on the QOF obesity register, patients need to be aged 16 or over, and have a body mass index greater than or equal to 30 recorded in the previous 15 months.

What practice list sizes are used in calculating prevalence rates?

The 2012/13 QOF information published by the HSCIC includes practice list sizes supplied to QMAS from Systems and Service Delivery (SSD), the national general practice payments system, as at 1st January of the reporting year. These figures are used in QMAS 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.

Are there issues with prevalence for specific clinical areas?

Other factors in interpreting information on specific registers include the following:

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.

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 QMAS. For example, QMAS 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 these diseases.

The qualification to this statement is that from 2006/07 the QOF clinical domain included depression and smoking indicators that are based on other clinical registers.

Is it possible to obtain QOF prevalence information by age group? I understand that age-specific prevalence information is available.

We do not have age-specific prevalence data from QOF. QOF registers are not broken down by age.

Reference to ‘age-specific prevalence’ relates to those QOF clinical areas where QOF registers exclude young people, and where the HSCIC calculated an alternative prevalence rate to exclude young people on practice registers from the denominator for prevalence rates.
For example, QOF diabetes registers relate to ages 17+ only. So an alternative ‘age-specific' prevalence rate was calculated, based on people on practice registers who are aged 17+.

All figures are in the published prevalence data tables.

**Where can I find information about individual patients? How do I find out about patients with more than one disease?**

There is no patient-specific data in QMAS because this is not required to support the QOF. For example, QMAS 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 on individual patients.

It is not possible, for example, to identify the number of patients with both of these diseases.

**Can I have figures for specific conditions from the Mental Health register, eg for schizophrenia, separately?**

The QOF mental health register is a count, for each GP practice, of the total number of people "with schizophrenia, bipolar disorder and other psychoses". The information is not captured from GP systems at any lower level of aggregation. The data are captured according to this definition to support QOF payments, and the data capture is designed only to meet payment requirements.

**How do I know if practices had special circumstances that have affected QOF achievement?**

During July 2013, the HSCIC consulted with ATs on the local QOF achievement information contained in the end of June 2013 extract of 2012/13 QMAS data.

ATs were asked to confirm that the extract contained all their practices. ATs were also invited to provide commentary on their practices' overall QOF achievement, as contained in the QMAS extract. Such commentary was invited because QOF achievement for some practices had not been approved for payment (i.e. was still subject to local sign-off) at the time of the QMAS extract (end of June 2013).

For some practices in England data annotations were provided by ATs to support the published QOF achievement information. Such notes generally referred to:

- Adjustments to QOF achievement that were agreed locally after the date of the QMAS extract for publication (i.e. after the end of June 2013).
- Notes on practices where QOF achievement remained subject to local review or appeal.
- Notes on practices providing specialist services, such as practices that served university populations or asylum seeker populations.

All notes on practice achievement provided by ATs are presented alongside practice-level QOF achievement data on the 2012/13 Online Practice Results Database, and in published spreadsheets of domain level achievement.

In addition, all ATs wished to emphasise that for PMS practices the published QOF achievement figures refer to QOF points achieved prior to the application of PMS deductions. This is because the published information covers QOF achievement, not QOF
payments, and therefore it was decided that where GMS and PMS practices have maximum QOF achievement (for example), both will be shown as having achieved 1,000 QOF points.

Some AT-specific notes were also received about practice codes that are not included in the QOF publication, for example about practices that participated in the QOF but did not use QMAS, or practice codes that did not participate in QOF.

Should I make a league table to show which practices provide the best care or the worst?

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 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 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.

Robust 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 QMAS. For example, QMAS 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 QMAS, and the source for the published tables, is dependent on diagnosis and recording within practices using practices’ clinical information systems.

Can I re-use or publish the QOF data?

This information has been produced by the HSCIC. If you wish to re-use and/or publish this data independently, please refer in the first instance to the standard terms and conditions at http://www.hscic.gov.uk/terms-and-conditions.
Where can I find information on QOF for Scotland, Wales and Northern Ireland?
Scotland:
http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/

Wales:

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

How can I obtain a list of practice names and addresses?
NHS organisation codes are managed by the Organisation Data Service (ODS):
http://systems.hscic.gov.uk/data/ods

I have a problem with my practice’s data on QMAS reports
The HSCIC has no role in the management of QMAS. The HSCIC's role is in publishing QOF data annually, using an extract from QMAS.

The QMAS system closed at the end of July 2013, to be replaced by CQRS and GPES. Any issues with these systems should be referred to cqrsservicedesk@gdit.com (for CQRS) and enquiries@hscic.gov.uk (for GPES).

I don’t agree with the published QOF information for my practice
The HSCIC’s annual QOF publication is based on an extract from QMAS, taken at the end of June or July in that year. All information in the 2012/13 publication is as held on QMAS at the end of June 2013, and relating to the period April 2012 to March 2013. Notes accompanying the publication clearly state this.

Before publication the HSCIC undertook a consultation exercise with all Area Teams to confirm that the total QOF points to be published were as held on QMAS at the end of June. The exercise also allows ATs to notify the HSCIC of issues or circumstances relevant to practice achievement, including adjustments to QOF achievement (for whatever reason).

Relevant comments from ATs are shown alongside each practice on the Practice Domain Summary spreadsheet in the latest QOF publication, and are also shown on the practice screens on the QOF online database.

How do I complain about QOF indicators or suggest changes to the QOF?
The National Institute for Health and Clinical Excellence (NICE) has responsibility for recommending QOF indicators (including changes); this work in undertaken in the context of the development by NICE of Quality Standards. Comments and suggestions can be sent to NICE via their web site:
http://www.nice.org.uk/aboutnice/qof/qof.jsp
Where can I find information on QOF payments to practices?
The HSCIC does not publish data on QOF payments. For information on QOF payments it would be necessary to contact the relevant AT.

The QOF publication (showing QOF points achievement, etc, but not payments) is based on an extract of data from the national QMAS system, taken at the end of June, but relating to the previous financial year (April to March).

However, many practices / ATs continue to review QOF achievement (and therefore payments) after the end of June, and any such amendments to achievement would not be included in our publication database. The reason for not publishing financial information 'as at end of June' is that this would not always be a robust presentation of final payments, where payments are not agreed until after June.