hscic Health & Social Care Information Centre

Quality and Outcomes Framework (QOF)

Publication Consultation Results

Prescribing and Primary Care Team

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Contents

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Between the 5th June and the 8th August 2014, the HSCIC held a consultation on the publication of the QOF information on achievement, exceptions and recorded prevalence.

We provided example reports and tables and asked for opinions on proposed changes for the 28th October 2014 report.

We received 15 external responses to this consultation; some on behalf of organisations and others individually. All the responders had previously used the QOF publication.

All external comments given and the HSCIC response(s) to those comments are in the table below.

A summary of the changes that will be taking place are as follows:*

1) New look report with extended prevalence section and shortened executive summary
2) Revised groupings of QOF categories into the following areas:
    a. Cardiovascular
    b. Respiratory
    c. Lifestyle
    d. High dependency and other long term conditions
    e. Mental health and neurology
    f. Musculoskeletal
    g. Fertility, obstetrics and gynaecology
    h. Quality and productivity
    i. Patient experience
3) Inclusion of indicator definitions in the spreadsheets
4) Separate prevalence spreadsheet
5) Revised spreadsheet formats

Changes we are intending to introduce depending on time available:*

1) Inclusion of flat file formats of the data (e.g. CSV)
2) Inclusion of a mapping table for GP Practices to Local Authority to aid further interrogation for users
3) On the Area Team spreadsheet, splitting the London region into 3 areas, for greater granularity of detail and to avoid duplication across Area Team and Regional figures

Changes we are unable to make in this year, but may look at for future:*

1) Introduction of new interactive or further spreadsheet tools for interrogating data
2) Inclusion of a more detailed exceptions sheet
3) Deprivation Index

Changes we will not be making:*

1) Inclusion of any ‘expected’ prevalence. QOF deals with recorded prevalence only.

* Please note these lists are not exhaustive

Table of QOF Publication Consultation Results

Comments/Suggestion	HSCIC Response
Good to have exceptions and exclusions separated.	We report on the number of exceptions only. We do not report exclusions.
It is good to have Each sub indicator definition in the spread sheet along with technical guide (which is already)	Will be provided as part of publication this year.
Good to have best practices examples with analysis. This helps non clinical people to carry out analysis (which indicator to pick example is AF1 or AF2 or AF3) with minimal clinical support	Indicator definitions will be included. The HSCIC's role is to provide the data. We will be adding context to the report to aid support of QOF compliance by non-clinicians.
I would recommend to turn the QOF files into interactive web tool with selection, RAG rating and export features. This saves lot of time for the people across the country	There is a web tool currently available at http://www.qof.hscic.gov.uk/ Further development is not currently available. Unfortunately we do not have capacity or funding to extend interactive capabilities at this time. We will be looking into this for future.
An update concentrating on indicators which can be compared year on year	Will be attempting some focus on this – this will evolve over time. Indicator changes for each year are available on the NHS Employers website: http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework
The categories are clear, although inevitably a little arbitrary. I would prefer "Cardiovascular" to "Heart and Blood" but that may be because I am a doctor!	We originally proposed Heart and Blood so that people would not confuse the grouping with the actual indicator. We have now updated it to Cardiovascular. We are happy to use this term as it is preferred by respondents to this consultation.
My main interest is in parsing the data into a database. This powers not only the website but also allows for downloads for users. (see www.gpcontract.co.uk/downloads). The most popular download by far is the Access database. There is demand for users who want to work with and process the data. Having it parsed into a normalised format is extremely useful to people – especially when they are	CSV files will be provided as long as we have the time to produce them after we have completed the spreadsheets. The columns on the spreadsheets this year are more consistent.

planning on presenting it in their own format for further use. I get emails every year asking when the Access data is coming out. The current (and proposed) format is fiddly to use as the columns vary from one area to another. An example of more useful and easily parsed data can be seen at the Scottish QOF site (www.isdscotland.org/QOF) where each indicators for each practice has one line. It makes a little more sense to have the prevalence on one spreadsheet but makes more sense to publish as a database (Access or CSV or similar).	
I would like to see the inclusion of a deprivation index for the locality, AT, CCG and Practice, for the clinical and public health areas that are most impacted by deprivation in a way that we can evaluate the impact, or not, that is being made vs the challenges faced. Hospital admissions data and A&E attendances should also be included in this dataset as it can be used as and indicator of care being given at a practice and CCG level.	We will not be including a deprivation index this time around, but will look at this possibility for future. We will be providing signposts to the ONS website, should users wish to make their own comparisons in the meantime. We will be signposting to other data sets and may include some data from them if relevant for the publication.
Exec Summary - Needed as a pointer to what the report is saying, and especially important for public readers who might need more guidance	Agreed
Overall Achievements, Exceptions and Prevalence Data - These are all good, but where appropriate there needs to be included the hospital admissions data, A&E attendances and if possible length of stay.	We will predominantly be signposting to appropriate linked services e.g. length of stay, A&E attendances. We will provide some relevant data within the text as context for the report.
Individual QOF Registers - The categories are clear, but again I would either include, or provide a link to, the disease code descriptors for ease. There is a need to keep it succinct in the spreadsheet and codes being used, but it is not always easy to remember what they all mean and you don't always have a copy to hand.	A spreadsheet containing a full indicator list with each full definition will be provided. The specific indicator descriptions will be included in each worksheet for ease of use.
You might add expected prevalence as a	We will not be doing any work on

column, last year and current year so we can see the progress being made to uncover missing patients.	expected prevalence. QOF concerns only recorded prevalence.
I don't see the need for a separate prevalence sheet, you can always cut down the big one as necessary and prevalence on its own does not tell you much.	Thank you, other feedback suggests this may be useful to others so we will be providing it.
The ability to drill down through the data to practice level is important and the facility to turn the spreadsheet information into charts, graphs etc would be helpful. It might add levels of complexity that at this stage you don't want to include. But for the next iteration maybe. The CCG/Practice data on the PHO website allows some of this functionality but the information is limited. A format where you can compile your own bespoke report by moving headings from a list into a compilation box and then press "GO" would be very useful.	Unfortunately we do not have capacity or funding to extend interactive capabilities at this time. We will be looking into this for future.
I need to be able to see the achievements of the practices in my own Area Team in terms of points achieved in each clinical domain benchmarked against national averages and shown by CCG and compared to last year. I also need to see the prevalence rates and exception reporting rates of each of the practices for each clinical domain, for my own Area Team again broken down into each CCG and compared to national averages- preferably in both graph and table formats.	Newsworthy tables and graphs will be provided at regional and Area Team level within the report if deemed appropriate. Where there is little change all the information can be gleaned from the spreadsheets, though graph format would need to be carried out by the users
As stated above I need more information at my own Area Team, CCG level and Practice Levels that I can use for benchmarking our GP practices in each of the clinical domains and to easily identify outliers and practices who are high users of exception codes. Graph formats are better as we are not data analysts and cannot easily download and manipulate raw data.	Please see comment above for graphs. More context will be provided in this year's report.
The new layouts look to be more user friendly – am not clear if the information that I need and have stipulated as being	Full breakdown at practice levels will be available on the spreadsheets as they have been in previous years.

required above are to be included in your new reporting formats although your example report does say there will be breakdowns to practice levels.	
The spreadsheets with the data could include the following: Please can the indicators be labelled to explain what the indicator actually is e.g. 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 mm Hg or less. If this cannot be included in the header can we include an index table within the spreadsheet document which gives you the list of each indicator no by disease area and provides information of the definition or description of the indicator.	A spreadsheet containing a full indicator list with each full definition will be provided. The specific indicator descriptions will be included in each worksheet for ease of use.
Establish a fully interactive reporting suite that supports comparative pan organisational (area team / CCG / practice) analysis – building on current 'on-line' tool. Exception reporting needs further development – used to have access to a dataset highlighting reasons for exception – this could do with reinstating (as as far as I am aware this was not published in for the 2012-13 data)	Unfortunately we do not have capacity or funding to extend interactive capabilities at this time. We will be looking into this for future. We will be looking into providing this for future years but this is unlikely to be possible for the October publication.
This attempts to compare points in 2013-14 against 2012-13 … yet the exec summary highlights that there were many changes in 2013-14 – therefore a challenge could be 'are we comparing like with like' ? The exception bit may benefit from a touch more description on what an exception is – maybe with the main categories ? Prevalence figures are fine…how about showing alongside the prevalence from last year…vs. expected prevalence where available ?	We will attempt to provide like with like comparisons where available only. We will provide more of an explanation on exceptions in the report. We will not be doing any work on expected prevalence. QOF concerns only recorded prevalence. Last year's prevalence rates will be included at clinical area level where appropriate for comparison.
Overall Achievements Exceptions and Prevalence - I wonder whether some geographic variation (map / charts)	We are looking to provide more context and this may include more on geographic variation. This depends entirely on the

showing average points per CCG / area team / region would be useful to support this section	numbers from QOF.
I personally do not find the new spreadsheet format useful… I am sure many users would… however, to support more in-depth analysis it would be better to have a restructured format that almost has every indicator on a single sheet (example attached with this return email). From my point of view I would benefit from a 'flat-file' sheet with everything in that I could then analyse (in the absence of any tool nationally doing this)	It is our plan – time permitting – to provide 'flat files' for further use by users.
As referenced earlier – will there be a more detailed 'exceptions' sheet as has been accessible previously..?	We will be looking into providing this for future years but this is unlikely to be possible for the October publication.
Exception reporting (as we now have) is important.	Will be carrying on providing this as usual.
The one improvement which could be made without collecting any more data, which would allow a substantial enhancement to the usefullness of the QOF prevalence data would be to gather information about the scope of overlap between the 20 or so registers. This could be simply gathered in the form of a bloc of 20 characters set to 1 or 0 and the number of people matching the pattern in each practice. This would allow the publication of important information about the extent and nature of many types of multi-morbidity. For GPs it would show the extent of the complexity of the caseloads they handle.	QOF figures show overall list sizes at surgery level only. It is not possible to get any overlap figures from QOF as we do not receive any patient level data. The coding is much more complex than perceived here.
Personally I am only interested in the prevalence data. To be able to get the whole country data by a Practee, a CCG, an AT and an England spreadsheet is useful. As long as all the information is still available I'll find my way around any output format.	This will be provided.
The executive summary - in its proposed form - is too brief to provide a meaningful explanation and could be open to manipulation. Many users will read the executive summary in-depth, unlike the rest of the document, therefore it is	Our statistical governance guidelines are such that an Executive summary should not be more than two pages in length and should only be a highlight or overview of what is contained in the full report.

crucial that it contains comprehensive information. We also have concerns about the process which determines which findings are most useful to go into the executive summary.	For this reason, we are planning an Executive Summary of two pages or less.
Great care needs to be taken to ensure there is no possible way to identity patients, particularly where there are a minimum number of items within a dataset. Where there are low numbers, the relevance of the data will also decrease. We would point to work carried out by the National Primary Medical Services Assurance and Quality Improvement Steering Group, which recommends minimum numbers which should be released. Their advice should be sought before these figures are published.	The HSCIC has a duty to ensure private information remains private and we take this role extremely seriously. We adhere to strict statistical and information governance rules and guidelines when dealing with any possible small numbers and comply with the UK Statistical Authority (UKSA) regulations. The QOF is an established time series of data going back to 2005/06 and we carry out a risk assessment on the data each year before publication.
We have a number of concerns about the proposed categories. The medical terms should be used, for example, 'Cardiovascular' should be used instead of 'Heart & Blood'. We also have concerns about the items which have been included in the groupings. Obesity is inappropriately grouped under 'Glandular and Weight Management' which reinforces the misconception that obesity is the result of endocrine dysfunction. It is also incorrect to place epilepsy under 'Cognitive'. In addition, it is questionable whether CKD should be placed under 'High dependency conditions'. We recommend the inclusion of an 'other category' which would ensure that inappropriate groupings did not occur. We would suggest the following groupings: Cardiovascular Coronary Heart Disease Cardiovascular Disease Heart Failure Atrial Fibrillation Peripheral Arterial Disease	We have updated some categories based on this feedback, thank you. We are not introducing an 'other' category as this would lead to complications as QOF evolves over time.

Stroke Hypertension (not including blood pressure, which is a biological value and not a disease) Respiratory Asthma COPD Lifestyle Smoking Obesity Mental Health and Neurological Depression Mental Health Dementia Learning Disability Epilepsy Musculoskeletal Osteoporosis Rheumatoid Arthritis Other Diabetes (hypothyroidism is no longer part of QOF) Palliative Care CKD Cancer We also do not understand the value in looking at the number of GPs working in a practice, and how locums can be excluded.	Hypothyroidism is part of the 2013/14 QOF and is therefore included in this publication.
BACP is recognised by legislators, national and international organisations	Cognitive has been updated to Mental health and neurology in line with previous

and the public, as the leading professional body and the voice of counselling and psychotherapy in the United Kingdom, with over 40,000 members working to the highest professional standards in a wide range of settings. We welcome the proposal to continue having separate registers for depression, mental health and dementia under the category of 'cognitive'. We also welcome the proposal to link registers to relevant datasets on a case-by-case basis. However we note that the proposed datasets to be linked up to the depression register in the example report - HES Hospital Admissions and ONS deaths – while valuable, only highlight data around the severe end of depression. We recommend that further linkages which could also provide useful data on cases of mild-to-moderate depression be considered. Furthermore, and to this end, we recommend that datasets on referrals to services (which General Practitioners could provide) and outcomes should be linked to the registers for mental health and depression. We further note that the draft QOF does not highlight the significant population with co-morbid mental and physical ill health – for example, 30% of those with a long-term physical condition also have a mental health difficulty (Department of Health, 2011). As the draft does not illustrate this prevalence, it limits its ability to meet customer needs. We therefore suggest that data on dual diagnosis should be collected and linked to the registers. Case management systems, such as the PC-MIS database used in IAPT services, can be used to note if a patient has a dual diagnosis.	feedback. Our intent is not to highlight only severe ends of scales so apologies for giving that impression. We listed only possible signposts, but as we are developing the publication, more relevant (and less severe) signposts will be used throughout. QOF does not contain any information on co-morbidity as no data are available at patient level. If we are aware of any co-morbidity figures via other reputable sources, e.g. IAPT as suggested, we would highlight/signpost these within the publication.
I would like the prevalence data to be calculated for every indicator and not just the main ones i.e. Smoking has the numbers but not the prevalence which means then doing the calculation yourself. It would also be useful for the	This was a slight misunderstanding on behalf of the customer that was resolved once we received this comment. Prevalence will be provided on a

clinical indicator titles to actually be written in full rather than for example CHD05. This would enable colleagues not so used to using QOF documentation to understand it's meaning and help in their learning process. I would also like prevalence to be on a separate document containing just those figures.	separate sheet.
I have thought for a long while that this summary was far too long, so any proposal to shorten would be gratefully received by both myself and colleagues in PH Birmingham.	Thank you.
Adding these extra areas would be very useful. (Introduction)	Thank you.
I feel the comparisons are useful but would comment that now we have moved into local authorities another area which would be useful is at Local Authority. I am also conscious that prevalence by age categories is a constant request which obviously at the moment can't be given from QOF, so if that comparison could be included it would also help.	We cannot provide comparison at LA level, however, if we have enough time we will provide a mapping table so that users will be able to work this out themselves. As QOF does not contain age categories, this is not possible at all, any possible relevant signposts to age will be highlighted in the report.
The proposal to link other datasets such as admissions and deaths would be a really useful addition as I continually be asked gather this information together for Needs Assessments so would enable this request to be satisfied quickly and efficiently, the only downside is I'm presuming it would be trend related data but just for the year the QOF is being released in. I would suggest maybe hyperlinks to other datasets that give the trend data would help as well.	Thank you, we will be looking to provide these throughout the report where relevant. Some time series data will be included at England level, but PCT/CCG and SHA/Area Team boundaries are not comparable to last year so time series at a lower level will not be possible.
A prevalence only sheet by category would be really useful	Will be providing.
I like the idea of grouping the indicators into categories and not having an 'other' area. This would help when doing needs assessments.	Thank you.
We would like to see the area team data report updated for London. Although useful to have the London Area Team data as provided in the region report, for	In the Area Team spreadsheet we are planning to split into the 3 areas as requested, provided we have the time, to provide greater granularity and reduce

data comparison we would need the area team report separated by the 3 area teams in London.(NWL South and North East Central) On the regional national level London is still categorized as London Commissioning Region so the data is duplicated on both the area team and regional team reports. This will disadvantage the individual area teams in London as we will lack a further source of data comparison (Comparing NWL achievement with NEC for example) Team will also have no way of looking at their total area team QOF achievement (eg total achievement for NWL)	duplication.
Exec Summary - Ok – but for further accuracy would it be possible to show the actual raw prevalence rates on the bar chart as well.	Will sort this during production.
Both the bar and line graphs could be more descriptive by including actual achievement on the graphs for further clarity.	Will sort this during production.
Would it be possible to see all of the data together for each indicator? This would make the data easier to analyse.	Combining the data more than is already planned currently means the spreadsheets would be too large for transfer and download; we will look to other options for future. It may be possible for the CSV files (flat files) to have this capability.
The level of reporting needs to be flexible and needs to v=cover ATS and CCGs. The report needs to follow the indicator structure so it is more user friendly Time to navigate, select then open the correct report can be laborious. Spreadsheets are very large	We understand that the spreadsheets are large but we are attempting to make them more user friendly by having the data together rather than in 210 separate sheets. This should cut down on navigation needed. The spreadsheets contain reporting at Area Team and CCG level and we will look to include relevant results within the report itself.
Proposed template with links seems good. Exec summary should not be too long – some of the previous reports were. Chart placement should perhaps be reconsidered	Thank you. When we have final charts with real data we will consider the placement.

Exception reporting for 2013/14 – some practices have had to undertake manual uploads of QOF data, this negates the requirement to add exception reports therefore commentary should be added to that effect – this applies to all sections below	We will add commentary on this in the exceptions section, thank you.
All the data – it is easiest to see all the data in one place. Option 2 would be better Spread sheets are very large – filters would be useful or remove columns eg, practice spreadsheet really only requires CCG?	Because of the way the spreadsheets are produced we need a consistent layout and titling (this allows us to automate production more). Filters are useful and we will look to add these in with brief instructions for users who are unfamiliar with excel.
Efficient navigation to required reports on HSCIC site The categories in the individual registers seem clear and comprehensive and possibly an extra prevalence only spreadsheet would be of value to commissioners.	Thank you, we will provide the prevalence only spreadsheets as well as the grouped (see previous comments).

