INFORMATION ANALYSIS DIRECTORATE

General Practice Quality and Outcomes Framework in Northern Ireland

User Guidance Notes

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1. Introduction

1.1 The Quality and Outcomes Framework (QOF) is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced on 1st April 2004. The core philosophy underpinning the QOF is that incentives are the best method of resourcing work, driving up standards, and recognising the achievements of practices.

1.2 The QOF measures achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement. It is a voluntary part of the new GMS Contract; general practices may aspire to achieve all, part or none of the points available in QOF. The QOF gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. The final payment is adjusted to take account of surgery workload, local demographics and the prevalence of chronic conditions in the practice's local area.

1.3 The benefits of the information available through the introduction of the QOF include:

- Enabling individual practices to identify/prioritise practice developments;
- Enabling the Health and Social Care Board (HSCB)[1] to consider practice developments, and identify areas of health inequalities at a local level;
- Enabling the Department of Health (DoH) to plan health services.

1.4 Publication of detailed results for every general practice in the country is inevitable under the Freedom of Information Act 2000, but it is important that the data are not taken out of context. A lower quality achievement does not necessarily mean that patients are receiving poorer quality care. Taking part in the QOF is voluntary and there will be a variety of reasons why some practices may not achieve as high quality scores as others, many of them outside the direct control of the practice. Users should bear in mind that a practice which has no patients who have a particular QOF-measured condition cannot score any QOF points for that clinical area and could wrongly be perceived as being a lower performer in any rank of points scored. This is particularly relevant for those with specific demographics, e.g. a university practice whose patients are primarily students.

[1] The Health and Social Care Board (HSCB) closed on 31 March 2022; responsibility for its functions transferred to the Department of Health (DoH). The latest release of Quality & Outcomes Framework (QOF) achievement and exceptions data refers to data for the financial year 2021-22 when the HSCB was still in operation; the publication and associated materials retain the term HSCB as appropriate for that time period.

1.5 The QOF only reflects part of the work that a practice is responsible for; it measures only those conditions specified within the current financial year GMS contract. As such it is not recommended to use QOF data to rank practices into league tables. The QOF is not a comprehensive source of data on quality of care in general practice, but it is a potentially rich and valuable source of information for healthcare organisations, analysts and researchers, providing the limitations of the data are acknowledged. It should be stressed that participation in the QOF is only one measure of the quality of clinical care provided to patients. This context should be taken into consideration when looking at the figures. Specific data caveats will be examined later in this factsheet.

2. Source of QOF and Prevalence Data

2.1 The source of QOF tables published by the Department of Health (DoH) is the Payment Calculation and Analysis System (PCAS)[2], a Northern Ireland IT system that supports the QOF payment process. PCAS was developed to provide practices with objective evidence of the quality of their patient care and to reward them financially for providing that care. The system ensures consistency in the calculation of quality achievement and prevalence, and is linked to payment. This means that payment rules underpinning the GMS Contract are implemented consistently across all GP clinical systems and across all practices in NI. PCAS also gives general practices and the HSCB objective evidence and feedback on the quality of care delivered to patients. PCAS was originally developed by MSD Informatics; CACI Application Services Group now maintains PCAS.

2.2 Users of data derived from PCAS should recognise that PCAS was established as a mechanism to support the calculation of QOF payments to practices, so it is not a comprehensive source of data on general practice. But as previously noted, it is a potentially rich data source.

2.3 The DoH QOF publication is based on data for the period April to March each year. Data are downloaded from PCAS at the end of June. The time lag between the end of the reporting year and the download date is to allow for adjustments agreed between practices and the HSCB, prior to sign off. Although QOF is voluntary, since the introduction of the new Contract and therefore the QOF in NI, all practices have participated.

2.4 A practice's data enters the PCAS system in two ways:

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[2] PCAS was replaced on 1st July 2022 with an in-house solution incorporated within the General Practice Intelligence Platform (GPIP); PCAS was still in operation for the collection and reporting of QOF data for the 2021-22 financial year and therefore PCAS is referred to throughout the QOF publication and associated materials for the 2021-22 release.

- The data to support the clinical quality indicators, including the Public Health and Additional Services, is extracted from individual practice GP systems using a software tool supplied by the relevant clinical software supplier, which ensures that this particular practice system produced the accredited QOF extract. The data is then extracted and transferred electronically to the PCAS system.
- Patient experience and Records & Systems indicators (that is those indicators that require simply a yes/no response) are entered by the practice directly into a spreadsheet and submitted by practices to the PCAS system via the remote server.

2.5 QOF data is captured from GP practice systems according to coded 'business rules'. QOF business rules are published on the DoH website at: https://www.health-ni.gov.uk/articles/about-quality-and-outcomes-framework-QOF

Practice List Sizes

2.6 The QOF tables published by the DoH use practice list sizes supplied to PCAS from the National Health Applications and Infrastructure Services (NHAIS), the national general practice payments system, as at 1st January of the reporting year. A more familiar term may be the 'Exeter Payment System'. These are the figures used in PCAS for the list size adjustments in final QOF payment calculations.

Level of Detail

2.7 QOF information is collected at an aggregate level for each general practice. There are no patient-specific data within PCAS. For example, PCAS will capture practice-aggregated information on patients with Coronary Heart Disease and practice-aggregated information on patients with diabetes, but it is not possible to identify or analyse patients with both of these diseases.

3. Secondary Use Issues

3.1 The DoH can only provide information that it holds in its QOF database, derived from the PCAS system. Any additional information about general practices, or activity of general practices that is not held in the PCAS system, is not available. For example, there is no information available about individual patients. PCAS was designed to collect information to support the calculation of practice QOF payments. It does not hold additional information around QOF, such as information on practice annual review visits by the HSCB.

3.2 The published QOF tables for NI provide healthcare organisations, analysts and researchers with a potentially rich source of information on the provision of general medical services. However, it is recognised that levels of QOF achievement will be related to a variety of local circumstances and should be interpreted in the context of

these circumstances. Users of the published QOF tables should be particularly careful to undertake comparative analysis on this basis. The following points should be noted:

- 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 payments include adjustments for both these factors.
- Comparative analysis of practice or LCG level QOF achievement may also be inappropriate without taking account of the underlying social and demographic characteristics of the populations concerned. The delivery of services will be related to, for example, age, gender, socio-economic and deprivation characteristics not included in the QOF data collection process.
- 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 of students, homeless people, drug users and asylum seekers.
- Information on QOF achievement should also be interpreted with respect to local circumstances around general practice infrastructure. Users 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.
- Analysis of co-morbidity (that is, patients with more than one disease) is not possible using QOF data. There are no patient-specific data held within PCAS. For example, PCAS will capture practice-aggregated information on patients with coronary heart disease and practice-aggregated information on patients with diabetes, but it is not possible to identify or analyse patients with both of these diseases.
- It is important to note that the information held within PCAS and therefore the source for these published tables, is dependent on diagnosis and recording within practices using the clinical information systems.

4. Summary of QOF points and pounds available in 2021/22

4.1 The QOF is not about performance management of general practices but about resourcing and rewarding good practice. This will benefit both patients and the wider Health Service. For example, there should be a reduction in avoidable hospital admissions due to improved chronic disease management. The QOF measures a general practice's achievement against a scorecard of 63 evidence-based indicators, allowing a possible maximum score of 547 points in 2021/22. The evidence-based indicators span four domains: Clinical; Public Health, which incorporates Additional Services; Records & Systems; and Patient Experience. The details of these domains are set out below. A summary of the distribution of points is given in Table 4.1.

- **Clinical Domain:**
  51 indicators in 15 areas: maximum QOF achievement of 380 points (69.5% of the total QOF points available).

Area	Number of Indicators	Number of Points
Asthma	3	41
Atrial Fibrillation	2	22
Cancer	1	6
Coronary Heart Disease	4	48
Chronic Obstructive Pulmonary Disease	5	32
Dementia	2	21
Depression	1	21
Diabetes Mellitus	10	73
Heart Failure	3	25
Hypertension	1	20
Mental Health	6	22
Osteoporosis	2	6
Palliative Care	2	6
Rheumatoid Arthritis	3	17
Stroke and Transient Ischaemic Attack	6	20
Clinical Domain	**51**	**380**

- **Public Health Domain**: The Public Health domain has a maximum QOF achievement of 49 points (9.0% of the total QOF points available). This is comprised first of 4 indicators in 3 areas worth a maximum of 35 points (6.4% of the total points available) and then secondly this domain incorporates Additional Services: 2 indicators in 2 areas (Cervical Screening and Sexual Health) worth a maximum of 14 points (2.6% of the total points available).

Area	Number of Indicators	Number of Points
Cardiovascular Disease – Primary Prevention	2	10
Blood Pressure	1	15
Smoking	1	10
Additional Services		
Cervical Screening	1	11
Sexual Health	1	3
Public Health Domain	**6**	**49**

- **Patient Experience Domain:**
  1 indicator in 1 area: a maximum of 18 points (3.3% of the total points available).

- **Records & System Domain:**
  5 indicators in 1 area: a maximum of 100 points (18.3% of the total points available).

Table 4.1 QOF – points and payments available to GMS practices, 2021/22

Evidence-based indicators	Number of indicators	Total points available	Pounds per point
Clinical domain	51	380	Variable[3]
Public Health	6	49	Variable[4]
Patient Experience domain	1	18	£178.25
Records & System domain	5	100	£178.25
Total[5]	63	547	

4.2 Within the QOF annual publication, achievement data is also presented using the classification in Table 4.2 (this classification is consistent with the presentation of data within the Raw Disease Prevalence Data NI publication; this can be found at: https://www.health-ni.gov.uk/articles/prevalence-statistics). Detailed definitions of all indicators are given at Section 12 of these User Guidance Notes.

[3] Within the Clinical Domain, the baseline £178.25 per point (2021/22) is adjusted up or down for each practice according to the prevalence of each clinical condition for that practice's patients. See "Prevalence User Guidance Notes" for further information. https://www.health-ni.gov.uk/publications/QOF-user-guidance-notes

[4] For Additional Services within the Public Health Domain, the baseline £178.25 per point (2021/22) is adjusted up or down for each practice according to the target population factor for that practice's patients. See "Prevalence User Guidance Notes" for further information.
https://www.health-ni.gov.uk/publications/QOF-user-guidance-notes

[5] Payments across all the domains are added together to give the total payment for the practice. This payment is then adjusted up or down by the practice's list size relative to the Northern Ireland average list size.

Table 4.2 Summary of QOF Indicators & Points Available by QOF Groups

QOF Group	Condition/Measure	Number of indicators	Total Points Available
Cardiovascular	Atrial Fibrillation Blood Pressure CVD – Primary Prevention Coronary Heart Disease Heart Failure Hypertension Stroke and TIA	19	160
Fertility, Obstetrics & Gynaecology	Cervical Screening Sexual Health	2	14
High Dependency & other long-term conditions	Cancer Diabetes Mellitus Palliative Care	13	85
Lifestyle	Smoking	1	10
Mental Health & Neurology	Dementia Depression Mental Health	9	64
Musculoskeletal	Osteoporosis Rheumatoid Arthritis	5	23
Respiratory	Asthma COPD	8	73
Undefined Group	Patient Experience Records & Systems	6	118
Total		63	547

5. Revisions to QOF Indicators since its Introduction

5.1 As of 1st April 2006, the quality practice payment points and the access target points were removed from the QOF. The access target at that time became a directed enhanced service; this ceased in 2010.

5.2 As of 1st April 2008, the Holistic Care payments were removed from QOF and the points reallocated to the new patient experience indicators.

5.3 From April 2009, 9 new indicators were added to the QOF, the points for the new indicators were reallocated from adjustments to the points of 6 existing indicators. 4 indicators were also removed; the total QOF points available remained at 1,000 points.

5.4 From April 2011, key changes were: the retirement of 8 clinical indicators and 4 non-clinical indicators; the introduction of 3 new clinical indicators and 11 new organisational indicators for improving Quality & Productivity; and the rewording or replacement of a further 15 existing indicators with 21 new or amended indicators.

5.5 From April 2012, 2 new clinical areas were introduced – Osteoporosis (3 new indicators) and Peripheral Arterial Disease (4 new indicators). 5 Quality & Productivity indicators were removed and replaced by 3 new indicators, 2 clinical indicators were retired and 2 new indicators were added to existing clinical areas. A further 13 existing indicators were revised and replaced with 14 new or amended indicators.

5.6 The 2013/14 QOF brought a number of key changes. From April 2013, a new clinical area on Rheumatoid Arthritis (4 new indicators worth 18 points) was introduced. 4 new indicators, worth 24 points, were added to the Diabetes area and a new indicator (10 points) was added to COPD. 7 clinical indicators were also replaced. A new Public Health Domain was established, covering Cardiovascular Disease – Primary Prevention, Obesity, Blood Pressure and Smoking. The Public Health Domain also incorporated Additional Services (Cervical Screening, Child Health Surveillance, Maternity Services and Contraceptive Services). The Organisational domain was reduced to 1 area, Medicines Management (3 indicators, worth 23 points). Although the points and indicators within Quality & Productivity remained unchanged, this was established as a separate domain. Patient experience remained unchanged.

5.7 In 2014/15 CKD, Hypothyroidism and Conditions assessed for smoking were retired.

5.8 QOF NI changed substantially in 2015/16, as most of the indicators for the keeping of a register of patients diagnosed with a condition were subsumed into core funding. This removed the first indicator (that is, maintaining a register) for: Atrial Fibrillation, Asthma, Cancer, CHD, Sexual Health, COPD, Dementia, Diabetes, Epilepsy, Heart Failure, Hypertension, Learning Disabilities, Mental Health, Obesity, Osteoporosis, Peripheral Arterial Disease, Rheumatoid Arthritis and STIA, removing 18 indicators and 71 points from the QOF assessment. Four domains (Epilepsy, Learning Disabilities, Obesity and Peripheral Arterial Disease) had no associated indicators other than register maintenance and therefore as a consequence, these are no longer reported within QOF. Atrial Fibrillation had 1 indicator retired and 2 replaced, with no change in total points. CHD lost 1 indicator and 10 points, PAD lost 3 indicators and 7 points and Diabetes lost 2 indicators and 14 points. The Records & Systems domain completely replaced the Quality & Productivity domain, maintaining the same number of points (100), but with fewer indicators (6).

5.9 The majority of indicators remained unchanged in 2016/17, in terms of both definitions and points available. Only the Records & Systems domain saw changes to indicators, with the wording for all indicators being amended (although largely keeping the same meanings) and the points available for each indicator changing. However, the overall total points available for the Records & Systems domain remained unchanged at 100 points. Indicator RS006 was retired this year, but the points for it were incorporated into

the changes to the points for the other Records & Systems indicators. There was therefore no change to the overall maximum QOF points available to practices (547).

5.10 There have been no changes to indicators or points from 2017/18 onwards.

6. Definitions

6.1 **Registers** relate to each of the indicator groups within the clinical domain of the QOF. The information systems which underpin the QOF hold the numbers of patients on each of these registers, for each participating practice. For example, there is a register count for all people diagnosed with coronary heart disease (CHD) at each practice. There is no longer any financial incentive associated with keeping a register for most clinical areas, as most register-focused indicators, and their associated funding, were subsumed into core funding. However, registers for some clinical areas still exist if other indicators still assessed for QOF remain on the system (Asthma or CHD, for example), but the subsuming of registers for other conditions resulted in their complete removal from the QOF assessment (Epilepsy, Learning Disabilities, Peripheral Arterial Disease and Obesity).

6.2 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.

6.3 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, e.g. 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 as **exclusions**.

6.4 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 defined exception criteria. The normal relationship between registers, denominators, exclusions and exceptions is therefore:

Register = Denominator + Exclusions + Exceptions

7. QOF Measures

QOF Achievement

7.1 Reference to 'QOF achievement' often refers to the percentage of available points achieved. So if a practice achieves the full points available, it may be said to have 100% 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 clinical QOF points available can be said to have 100% clinical achievement even though it may not have 100% 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.

Underlying Achievement (Net of Exceptions)

7.2 *Underlying achievement (net of exceptions)* data are provided in the spreadsheets associated with the annual NI QOF publication. Since a practice can deliver the required care to fewer than 100% of its patients (i.e. within the upper threshold) to achieve the full (100%) points available, there is an important distinction between percentage achievement in terms of QOF points available and the underlying achievement (net of exceptions) for specific indicators.

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

$$\text{Underlying Achievement (Net of Exceptions)} = \frac{\text{Indicator Numerator}}{\text{Indicator Denominator}}$$

7.4 For some indicators, points are awarded on a sliding scale based on the level of underlying achievement. Practices will achieve maximum points if their underlying achievement is greater than or equal to the upper threshold of the scale; practices can therefore have 100% achievement of points with an underlying achievement of less than 100%.

8. Exception Reporting

8.1 The QOF includes the concept of exception reporting. This has been introduced to allow practices to pursue the quality improvement agenda but not be penalised where, for example, patients do not attend for review or where medication cannot be prescribed due to a contraindication or side effect. Patient exception reporting applies to those indicators in the clinical domain of the QOF where the level of achievement is determined by the percentage of patients receiving the specified level of care. Practices can exclude specific patients from data collected to calculate QOF achievement scores. Patients with specific diseases can be excluded from the denominators of individual

QOF indicators if the practice is unable to deliver recommended treatments to those patients (the GMS Contract sets out valid exception criteria).

8.2 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 3 occasions during the preceding 12 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 or who have recently registered with the practice who should have measurements made within 3 months and delivery of clinical standards within 9 months, e.g. blood pressure or cholesterol measurements within target levels.
D – Patients who are on maximum tolerated doses of medication whose levels remain suboptimal.
E – Patients for whom prescribing a medication is not clinically appropriate, e.g. those who have an allergy, contraindication or have experienced an adverse reaction.
F – Where a patient has not tolerated medication.
G – Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their medical records following a discussion with the patient.
H – Where the patient has a supervening condition that 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. [6]

8.3 In the case of exception reporting on criteria A and B, these patients would be subtracted from the denominator for all other indicators in that disease area where the care had not been delivered. For example, a contractor with a Coronary Heart Disease (CHD) register of 100 patients, but 4 of these patients did not attend on the 3 occasions when they were recalled for follow-up and 1 of these patients has become terminally ill with metastatic breast carcinoma during the year, would have a denominator for reporting of 95 and those 5 patients would be excepted from assessment. However, all 100 patients with CHD would be included in the calculation of practice prevalence. This would apply to all relevant indicators in the CHD set.

8.4 In addition, practices may exception report patients from single indicators, e.g. a patient who has heart failure due to LVD but who is intolerant of angiotensin converting enzyme

[6] General Medical Services, Statement of Financial Entitlements (Northern Ireland).
Available at: https://www.health-ni.gov.uk/publications/gp-contract-statements-financial-entitlements

inhibitors (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. Practices will not be expected to report why individual patients were exception reported. However, practices may be called on to justify why they have "excepted" patients from an indicator during verification and this should be identifiable in the clinical record.

8.5 Within PCAS, the reasons used to except patients are all classed as exceptions, however, for the purposes of the QOF Exception Reporting publication, a distinction has been made between those that are true exceptions and those that are exclusions. Exclusions refer to reasons that make the patient ineligible for inclusion in an indicator's denominator, e.g. because they do not meet the age requirement of the indicator.

8.6 The exception rate is calculated as follows:

$$\text{Exception Rate} = \frac{\text{Number of Exceptions}}{(\text{Exceptions} + \text{Indicator Denominator})} \times 100$$

8.7 The exclusion rate is calculated as follows:

$$\text{Exclusion Rate} = \frac{\text{Number of Exclusions}}{(\text{Exclusions} + \text{Exceptions} + \text{Indicator Denominator})} \times 100$$

8.8 PCAS is primarily a system to support QOF payments and exception reporting is recorded as part of that process. However, PCAS was not designed to deliver specific reporting around exceptions and therefore PCAS does not allow presentation of exceptions broken down by the 9 exception criteria. There are a number of technical reasons for this:

- PCAS reporting functionality does not make a distinction between exception reporting and definitional exclusions; both types of omissions are included in the PCAS reports.

- Any individual patient can be associated with more than 1 exception criteria but only one reason needs to be identified by the PCAS system in order to exception-report a patient from inclusion in the indicator denominator. Only the first reason is captured, no other information is captured for other potential reasons.

- Linked to patients potentially being excepted for more than 1 reason is the sequencing by which the different GP clinical systems search for exception reasons. Where a patient has been excepted for more than 1 reason, it is not clear which sequence has been used by each clinical system and therefore which

exception reason was chosen. Different systems may follow different sequencing, without this impacting on payment accuracy (sequencing is secondary to identifying any exception, as this still ensures the data values for achievement calculations are accurate for payment purposes).

9. Prevalence Data in the QOF

Overview

9.1 Prevalence data are used within QOF to calculate points and payments within each of the clinical domain areas. Specifically:

- Points can only be awarded to a practice for a given clinical domain area if the practice can produce a register of patients with that disease or condition, and
- The number of pounds per point in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the estimated regional Northern Ireland prevalence for that disease or condition.

9.2 A separate user guide on prevalence is available; therefore this section deals specifically with how prevalence is calculated and how it is used in the final payment calculations.

Reported Prevalence

9.3 The raw prevalence for each practice is calculated by dividing the number of patients on the relevant register by the number of patients the practice has on its total registered list. The prevalence data published are shown as rates per 1,000 patients. For example:

Calculation of Practice Asthma Prevalence

A practice has 105 patients on its asthma register as at National Prevalence day.
The practice's total list size at 1st January was 2,500.
The raw prevalence estimate (per 1,000 patients) = (105 / 2,500) x 1,000 = 42

9.4 For Northern Ireland reporting of QOF information, the Department reports raw (unadjusted) prevalence – that is, the number on a register on prevalence day of each year reported as a proportion of patients on a practice list as at 1 January of the same year. Note that for 4 clinical areas (Diabetes, Depression, Osteoporosis and Rheumatoid Arthritis), the registers are age-specific; age-specific prevalence rates are also published in the Raw Disease Prevalence Data NI annual publication.

Prevalence used in the Final Payment Calculations

9.5 Practice register counts used for final payment calculations in PCAS are based on National Prevalence Day (14 February of each year up to 2008/09, when Prevalence day was moved to 31st March to bring it in line with Achievement day). PCAS uses these counts to perform an adjustment to practices' QOF payments, based on levels of

prevalence. The 'adjustment factor' is calculated centrally within PCAS and verified by Information and Analysis Directorate (IAD), DoH.

Use of Prevalence Data in Calculating Points and Payments

9.6 The aim of the prevalence adjustments in each of the QOF clinical domain areas is to deliver a more equitable distribution of payments in the light of different workloads that practices face in achieving the same number of points. Practices with a high prevalence of a specific disease or condition will receive more pounds per point for that clinical domain area than practices with a low prevalence of the same disease or condition.

9.7 The basic pounds per point, £178.25 in 2021/22, in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the estimated Northern Ireland prevalence for that disease or condition. The amount by which the pounds per point is adjusted up or down is known as the Adjusted Practice Disease Factor (APDF). For example, a practice with an APDF of 1.20 for Asthma has a 20% higher adjusted prevalence than the Northern Ireland figure, and the adjusted pounds per point for asthma would equal = £178.25 * 1.20 = £213.90 per point. A worked example of the APDF calculation is given in Section 10.

9.8 The additional services indicators within the Public Health Domain (cervical screening and sexual health) do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are: (i) for Cervical screening services - females who have attained the age of 25 years but not yet attained the age of 65 years and (ii) for Contraceptive services - females who have not attained the age of 55 years. The basic pounds per point, £178.25 in 2021/22, in each additional services area is adjusted up or down by a Target Population Factor. The Target Population Factor for the additional service is to be multiplied by the pounds per point (£178.25 in 2021-22) and by the Achievement Points obtained in respect of the additional service to produce the cash total in respect of the additional service. The resulting cash amounts, in respect of each additional service, are then added together for the total amount in respect of the additional services domain. In turn this cash amount is added to those in respect of the other domains (that is, the clinical domain, reminder of the Public Health Domain, the patient experience domain and records and systems domains).

9.9 A more detailed explanation of the method used to calculate Target Population Factors and APDFs is contained in Annex E and Annex F respectively of the GMS Statement of Financial Entitlement[7].

[7] General Medical Services, Statement of Financial Entitlements (Northern Ireland).
Available at: https://www.health-ni.gov.uk/publications/gp-contract-statements-financial-entitlements

10. Calculation of the Adjusted Practice Disease Factor (APDF)
Payment per Quality Point in 2021-22 = £178.25

		STEP 1		STEP 2		STEP 3		STEP 4	
Practice	Registered List	No. of patients on COPD Disease Register	Raw Prevalence per 1,000 patients	APDF	% difference from NI average	Adjustment (£) from £178.25	Final £ per Clinical Quality Point	Population Factor	Final £ per Point
A	9,971	14	1.4	0.07	-93.1%	-£166.01	£12.24	1.575	£19.28
B	5,328	87	16.3	0.80	-20.1%	-£35.90	£142.35	0.842	£119.83
C	6,329	129	20.4	1.00	0.0%	£0	£178.25	1.000	£178.25
D	2,774	53	19.1	0.93	-6.6%	-£11.69	£166.56	0.438	£73.00
E	3,165	71	22.4	1.10	9.7%	£17.34	£195.59	0.500	£97.79
F	12,658	258	20.4	1.00	0.0%	£0.00	£178.25	2.000	£356.50
N.I.	2,018,971	41,283	20.4	1.00					

NI Average List = 6329

Step	*Calculation instructions*
Step 1:	Calculate Raw Disease Prevalence for each practice as follows: $\left[\frac{\text{No. of Patients on Practice's Disease Register}}{\text{No. of Patients on Practice's Registered List}}\right]$ x 1,000 Patients Likewise NI Raw Disease Prevalence is calculated as follows: $\left[\frac{\text{No. of Patients in N Ireland on Disease Register}}{\text{Total No. of Registered Patients in N Ireland}}\right]$ x 1,000 Patients In the 2009/10 GMS contract negotiations, NHS Employers agreed with the General Practitioners Committee (GPC) that the square root adjustment employed in previous years should be removed from the calculations from 2009/10 onwards, and that the 5% cut off would cease to be applied from 2010/11 onwards.

Step 2:	The Adjusted Practice Disease Factor for each practice is then calculated as follows: Adjusted Practice Disease Factor (APDF) for each Practice = $\frac{\text{Practice Adjusted Disease Prevalence}}{\text{N Ireland Adjusted Disease Prevalence}}$ This compares each practice's Adjusted Disease Prevalence (ADP) around the NI average ADP of 1.0
Step 3:	The APDFs are used to adjust the contractor's figures depending on how far above or below the NI average they are. This determines the pounds per clinical quality point. The average contractor is assumed to receive £178.25 per clinical quality point. Practice C has an average list size and average CHD prevalence and therefore receives £178.25 per clinical quality point. The APDF does not adjust the contractor's achieved points, but rather the pounds per point they receive. The adjustment only applies to the clinical domain of QOF.
Step 4:	The payments per clinical quality point are then adjusted by the practice's list size relative to the NI average list size using a population factor. Population Factors for each Practice = Practice List Size / NI Average List Size The pounds per Clinical Quality Point x Practice Population Factor = Final Pounds per Point in the QOF
Examples	Practice C has a list size equal to the NI average and an average CHD prevalence, it therefore has an APDF of 1.0 and a population factor of 1 and receives £178.25 per QOF point. Practice E has a list size half the NI average but slightly higher than average CHD prevalence and has an APDF of 1.1. Practice E therefore receives a payment that is almost 10% higher than the £178.25 base payment per point, receiving £195.59 per clinical quality point. When adjusted for relative list size, practice E receives £97.79 per overall QOF point. Practice F has a list size twice that of the NI average and has average prevalence. Practice F has an APDF of 1.0, the same as the NI APDF, therefore Practice F receives £178.25 per clinical quality point. However, when adjusted for relative practice size, Practice F receives £356.50 per overall QOF point.

11. Key Stages in the QOF Process

11.1 The following is a summary of the key stages in the QOF process. Further details can be found in the GMS Statement of Financial Entitlement. The QOF reflects a voluntary cycle of continuous quality improvement in standards of patient care. This requires practices and the HSCB to:

- Plan – work out how many of the QOF points available it is realistic to aspire to, and ways to deliver care using the resources available.
- Action – deliver high quality services and record achievement on practice systems.
- Assess – calculate QOF points and payments.
- Learn – reflect on how quality of care and points scored could be improved for the next year.

11.2 **Agreement of QOF Aspiration Levels**: Before the start of each financial year, general practices are asked to identify how many of the total points available under QOF they think it is realistic for them to aspire to in the next financial year, given their local circumstances and resources. This aspiration level is agreed with HSCB.

11.3 **Monthly Aspiration Payments to Practices**: These payments provide in-year financial support against likely QOF achievements. The payments published within the QOF publication include both the aspiration payments and additional payments required once final achievement against the QOF was assessed.

12. Detailed Indicator Definitions

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Asthma (AST)	AST002	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis	15
Asthma (AST)	AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20
Asthma (AST)	AST004	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6
Atrial fibrillation	AF006NI	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more)	12
Atrial fibrillation	AF007	In those patients with atrial fibrillation whose latest record of a CHA_2DS2-VASc score is 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	10
Cancer (CAN)	CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis	6
Secondary prevention of coronary heart disease (CHD)	CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	17
Secondary prevention of coronary heart disease (CHD)	CHD003NI	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	17
Secondary prevention of coronary heart disease (CHD)	CHD005	The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or anti-coagulant is being taken	7

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Secondary prevention of coronary heart disease (CHD)	CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7
Chronic obstructive pulmonary disease (COPD)	COPD002NI	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register	5
Chronic obstructive pulmonary disease (COPD)	COPD003	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9
Chronic obstructive pulmonary disease (COPD)	COPD004NI	The percentage of patients with COPD with a record of FEV_1 in the preceding 3 years	7
Chronic obstructive pulmonary disease (COPD)	COPD005NI	The percentage of patients with COPD and Medical Research Council dyspnoea grade $\geq$3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 15 months	5
Chronic obstructive pulmonary disease (COPD)	COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6
Dementia (DEM)	DEM002	The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	15
Dementia (DEM)	DEM003	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before and 6 months after entering on to the register	6
Depression (DEP)	DEP001NI	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded	21
Diabetes mellitus (DM)	DM002NI	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Diabetes mellitus (DM)	DM003NI	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less	10
Diabetes mellitus (DM)	DM004NI	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less	6
Diabetes mellitus (DM)	DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3
Diabetes mellitus (DM)	DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17
Diabetes mellitus (DM)	DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8
Diabetes mellitus (DM)	DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10
Diabetes mellitus (DM)	DM010	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3
Diabetes mellitus (DM)	DM012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4
Diabetes mellitus (DM)	DM015NI	The percentage of male patients with diabetes, on the register, with whom erectile dysfunction has been discussed. Where appropriate patients should have been offered advice/investigation/treatment.	4
Heart failure	HF002NI	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 15 months after entering on to the register	6
Heart failure	HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Heart failure	HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9
Hypertension	HYP002NI	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	20
Mental health (MH)	MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6
Mental health (MH)	MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months	4
Mental health (MH)	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	4
Mental health (MH)	MH008NI	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years	5
Mental health (MH)	MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1
Mental health (MH)	MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2
Osteoporosis: secondary prevention of fragility fractures	OST002	The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent	3
Osteoporosis: secondary prevention of fragility fractures	OST005	The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent	3

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Palliative Care (PC)	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3
Palliative Care (PC)	PC002	The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	3
Rheumatoid arthritis (RA)	RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months	5
Rheumatoid arthritis (RA)	RA003NI	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years	7
Rheumatoid arthritis (RA)	RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years	5
Stroke and transient ischaemic attack (STIA)	STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15months) is 150/90 mmHg or less	5
Stroke and transient ischaemic attack (STIA)	STIA004NI	The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years	2
Stroke and transient ischaemic attack (STIA)	STIA005NI	The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	5
Stroke and transient ischaemic attack (STIA)	STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken	4
Stroke and transient ischaemic attack (STIA)	STIA008NI	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA	2

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Stroke and transient ischaemic attack (STIA)	STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2
Cardiovascular disease – primary prevention (CVD-PP)	CVD- PP011NI	The percentage of patients with a new diagnosis of hypertension recorded in the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who are aged 30 or over and who have not attained the age of 75, who have a CVD risk assessment score recorded in the preceding 15 months.	5
Cardiovascular disease – primary prevention (CVD-PP)	CVD- PP012NI	In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score in the preceding 15 months of ≥20%: the percentage who are currently treated with statins.	5
Blood Pressure (BP)	BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15
Smoking (SMOK)	SMOK001NI	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10
Cervical Screening	CS002NI	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11
Sexual Health	CON003NI	The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception in the preceding 3 years.	3
Patient Experience (PE)	PE001NI	The practice undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question “Would you recommend your GP practice to someone who has just moved into the local area?” and one follow-up question (see guidance). The practice should survey at least 2% of the practice list size and need to get a minimum of 50 responses. A summary report is required to be submitted to the Regional Board by 31 March 2021	18

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Records & Systems	RS001	General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialties.	20
	RS002	The Practice reviews its own CCG Referral Data. Firstly to ensure that ALL GPs, including locums, are using CCG for referrals to all (available) Consultant led specialties. Secondly to look at referral patterns compared to previous years and neighbouring practices.	20
	RS003	The practice engages with between three and six neighbouring practices to discuss outpatient referrals. This should include identifying any issues with CCG use and looking at referral patterns and pathways.	20
	RS004	The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter. Information should include Date of Admission, Specialty and Diagnosis	20
	RS005	The Practice runs the Data Quality in Practice (DQIP) minimum dataset queries (to include queries to calculate the electronic frailty index) in conjunction with the R&S tool, supported by the clinical informatics team on a six monthly basis. The extracts are shared with the HSCB in pseudonymised form. The practice will create and maintain a patient frailty register by coding patients identified by the electronic frailty index, presented in a dashboard in the R&S tool, using the appropriate Read code for mild, moderate or severe frailty.	20

13. Further Information

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Where Can I Find Information on QOF across the UK?

England: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-QOF

Scotland: https://www.isdscotland.org/health-topics/general-practice/quality-and-outcomes-framework/
(note: QOF was retired in Scotland on 31st March 2016; the final publication therefore relates to 2015-16)

Wales: https://gov.wales/general-medical-services-contract-quality-assurance-and-improvement-framework-october-2019

The Quality Assurance and Improvement Framework (QAIF) was introduced as part of the contract reform in 2019, it replaces the Quality and Outcome Framework (QOF), which was originally introduced as part of the new GMS contract in 2004.