Please note this document is in final draft format and PCC would welcome comments regarding the content from QOF leads, so that these can be taken into consideration and where applicable accounted for in the final version. Please send any comments regarding this document to marion.todd@pcc.nhs.uk
QUALITY AND OUTCOMES FRAMEWORK (QOF) MANAGEMENT GUIDE: VOLUME 1

This is a suite of [3] documents; Volume 1 – this document - is a simple iterative guide to QOF, function and purposes.

Volume 2 is an in depth guide to developing and delivering high class QOF assessment, with a large section on information management, uses, tools and analyses

Volume 3 with annual changes updating indicators is a guide to each individual QOF indicator, with best practice and individual indicator assessment tips.

Whilst each document stands alone, there are cross references within them and the intention overall is to achieve a comprehensive QOF guide.
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Introduction

The objective of the suite of guides is to be a reasonably comprehensive one-stop resource to enable PCTs to support the best care for patients by

- ensuring fair and meaningful achievement of QOF,
- helping to develop practices to deliver, and
- making better use of information.

The guide is accessible to all, from novice or lay expert to senior clinical and managerial levels of understanding. Throughout the three volumes of the guides, issues are considered successively in increasing depth and detail, so that readers can step into the guides at a level at which they are comfortable, depending on the level of knowledge and experience. The Executive Summary is short, reflecting the whole approach of the guide.

The Guide

- explains the meaning and purpose of QOF
- supports fair, developmental measurement, assessment and management process
- describes
  - assessment,
  - Pre Payment Verification (PPV),
  - random 5% checks,
  - contract management and QOF
  - wider use of QOF in Public Health (PH) and
  - uses in commissioning
- and in outline, management of QOF data

More help

There are many hyperlinks and readers should consult the source documents if in any doubt or needing more detail. NHS Primary Care Commissioning (PCC) will support all subscriber PCTs in all matters of QOF implementation. Much valuable material, including many of the references in this document, is available in the QOF section of the PCC website. Subscriber PCTs can access all the material as part of their subscription to NHS PCC.
Executive summary

QOF was set up as part of the GMS contract, as a voluntary quality incentive scheme for general practice that can benefit all patients. It contains a range of national indicators based on the best available research evidence, in domains of clinical, organisational, additional services and patient experience. Indicators identify the appropriate sector of the population, and record information and interventions about them, against a graded set of financial incentives.

Achievement payments take account of recorded disease prevalence and also the ability to except patients (exception reporting) from the QOF indicators (against a small number of criteria) without loss of reward to practices.

There are a maximum of 1000 points available, with each point achieved worth, on average, £126.77 in 2009/10. The value of each point is adjusted with respect to practice list size and relative prevalence in the different disease areas. Practices are paid in respect of points achieved in the previous 12 months by 31 March each year. Payments should be completed by the end of the following June, although they can be made earlier when the practice and PCT have agreed them. Payments are subjected to achievement thresholds and take account of the national prevalence of diseases in a standardised way. Nationally, since inception, there have been high levels of achievement in all clinical and non-clinical areas of the QOF. Results are published annually by the Information Centre.

The principles agreed initially for indicators to be included in QOF standards were that they should apply

- Where responsibility for ongoing management (of the patient) rests primarily with the GP and the primary care team
- Where there is good evidence for the health benefits likely to result from improved primary care
- Where a national accepted clinical guideline existed
- Where the disease is a priority across the UK.

A full set of indicators and of achievement thresholds is described in national guidance published by NHS Employers.

The payments for QOF nationally amount to approximately £1.1 billion – very roughly 15% of practice income. The opportunities to measure and increase health gain for most of the population are significant, as are the rewards. With the high levels of public investment and the opportunities QOF provides to improve health care, robust QOF assessment and development processes should be established and maintained by PCTs. The QOF is unique in the world in size and scope.
The QOF is proving of benefit to patients but there may be questions about:

- whether the QOF provides value for money,
- whether QOF in effect is just a large “bonus” payment and whether practices should be re-investing this reward payment to further improve patient care,
- PCTs management of practices,
- a lack of public health (preventive) interventions,
- a difficulty in effecting improvements to the framework.

The framework is supported by sophisticated data collection, as well as technical and management rules. A programme of assessment, prepayment verification and random fraud checks should ensure that the NHS gets fair value for money and patients get the best out of the indicators.

The assessment processes and information management issues are not always well understood and therefore there is a risk that patients do not benefit maximally from QOF and the NHS is less efficient as well. Volume 2 of this guide is therefore particularly intended to enhance understanding and the ability to carry out assessments effectively.

QOF assessment visits should take place between 1 October and January 31st. Prepayment verification (PPV) should be carried out between 31 March and end June to ensure that final payments are approved by the end of June. Random checks for fraud can be carried out anytime, but the most sensible time is also after the year end.

A robust QOF assessment will ensure that:

- patients get the maximum health benefit from the QOF
- practices are encouraged and developed to deliver more each year through the formative aspects of the assessment
- disease registers are verified and checks made to verify appropriate exception coding
- poor practice is curtailed.

Good information is at the heart of QOF, just as elsewhere in healthcare. The unique set of indicators helps practices to know how well they are delivering care and the data can be used in healthcare planning and commissioning of both primary and secondary care.

In the future, we might expect QOF to be more progressive and to deliver more public health objectives, producing indicators for interventions for practice populations to prevent ill health later in life. Following a national consultation, from now on NICE have been commissioned to develop and recommend both clinical and health improvement indicators for negotiation between the BMA and NHS Employers. The evidence for the indicators includes clinical and cost effectiveness and the recommendations to the negotiators will be accompanied by advice on cost-effectiveness at varying levels of uptake, payment thresholds and points values.
NICE will also review existing indicators and recommend whether they should be retained, or changed, or removed from QOF. From time to time, PCTs will be able to comment and make suggestions about existing and new indicators through the NICE website.

**Volume 2** of this guide describes in detail how to carry out successful assessments, prepayment verification and random 5% checks. It includes advice about information governance (including confidentiality and consent) and data management.

**Volume 3** looks at individual indicator performance.
Chapter 1

The basics:

What is QOF? What does it do? Why is it important?

QOF was set up as a voluntary quality incentive scheme, as part of the nGMS contract preparatory year in 2003-04. The framework was updated for April 2006, 2008 and 2009. Although it was originally part of GMS contract negotiations, all primary medical care contractors – and all patients – can take part in the QOF. If they choose to participate, GMS contractors are entitled to use all or part of the QOF as negotiated. For other contractors (ie PMS, APMS and PCTMS) PCTs have the opportunity to introduce local variation to QOF indicators, with appropriate local agreement, for example where practices have a high number of asylum seekers or are a university practice. In practice, so far, this has happened infrequently; there is near universal uptake of the national QOF. Policy development in this area continues, in order to ensure that as much patient need as possible is met through evidence-based frameworks. Where indicators from the NICE menu have not been included in national QOF they remain available for PCTs to adopt for local quality schemes, where the together with clinical and cost effectiveness evidence for the indicator.

PCTs should remember that QOF is not the only route to quality improvement in patient care; there are a number of Directed and Local Enhanced Services in use, as well as the benefits available through Practice Based Commissioning and other procurements. World Class Commissioners at PCTs will wish to use all of these to ensure services are sensitive to local needs.

The framework (you can download a description by NHS Employers, who negotiated it with the BMA) sets out a range of national indicators based on the best available research evidence. The indicators are divided into four domains:

- **clinical** indicators linked to the care of patients suffering from chronic diseases
- **organisational** indicators relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
- **additional services**, covering cervical screening, child health surveillance, maternity services and contraceptive services
- **patient experience**, based on patient surveys and length of consultations

1 PCTs could negotiate and agree changes to national QOF with GMS contractors if they wish. However, this is rare.

2 The 2004 PMS agreement Framework said, re a local QOF

* Possible variations are offered below:
  - A core from national QOF plus local add-ons
  - Local use of different indicators
  - A different evidence base
  - Different approaches.
  - Fewer indicators for the same disease areas
  - Different interventions for related fields
  - Use organisational quality frameworks (e.g. QTD)
The principles agreed initially for QOF clinical indicators were that they should apply

- Where responsibility for ongoing management (of the patient) rests primarily with the GP and the primary care team
- Where there is good evidence for the health benefits likely to result from improved primary care
- Where a nationally accepted clinical guideline existed
- Where the disease is a priority across the UK.

A full set of indicators with allocated points and thresholds for each domain, set against the indicators for each domain is described in national guidance published by NHS Employers. The guidance also describes the rationale for each indicator and how achievement should be recorded.

The clinical indicators are split into three different types. Each indicator defines specific actions that practices are asked to achieve for their patients in terms of;

i. **structure**. For example, is a disease register in place?

ii. **process**. For example,
   - is the indicator being measured and
   - is an appropriate intervention being made,
   - across what percentage of the relevant population?

iii. **outcome**. For example,
   - how well is the condition being controlled,
   - across what percentage of the population?

An example, demonstrating the 3 types of indicator, from the clinical domain for heart failure (HF), is below:

**Records**
HF 1: The practice can produce a register of patients with heart failure

**Initial diagnosis**
HF 2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment

**Ongoing management**
HF 3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication
If the indicators are achieved, QOF rewards to GP practices for how well they care for patients, rather than simply how many they treat.

This is done by practices scoring a set number of points for achievement against indicators. Points are distributed according to:

- the workload for the practice and
- the potential improved outcome for the patient, of each indicator.

### The principles agreed for the indicators are that:

- indicators should, where possible, be based on the best available evidence
- the number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care
- data should never be collected purely for audit purposes
- only data which are useful in patient care should be collected. The basis of the consultation should not be distorted by an over-emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling
- data should never be collected twice i.e. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

There are a maximum of 1000 points available, with each point achieved worth on average £126.77 in 2009/10. Payments on account – aspiration payments – are made throughout the year. Practices are now paid in full at the end of the first financial quarter in respect of points achieved by 31 March the previous year.

Nationally, since inception, there have been high levels of achievement in all clinical and non-clinical areas of the QOF. Final achievement payments take account of recorded disease prevalence, the ability to except patients (exception reporting) from the QOF indicators (against a small number of criteria), without loss of reward to practices and the monthly aspiration part payments made throughout the year.

The results are published on the [Information Centre](#) website. In England, in 2006-07, QOF achievement per general practice (maximum = 1000) was an average of 954.5 points, 95.5 per cent of the 1,000 available, compared with an average achievement of 96.2 per cent in 2005/06 and 91.3 per cent in 2004/05, before the first revision of the QOF3.

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3 Because many PMS practices already have some quality payments included in their baseline payments, to ensure financial fairness between GMS and PMS practices, in each year there is a value based points deduction. The value is fixed at £13,050, represented by a deduction of 102.9 points in 2009/10. This does not affect the scores shown here.
Practices achieved an average of 968.0 points or 96.8 per cent in 2007/08. In 2008/09, practices in England achieved an average of 954.2 points, 95.4% of the 1,000 points available. The reduction in the average level of achievement is attributable to changes to the QOF in 2008/09, especially the change to the Patient Experience domain (the other three domains did not have reductions in average achievement).

The payments for QOF nationally amount to approximately £1.1billion. It amounts to about 15% of practice net income. The opportunities to measure and increase health gain for most of the population are significant, as are the rewards. With the high levels of public investment and the opportunities QOF provides to improve health care, robust QOF assessment and development processes should be established and maintained by PCTs. The QOF is unique

So, how well does it work?

Indicator achievement may be more difficult in practices in areas of high social deprivation and where practices may be understaffed or working from poorer premises, but the rewards are the same. Practice population characteristics make very little difference to QOF achievement scores. The move to a true prevalence adjustment should ensure that rewards reflect need and encourage increased case-finding.

The QOF has excited a lot of political and research interest. There is no doubt that it is proving of benefit to patients; however, there may be questions about whether

- initial gains are being sustained.
- the benefit to patients is value for money (can investment elsewhere bring better care?)
- the large “bonus” payments distort what general practice should be delivering
- there is any evidence of investment of QOF incentives to develop skill mix and delivery within practices
- unincentivised areas of care may be neglected
- PCTs have sufficient resources to support and manage practices in delivering the best patient outcomes under QOF
- it could focus more on public health interventions, skewed to a healthier population
- as part of a negotiated settlement, the framework can be updated quickly enough to challenge practices, given the generally high achievement levels.

Research by NPCRDC published in 2009 in the New England Journal of Medicine shows that for asthma and diabetes, care improved more rapidly at around the time when QOF was introduced. For coronary heart disease, where care was already showing major change, the improvement continued at the same rate.
However, since 2005 further gains have proved more difficult and in fact the underlying pre-QOF trend line has not changed much overall; meaning that QOF just helped practices to get there more quickly. The QOF will only continue to support improvements in quality of care provided that the indicators and payment thresholds are regularly reviewed and updated to reflect current performance and up to date evidence of best practice.

How might it be improved?

As part of a negotiated settlement there must be compromise. It is part of a bigger picture, including other incentives and obligations on practices. However, it might be improved if indicators were time limited and if thresholds could be raised each year, because quality of care is a journey. And whilst the biggest areas of morbidity are covered, most indicators look at disease processes not prevention of ill health; this could only change through a national negotiation.

From March 2009 there is a change in the process, which will begin to affect QOF from 2010/11. Following a national consultation, from now on NICE have been commissioned produce all suggested evidence based indicators for negotiation between the BMA and NHS Employers. The evidence includes cost effectiveness and there will be a suggested range of points and thresholds in the description of each indicator. NICE will also review existing indicators and recommend whether they should be retained, or changed, or removed from QOF.

As part of Lord Darzi’s NHS Next Stage Review, the Department of Health proposed a fresh strategy for developing the Quality and Outcomes Framework, aiming to:

- Develop an independent and transparent process for considering new, and reviewing existing, QOF indicators;
- Ensure QOF rewards better reflect the prevalence of illness amongst the populations served by different GP practices.
- Reduce the number of organisational or process indicators in the QOF so that resources are increasingly focused on new or enhanced indicators that promote health and greater clinical quality;
- Give greater flexibility to the local NHS to select indicators (potentially from a national menu) that reflect local priorities;

The first two objectives have already been achieved – NICE took on management of the new process from 1 April 2009 and a true prevalence adjustment is being phased in during 2009/10 and 2010/11. Realisation of the second two objectives is supported by the new NICE process, but will ultimately depend on negotiations with the BMA in future years.
Chapter 2

More detail on the basics

Domains and indicators

This table shows the disease areas within the clinical domain and their associated number of points over the first QOF and three iterations.

<table>
<thead>
<tr>
<th>Disease areas</th>
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<th>2006/08</th>
<th>2008/09</th>
<th>2009/10</th>
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<td>CVD - primary prevention</td>
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<td>Heart failure</td>
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Thresholds

In the clinical areas, practices are rewarded with points only if their achievement is over a certain threshold. In other words, unless an indicator is achieved for (in most indicators) more than 40% of the register of people with that condition (see the description on page 7 of the heart failure indicator for an example), the practice will receive no payment. The practice will generally receive maximum points for an upper threshold of 90%, and proportionately between those limits.

Exception reporting

In some circumstances, practices can exception report a patient. The purpose of exception reporting, as described in the 2003 contract documentation is

“....to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.”

In effect, patients can be exception reported and the practice still receives an incentive payment. Patients for whom the indicator is achieved are included in both the numerator and the denominator, (see Chapter 3), even if they also fall within one of the exception rules (for example because of recent registration or diagnosis). If an indicator is not achieved for an eligible patient and they are excepted under one of the nine exception criteria, they are removed from the denominator as well as the numerator. The practice achievement is therefore higher than it would have been had they been included in the denominator but not in the numerator.

The clinical domain, originally comprising 10, and now 17, disease areas (+ obesity, smoking and learning disabilities), dominates the QOF and the way people think about it; currently that is nearly two thirds of the points that can be awarded (whilst in the original QOF it was just more than half).

The organisational domain rewards good organisational and HR practice. It covers five areas: records and information about patients, information for patients, education and training, practice management and medicines management. It is based extensively on the Royal College of General Practitioners’ Quality Practice Award.

The patient experience domain covers length of consultation and experience of access; the access indicators rely on results from the national survey which is now carried out quarterly.

The additional services domain covers four of the GMS contract additional services: cervical screening, child health surveillance, maternity services and contraceptive services.
The excepted patient continues to be included in the disease register and therefore counts towards the practice’s prevalence weighting. This is further explained in the section in Chapter 3 on payment.

When properly applied and used fairly, exception reporting a patient shows that the practice is aware of the patient, even if a particular indicator will not apply to them. However research shows that variation in exception reporting between practices is not explained by patient population characteristics (exception rates for deprived practices are only marginally higher than rates for more affluent practices) and may be simply due to how the practice chooses to behave as an organisation. There is evidence of inappropriate exception reporting¹. More “difficult” indicators may be more liable to be excepted and this may be unacceptable⁵.

High levels of exception reporting of patients who have not met target levels for cholesterol, blood pressure, HbA1c and other measures might mean poorer care for this group of patients if they are not then being monitored for their condition. Once a patient has been excluded from a call/recall system, an exception can last 15 months. During this time the clinical system may not flag a patient for review - which means that a patient with a chronic condition may not be reviewed. PCTs should look in particular at exceptions for:

- did not attend, to see what the reasons are for non-attendance - it could be because patients are dissatisfied with the service or the communications with those patients are not effective;
- maximum tolerated dose - is the practice actually prescribing effectively and is it doing all that it can in terms of lifestyle advice?

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- Practices serving the most deprived populations had an exception rate that was only 0.67% higher than practices serving the least deprived populations in 2006/07.
- Increases in reported achievement between years two and three of the QOF (2005/06 to 2006/07) were associated with concurrent increases in exception rates, some of which might have been inappropriate - for example by excluding difficult patients.


⁵ The National Quality and Outcomes Framework Exception Reporting Statistics for England published by the Information Centre said that: “in2006/07 In general, the lowest exception rates relate to indicators that measure a process (such as recording smoking status or recording blood pressure). Five of the ten indicators with the lowest exception rates relate to the recording of blood pressure. The highest exception rates relate to indicators that measure outcome or action in respect of a diagnosis. For example, relatively high exception rates were found for the three new indicators that measured objective clinical outcomes.”
Exception reporting is different from exclusions from an indicator, where patient does not fit the criteria. The agreed guidance on exception reporting describes this as follows:

**Exclusions** are patients on a particular clinical register, but who for definitional reasons are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g., those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

**Exceptions** are 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 exception criteria set out in the Statement of Financial Entitlements. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

The overall effective exception rate for England was 5.83% for 2006/07 and 5.26% in 2007/08 but at practice level there is a lot of unexplained variation that goes beyond statistical tolerances. Practices need to have robust policies and procedures for deciding when a patient should be excluded from follow up, or excluded from reaching optimal levels of control for their condition. Those policies might minimise exceptions and maximise the benefit from exercising clinical judgement in making exceptions.

Exception reporting is contentious. Some argue that as the top payment threshold is less than 100% there is no reason to have exception reporting as well. Others argue that exception reporting should be continued.

The agreed set of exception criteria, taken from the nGMS contract in 2003-4, are in the box below. They remain unchanged.

The following criteria have been agreed for exception reporting:

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

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

C. patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels
The importance of exception reporting in relation to clinical care is such that *Delivering investment in general practice* said that “...There will be some form of verification of exception reporting during every QOF visit.”

Guidance on exception reporting has been published jointly by the BMA and NHS Employers.

Prevalence

Prevalence is defined as the number of cases in the practice population for a given condition expressed as a percentage.

Prevalence affects payments. A higher prevalence rate compared to other practices means higher price per point for the clinical domain. This is intended to encourage case finding, shown in the payment equation in the next box. A good register of patients, accurately maintained, is a foundation of good care. Not identifying patients who are at risk of chronic diseases or those who are as yet to be diagnosed, are among the causes of increased A&E admissions and higher morbidity.

Mainly because of concerns about wide ranges of payments, until March 31 2009 the effect of prevalence was dampened, by a rounding up of the bottom 5% the range and square rooting prevalence rates. In practical terms and taking into account list size, this had meant that a large practice with, say, 100 people with heart failure would be paid more than a smaller practice with 100 people with heart failure. The rationale was to protect practices with large list sizes and low prevalence in the population – for example University practices. The effect of the bottom 5% of prevalence being rounded up means that even practices with very little morbidity in any disease area can still receive some reward.

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

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

F. where a patient has not tolerated medication

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

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

I. where an investigative service or secondary care service is unavailable
This was intended to reflect the costs of setting up a service, but the evidence for high fixed costs, particularly now that registers have been set up for existing disease areas, is not strong. The fact that prevalence was damped (and not list size) led to very large variations in the payment per patient and to reducing rewards per patient as more patients were added to the register. The square root was removed in 2009/10 and the rounding up will be removed for 2010/11.

PCTs are expected to work with the small number of practices who are substantially financially affected to manage the transition appropriately. Support may comprise helping practices to identify more patients raising prevalence and therefore pay. There is a ready reckoner that helps to demonstrate impact on the PCC website.
Chapter 3

How is achievement measured, and how is payment calculated?

This is a process that is largely automated through QMAS and the payments mechanism. The chapter below describes the processes underlying the calculation. Year end issues will be much simpler to deal with if PCTs understand these mechanisms.

Introduction

Working out QOF payment has two distinct, but related, phases:

• The calculation of points achievement
• The conversion of these points into a QOF payment

This paper goes through the principles and practicalities of achievement points and payment calculation

Calculation of point achievement

Each indicator in the QOF is worth a number of points, totalling 1000 in 2009/10. The process by which points are allocated to practices varies according to the type of indicator. Within QOF at present there are three main types of indicators:

1. Boolean indicators – a practice receives all of the points available if it achieves the indicator and none if it does not;
2. Pivot indicators – a practice receives all of the points available if it achieves or exceeds a target for the proportion of patients for whom the indicator is achieved and none if it does not achieve the target.
3. Fraction indicators – a practice receives a proportion of the points available, depending on the proportion of patients for whom it achieves the indicator, between lower and upper thresholds (0% of points at, or below, the lower threshold and up to 100% of points at or above the higher threshold);
In other words...

1. Some indicators – in the organisational domain and having registers in the clinical domain – points are either rewarded in full for achievement or not at all.

2. Some indicators have a single threshold for the award of points, such as Records 17 – The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients

3. Most of the indicators in the clinical domain reward practices for the percentage of patients for whom they achieve the indicator. Practices receive a proportion of the points available for the percentage of patients covered, within lower and upper payment thresholds, most now set at 40-90%. That means that the points awarded are determined by two factors:
   - the percentage of patients in whom the care described is achieved
   - where this percentage figure falls within the target payment range for the indicator.

In other words, if achievement is 40%, points awarded are zero; if achievement is 50%, points awarded are a fifth of the maximum for the indicator, because that is a fifth of the way up the scale from 40 -90.

**Worked examples of points calculation for each type of indicator**

Indicator type 1 just gives straightforward achievement payments. Two examples are

**Box 1**

<table>
<thead>
<tr>
<th>Education 6</th>
<th>The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team</th>
<th>4 points</th>
</tr>
</thead>
</table>

The practice can produce evidence it has done this, then 4 points are awarded; if it can’t, no points. And

**Box 2**

| AF 1. | The practice can produce a register of patients with atrial fibrillation | 5 points |
Although Atrial Fibrillation 1 is a clinical indicator, this is a Boolean indicator in that practices either can produce a register (5 points), or not (zero points).

**Indicator type 2** is achieved by hitting the target

**Box 3**

<table>
<thead>
<tr>
<th>Records 17</th>
<th>The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients</th>
<th>5 points</th>
</tr>
</thead>
</table>

So, if a practice has only recorded the BP in 75% of this group, no points are awarded; if it has recorded 80%, or 90% or even 100%, 5 points are awarded.

**Indicator type 3** is where most of the complexities in payment come from - the fraction indicators. The fraction achieved gives the points score.

**A worked example of points calculation for a fraction indicator, using indicators CHD 5 and 6**

**Box 4**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Payment stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD 1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>CHD 5.</td>
<td>7</td>
<td>40 - 90%</td>
</tr>
<tr>
<td>CHD 6.</td>
<td>17</td>
<td>40 - 70%</td>
</tr>
</tbody>
</table>

Calculating points achievement for these indicators depends on

- Calculating a denominator
- Calculating a numerator
- Applying that calculation to the number of points available for the indicator

The process to be followed in order to calculate the denominator and the numerator is described in detail for each indicator in the [QOF Dataset and Business Rules](#).
Calculating a denominator

The starting point for the denominator calculation is the identification of the target population for the indicator; usually the disease register\(^7\).

The denominator rule set is then applied to the target population. This allows for patients who are either exclusions to the care described or have been exception reported to be removed from the denominator. Thus the denominator calculation can be thought of as:

**Denominator = target population minus exclusions and minus exceptions**

There is an important conceptual difference between exclusions and exceptions, which is defined below (as well as on p xx of this guide and in volume 2).

Box 5

**Exception reporting** allows practices to remove patients who would otherwise be eligible for the care described from the denominator of an indicator. There are nine exception reporting criteria, detailed in the [QOF Guidance 2009/10](#). Some of these criteria are applied automatically by the rule set whilst others require the practice to enter an exception code.

**Exclusions** are patients who are removed from the denominator of an indicator because they are ineligible for the care described in the indicator. For example, CHD2 only applies to patients with a diagnosis of angina after the 1st April 2003. However the CHD register will include patients diagnosed with angina before this date. It is therefore necessary to remove those patients from the denominator. This is done automatically by the rule set.

The end result is that both these groups are removed from the target population in order to create the denominator for an indicator. Given that the number of exceptions and exclusions can vary from indicator to indicator this explains why there can be variation in the size of the denominators between indicators in the same clinical indicator set.

Calculating a numerator

The numerator is made up of those patients who have received the care described in the indicator. Again, this calculation is supported by a numerator rule set, which is applied to all the patients in the denominator.

No points are awarded for 40% achievement and, whatever the achievement, the maximum points are 10, with a sliding scale between 40 and 90%.

\(^7\) Where an indicator set is not supported by an indicator which requires practices to have a disease register the rule set will still describe one e.g. Depression2.
A type 3 indicator with 10 points and achievement threshold 40 - 90%

Note that if clinical care as outlined in the indicators is performed, then **regardless of any valid exception criteria present in the patient records**, the patient will be included in the indicator denominator and numerator.

**Worked examples**

Now we can apply these principles to indicators CHD 5 and 6.

The starting point for the calculation of the **denominator** is the target population for the CHD indicators, the register as defined in CHD1 in Box 4. For this example let us say that the register has 255 people on it. There are no exclusions to CHD 5 and no patients have been exception reported. This gives a denominator of **255**.

To calculate the **numerator** for CHD5 we need to know the number of people who have had their blood pressure recorded. For this example, let us say that **225** people a record of blood pressure.

---

8 Meaning that the practice is always rewarded for the care given, even if the patient has been excepted
**Box 6**

To calculate the points which would be awarded for CHD5 in this example: The practice has 255 patients in the indicator denominator and recorded the blood pressure in the last 15 months in 225 of them. So, this percentage is \( \frac{225}{255} \times 100 = 88.24\% \).

The payment stages are 40 - 90\%. 88.24\% is 48.24/50 of the maximum (48.24 is the score over the lower threshold and 50 the range of the threshold). So the practice scores 48.24/50 of the 7 points = **6.75 points**.

**Worked example for CHD6:**

**Box 7**

CHD 6 The practice has 255 patients in the indicator denominator and measured the blood pressure as 150/90 or less in 15 months in 100 of them. So, this percentage is \( \frac{100}{255} \times 100 = 39.22\% \).

The payment stages are 40 - 70\% 39.22\% is lower than the lower threshold. Therefore, **no points** are awarded for this indicator, as illustrated below.

CHD 6; 17 points available

![Graph showing points and threshold 40-70%](image)
Box 8

If the practice had exception reported 50 patients in CHD 6, then the denominator would be reduced to 205 patients (255-50). The numerator figure would remain at 100. This percentage would be \((100/205) \times 100 = 48.78\%\).

This is within the payment range of 40-70% and the practice would be awarded 4.98 points, as illustrated below.

CHD 6; 17 points available

Thus, by reducing the number of patients in the denominator, whilst holding the number in the numerator constant, exception reporting can help practices to achieve a greater number of points than they would if this option was unavailable.

Calculating QOF payments

The calculation of QOF payment depends on the domain i.e. clinical, organisational, patient experience and additional services, in which the points were awarded.
Payments within the clinical domain

To calculate payment within the clinical domain, as well as points awarded, two more pieces of information are required:

- Practice list size
- Practice prevalence
- Raw value of each QOF point; for 09 -10 this is £126.77

Practice list size

Practice list size is taken on the 1st January. It is then set against the national average list size which is detailed in the Statement of Financial Entitlement and is currently set as 5891, to calculate a list size adjustment.

Practice prevalence

Raw practice prevalence for each disease area is calculated by dividing the register or target population by the total registered list size and converting to a percentage. This figure is then compared to the national prevalence to calculate an adjusted practice disease factor (APDF). National prevalence figures are published annually by the Information Centre

Where a practice has a raw practice prevalence of less than 5% of the national average prevalence, then it is rounded up to count as 5% for payment purposes. This ‘trim’ is to be removed for 2010/11.

So applying this to our earlier example of CHD5:

- We will assume a practice list size of 11,010
- From Information Centre figures, the national figure for CHD in 2007-08 was 3.5% and will be used in this example. A register of 255 means that the practice prevalence is 
  \[(255/11,010) \times 100 = 2.32\%\]

In reality, all the calculations are done simultaneously rather than sequentially as shown in the following example
Box 9

CHD5  As described in Box 6, the practice has 255 patients on the register and recorded the blood pressure in the last 15 months 225 of them. So, this percentage is \((225/255) \times 100 = 88.24\%\).

The payment stages are 40\%-90\%. 88.24\% is \((48.24/50)\) of the maximum (48.24 is the score over the lower threshold and 50 the range of the threshold). So the practice scores \((48.24/50)\) of the 7 points = \textbf{6.75 points}.

The total number of points scored by the practice is multiplied by £126.77 to give a raw QOF achievement payment. £126.77 \times 6.75 = \textbf{£855.70}.

The practice prevalence is 2.32\%, against a national prevalence for CHD of 3.5\%. The raw achievement payment of £855.70 is therefore multiplied by \(2.32/3.5\) = \textbf{£567.21}.

The final sum paid to practices is adjusted to take account of total practice list size (relative to national average list size, taken as 5891). So, with the practice has a list (as at 31 January) of 11010, all points payments are multiplied by \(11010/5891\), a factor of 1.87. In this instance, that means £567.21 \times 1.87 = \textbf{£1060.67} (in reality this is applied at the end of the calculation to the accumulated calculations from all the fraction indicators).

Payment within the organisational domain

There are again different types of indicator. In the table, Medicines 10 is a Boolean indicator and Medicines 11 a pivot indicator

Box 10

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Payment stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines 10</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Medicines 11</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Medicines 10</td>
<td>The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change</td>
<td>4</td>
</tr>
<tr>
<td>Medicines 11</td>
<td>A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%</td>
<td>7</td>
</tr>
</tbody>
</table>
Calculating payment due under the organisational domain for a Boolean or pivot indicator requires

- the total points achieved and
- the practice list size.

As with the clinical domain a list size adjustment is calculated and applied to the value of a QOF point ie

Organisational domain payment = points achieved x £126.77 (average value of a QOF point) x practice list size adjustment.

Box 11

<table>
<thead>
<tr>
<th>For medicines 10 using the same practice size as earlier, 4 x £126.77 x 1.87 = £ 948.24</th>
</tr>
</thead>
<tbody>
<tr>
<td>For medicines 11, if the standard of 80% is reached, 7 x £126.77 x 1.87 = £1659.41</td>
</tr>
</tbody>
</table>

Payment within the patient experience domain

The patient experience domain comprises of two types of indicator: Boolean and fractional. Examples of these indicators are given below

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Payment stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE 1 Length of consultations</td>
<td>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria</td>
<td>33</td>
</tr>
<tr>
<td>PE 7 Patient experience of access (1)</td>
<td>The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP within 2 working days</td>
<td>23.5</td>
</tr>
</tbody>
</table>
Calculation of the payment due in respect of the Boolean indicators (e.g., PE 1) uses the same formula as that given for the organisational domain illustrated in Box 11 and preceding text.

Calculation of the points and payment due in respect of the fractional indicators (e.g., PE 7) is similar to that outlined in relation to clinical indicators illustrated in Box 9. First, the percentage of patients meeting the care described is calculated and converted to a point score. These points are multiplied by £126.77 (average value of a QOF point) and then by the practice list adjustment.

**Payment within the additional services domain**

First, achievement is calculated in the ways described earlier, depending upon the type of indicator. CS 5 is a Boolean indicator, CS 1 a fraction indicator.

**Box 13**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Payment stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years</td>
<td>11</td>
<td>40-80%</td>
</tr>
<tr>
<td>CS 5</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The pounds per point for each of the indicators in these additional services are then adjusted by the relative size of the contractor’s target population, compared to the national average. This is to protect contractors with large target populations and adequately reward them for their greater workload. The calculation is as follows:

\[
\text{(contractor’s target population) ÷ (contractor’s registered population)} \times \text{(national average target population) ÷ (national average registered population)}
\]

Although payment is finalised on the position at the year end, practices will receive 70% of payments on account during the year, uplifted with any increase in average pounds per point recognising their aspiration (Which must still be calculated for new practices) – and maintain their cash flow, as they are expected to invest in order to achieve the QOF outcomes.
Chapter 4

Recording information and the business rules

Practices must record what they are achieving. There are two main reasons for this:

◊ to record and benchmark their achievement in terms of delivery of a high quality service for patients
◊ to initiate payment.

Without being mechanistic, accurate coding and recording of consultations is the heart of high quality care.

QOF payment is underpinned by a set of documents called the business rules. These documents detail what should be recorded and the hierarchy of decisions that give effect to the extraction of the information required to calculate the numerator and denominator of the indicators.

People managing QOF should be familiar with these rules. There is an explanatory document, as well as the rules, available through PCC and NHS Employers.

These documents are updated twice a year to reflect any changes to the QOF indicators and the biannual Read code release.

Data collection for QOF

This section describes in outline the basic systems. It is important to see how QOF data can be combined with other primary and secondary care data to produce information that gives a real understanding of the contribution QOF is making to patient care. It is also important to use QOF information more widely in commissioning and capacity planning.

QMAS

Without systematic data collection and good analysis that turns the data into useful information, we would never know how QOF is leading to continuing improvement, whether practices are giving good care across all the QOF areas and whether achievement is better, or worse, than it should be.

The national data collection for England is QMAS – the Quality and Outcomes Framework Management and Analysis System. The prime purpose of QMAS is to provide information for payment, but there are many useful by-products considered in the section on wider uses of QOF information.
QMAS consists of two key parts

- **Data entry interfaces**
  - An automatic monthly data extraction from anonymised patient records on GP computer systems. The data is grouped into achievement and then submitted electronically to QMAS; A web interface for the organisational domains, where practices can enter details of achievement where no coding is practical, (such as whether staff have been appraised). These are largely yes/no answers.

- **Analysis & Reporting**
  - A calculation engine to determine practice achievement and national values (such as prevalence)

A web interface to a reporting suite for practices and PCTs to be able view progress of achievement through the year; the practice and PCTs can also download the achievement data at any time, so that they can analyse the QOF data outside of QMAS. The monthly reports can be used by practices and PCTs to predict and identify successes and challenges to improved patient care.

At the QOF year end (which is the same as the contract and financial year end), the system automatically analyses final achievement for payment and sends payment values (both for achievement and the following year aspiration) to the computerised GP payment system. An initial aspiration payment is calculated straight away and then adjusted once the final payment is approved.

A working page for the practice, for submitting organisational indicators, looks like this example, taken from a set of teaching materials (and therefore annotated).

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9 The National Health Applications and Infrastructure services (NHAIS), now renamed as NHS Connecting for Health Systems and Service Delivery, colloquially known as “Exeter”
The illustration on the previous page shows both great clarity yet the need for some training in the use of QMAS.

There is a wealth of training resource available on the CfH QMAS website from which these slides were taken if you use NHS (ie N3) connections (but not available more widely).

It may be helpful to compare practices with each other and with PCT, SHA and national prevalence. Much more detail is available in volume 2 (QOF assessment) which has a large section on information management.

QOF assessor toolkit

Separate from QMAS, downloaded onto most GP systems is the QOF Assessor Toolkit which produces QOF Assessor Validation Reports. This clinical audit tool (known colloquially as Apollo) enables both practices and the PCT to get under the raw achievement data in QMAS, see if sufficient detail exists in the patient record to justify the achievement claimed and to help practices improve on record keeping and clinical care. Data is completely anonymised. There is more detail in the chapter and annex on QOF assessment.

GP systems

Nearly all the GP systems have software to search the practice list to help to identify (and call/recall) patients who may be in need of support through QOF, to help the practices to fulfil the intention of the indicators (as well as increasing their reward). Some systems work to different periods from the QOF year or different patient population data and therefore results from searches may not be identical to QMAS results – but QMAS is the payment system and delivers exactly what is needed for that purpose.
Chapter 5
QOF assessment and audit

With such a large investment and potential for improved health, it is important that PCTs examine how well the objectives of QOF are achieved. There are three arrangements for improvement and inspection of achievement;

◊ QOF assessment process
◊ Prepayment verification
◊ random 5% checks

QOF assessment

This is a positive form of assurance to support the quality improvement that PCTs expect practices to make each year in delivering patient care. The purpose of assessment, as expressed in the original GMS contract document is quoted in the box below. In some PCTs however, the opportunities to use QOF assessment to improve patient care may not always have been maximised. QOF assessment is meant to be a positive and developmental process, whilst at the same time assuring the PCT that indicators are delivered rather than numbers merely recorded. Volume 2 of this guide describes a robust assessment process in detail, with examples of how the rich data from QOF can be combined with other data to both validate achievement and, as a by product, support commissioning and public health.

The GMS contract guidance in 2003-4 stated

...The practice quality review will be founded on the development of a relationship between the practice and the PCO based on the principles of high trust, evidence base, appropriate progression and development within the practice context, minimising bureaucracy, and ensuring compliance with the statutory responsibilities of the PCO. The PCO's role will be given appropriate underpinning in legislation. Within this the following arrangements will apply:

(i) achievement against the quality framework will be reviewed by the practice providing annual information on its performance, together with a PCO visit to the practice, which will initially take place annually. Over time, visits may become less frequent subject to the mandatory requirements for financial audit. This review will be strongly evidence-based against the agreed national standards set out in the quality and outcomes framework.

The practice will submit a single standard return form, which is being developed by the NHSC and GPC and which cannot be extended locally. It will be used for practices to self-evaluate their performance and to provide evidence to substantiate their achievement of the quality standards.

Each PCO visit will include a comprehensive review and discussion with clinicians and the practice manager. The visit will avoid disruption to patients or other members of the
practice. The LMC (or its equivalent) may be involved in this process at the discretion of either party. The practice costs of preparation for the visit are built into the aspiration element of payments.

(ii) the frequency of visits may increase and additional supporting evidence may be required where there is concern around, for example, inaccurate practice information or suspected fraud.

Subsequent contract guidance for 2006-7 stated

Delivering investment in general practice 2003 makes clear that PCOs should visit their contractors annually to review each contractor’s achievement against the QOF indicators. However, the frequency and intensity of visits may decrease if the PCO is confident of the contractor’s performance against the QOF indicators, subject to the mandatory requirements for financial audit. Equally, the frequency of visits may increase where there is serious concern about data accuracy or quality of patient care.

Prepayment verification and rescoring

Because of the large sums of money involved, this is an essential component of PCT audit. Whilst it should be unobtrusive as far as possible, it should also be rigorous and comprehensive. There are actions the PCT can take, described originally in Delivering Investment in General Practice (p88) and shown below.

The PCT is required to confirm the accuracy of all achievement before payments are made - pre payment verification.

In exceptional cases, the achievement payment should not be paid automatically: where monthly reports and/or annual visits identify issues around data accuracy, and these have not been remedied in sufficient time to the satisfaction of the PCT. This could for example include

• inexplicably low or high numbers of patients on disease registers given the PCT average prevalence, (a result of not coding or miscoding patient records), or unusually high levels of exception-reporting.
• if a PCT has evidence which shows that a contractor has been systematically and inappropriately referring patients to secondary care in order to maximise quality achievement points. The QOF is intended to reward contractors for the work that they are doing, rather than for work that is carried out on their patients in secondary care and funded by the PCT.
• Where there is a substantial unexplained variation between aspiration and achievement.
• In the event of suspected fraud or other illegality.

The PCT can rescore the achievement points (the process may include consultation with the LMC for GMS practices), although contractors are able to challenge decisions under the dispute resolution procedure, described in outline below.
Random 5% checks

The 5% Checks should complement and be informed by pre-payment verification (PPV) checks. 5% checks are a form of post payment verification. It is important to make the basis of selection clear and that no suspicion of fraud has been raised to cause a check. If a suspicion of fraud is raised in the check it should be reported to the PCT Local Counter Fraud Specialist in the usual manner.

The 5% Check must be conducted as a wholly separate exercise from the annual QOF review visit. The PCC guidance is a clear and comprehensive account of the best way to deliver the process.

Guidance issued by PCC in May 2007 shows how PCTs can sample a random 5% of their Practices so as to carry out an in depth analysis of Practice achievement against the QOF and describes this control process. The whole subject is clearly, simply and well covered in the guidance.

Delivering investment in general practice said that;

“A random 5% sample of contractors will also be checked thoroughly as part of counter-fraud measures. Wherever possible, this will draw on the pre-existing written material provided for the annual review, to minimise bureaucracy. Where checks require a visit, this would normally occur as part of the following year’s annual visit, to minimise disruption to contractors and their patients.”

In practical terms, PCTs may also pick out practices where they are doubtful about the possibility of fraud. However, as Delivering Investment in general practice also said

“Where the PCT has good reason to suspect fraud, it should involve the NHS Counter Fraud and Security Management Services (CFSMS) at the earliest opportunity. Any fraud or attempt to defraud relating to QOF payments will be treated as seriously as other forms of NHS fraud, and could lead to criminal prosecution. It could also lead to visits without notice or the contractor’s consent”

The three processes of assessment, ppv and 5% checks have some common features. Different PCTs place higher value on, and put more or less management effort into, these different processes – but PCTs should remember the purpose of QOF to improve patient care but they must also satisfy internal audit and probity.
Confidentiality, consent and the use of patient identifiable data

This is handled in much more detail in volume 2. But PCT staff should remember that in nearly all circumstances, patient data should be anonymous, and patient identifiable information should not be sought except if unavoidable. Contractors and PCTs should ensure that they comply with the Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS) Code of Practice which is intended to ensure compliance with current legislation and is underpinned by Directions.

Disputes

Although QOF is voluntary, any dispute is considered to be a matter arising out of or in connection with the contractor’s contract and is subject to the usual dispute resolution processes.

In a framework as complex as QOF differences in interpretation sometimes arise. Mostly these are resolved through local discussion and advice from experts. Very rarely, they become matters of dispute.

When a contractual dispute arises, the PCT and the contractor must make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute without the need to refer it for formal determination by the NHS Litigation Authority Appeals Unit (or in certain cases the courts\(^\text{11}\)). Either party may ask the Local Medical Committee to participate in any discussions. This is a contractual requirement\(^\text{12}\).

Expert advice on all aspects and interpretation of QOF is available from NHS Primary Care Commissioning (PCC), which supports all subscriber PCTs in detail in all matters of QOF implementation.

Where, and only where, the dispute is not a contractual dispute it may be possible to refer matters to the Implementation Coordination Group (ICG) for consideration. ICG has no formal legal role or status. The ICG comprises a negotiator from the Department of Health, NHS Employers and the GPC. The ICG will not consider cases unless the SHA has already used its best endeavours to resolve the matter in question. ICG only meets where it has outstanding business. Any PCT considering escalating a matter to ICG is advised to consult PCC first.

\(^\text{11}\) Special arrangements apply when the primary medical care contract is not an NHS Contract (see Part 4 and paragraph 99 of Schedule 6 to the NHS (General Medical Services Contracts Regulations 2004).

\(^\text{12}\) 99 (1) Subject to sub-paragraph (3), in the case of any dispute arising out of or in connection with the contract, the contractor and the Primary Care Trust must make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the NHS dispute resolution procedure (or, where applicable, before commencing court proceedings).

99 (2) Either the contractor or the Primary Care Trust may, if it wishes to do so, invite the Local Medical Committee for the area of the Primary Care Trust to participate in discussions which take place pursuant to sub-paragraph (1).
Where there is a contractual dispute that cannot be resolved locally, either the PCT or the contractor can refer the matter to the NHS Litigation Authority Appeals Unit (or in certain cases the courts) for formal resolution. These processes are described more fully in Volume 2 of these resources.
Chapter 6

Wider uses of QOF

“Other QOFs”

GMS practices are expected to take part in QOF. It is an important part of the contractual package, including reward. And although it is voluntary, the opportunities for health gain for the population are important. Even if practices do not take part in QOF directly, they should still be providing the care and treatment that each individual patient needs. However, PMS practices may agree a local alternative and there are more opportunities for APMS contractors. What is really important is that all NHS patients have the benefit of high quality care, which is not dependent on the contractual arrangement.

Delivering investment in general practice stated that

“PCTs should note that the core philosophy underpinning the QOF is that incentives are the best method of resourcing work, driving up standards and recognising achievement. The QOF is not about performance management of GMS contractors but resourcing and rewarding good practice. Participation in the QOF is entirely voluntary for GMS contractors.”

Sustaining innovation through new Personal Medical Services (PMS) arrangements suggested parameters for local QOFs. For example, points for development of, public health interventions, such as care for the homeless. This may fit especially well where the original focus of the PMS practice was to render some form of special care for special groups. However, QOF monies are only available to registered populations.

There may be some other options already being put into practice and working well. These should not be prejudiced by this guidance.

What is important is to avoid paying twice for what GP practices should already be delivering.

Some of the initial suggestions/conditions that are described in the web link above for local QOFs may look a little simplistic and local QOFs have not been generally produced. Although they have been used to focus on a population that is not well served by national QOF or where service delivery is more difficult, with hard to reach populations such as asylum seekers or drug misusers.

It is difficult to develop indicators, with good underpinning evidence that can be collected reliably and mean something in aggregate. However, as NICE may well produce more indicators than will be accommodated in each annual negotiation on QOF changes, there will be a library of indicators that will build up over time.
Whilst there are no specific rules for local QOFs except directions that apply to all contractors (e.g. Code of Confidentiality). PCTs are encouraged to consider the following when developing new local QOF indicators. PCTs should ensure that local QOF indicators:

- are based on NICE approved evidence for clinical and cost-effectiveness;
- use reliable sources for the actual indicator wording - for example previous QOF expert panel reports (various QOF expert panel recommendations are based on NICE guidance) or indicators suggested in Primary Care Service Frameworks;
- use economic advice in setting the price for the indicator based on best available information on costs and cost-effectiveness;
- use informatics advice in designing business rules for the indicators and extracting data on achievement.

Some of the conditions of a local scheme bear repeating. The box below contains an edited précis of the initial conditions for local QOF schemes for completeness.

### Local Schemes: (some)

The conditions of a local scheme should be:

- If national QOF clinical indicators are used, then the indicator in each disease area relating to registers must be used, so that prevalence can be taken into account – in each clinical area, this is the basic, standard indicator;
- The local scheme, or part local / part national QOF scheme agreed between the PCT and PMS practice must have a value equivalent to scores to enable movement between different schemes and the national QOF.
- The outputs must be seen to be delivering equivalent quality health care to the patients of the practice., accepting that PMS (and especially Specialist PMS) often care for non-standard groups of patients;
- The difficulty in achieving the outputs must be fairly assessed by the DPH as being broadly equivalent to the achievement in the average national QOF-using practice. This broadly settles the issue of prevalence-related workload on the practice and how well the practice does.
- PCTs may, in some circumstances, be able to apply locally devised prevalence factors.
- In year monitoring and annual review should be equally rigorous, in the first years, as the national QOF. It should be modelled on the methodology used for assessment of the national QOF;
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• PMS providers only partly using the national QOF should still be connected to the QMAS so that their prevalence data can be used to give a more accurate picture nationally and to provide a useful source of data about the population to the PCT.

• The same rules for dealing with patient confidentiality, potential fraud and PCT intervention will apply as for the national QOF originally developed for GMS, e.g. a 5% random check of practices.

Using QOF results for practice and PCT quality development

There are rich uses of QOF and the data it contains outside of looking at major disease and prevalence. An example is the possibility that significant event reports could be used for quality development in the practice, or aggregated across the PCT to form an agenda for learning needs, especially if coupled with Form 4 of the appraisal process (handled anonymously).

Some PCTs are using the quality indicators in QOF as part of a wider practice profile, for developmental reasons. A number of “balance scorecards” are helping to give objectivity to development and a degree of performance management. Although the QOF is voluntary and is not a performance management tool, it can contribute to the overall picture of how a practice is performing. Where a PCT has reason to believe a practice is performing poorly, it will intervene to support the practice as it sees fit. QOF can be used to support the process for reviewing how well a practice is functioning to support further development and target support for improvement. QOF can also be used by practices to demonstrate how well they are doing to both their commissioners and their patients. NCAS certainly take account of QOF in assessing practitioners and (rarely) practices.

Public Health and Commissioning

The QOF is essentially a public health framework. It is designed to measure interventions delivered across practice populations (covering therefore over 98% of the whole population). In addition to practice development, it is equally important to use QOF to see how well the PCT is doing in serving its population.

QOF data can also be used to identify what changes might be made to services where pick up of morbidity is poor or where services are being well covered in primary medical care, thereby reducing the need for secondary provision.

In this area, PCTs should look at guidance on care closer to home, in using QOF in Joint Strategic Needs Assessment (JSNA) and therefore in planning and commissioning capacity (with PBC clusters) across the NHS locally.
Chapter 7

Conclusions and future prospects.

QOF is now well established. QOF is not perfect as a framework and utilisation of QOF as a service delivery tool and as part of a wider system is not yet maximised. However, primary medical care practice and PCTs need to strive to maximise the benefit from it for their patients.

In the view of many, albeit subjectively, the best parts of QOF are the clinical indicators and they have been enhanced over the life of the framework.

Set in the context of the pattern of service delivery in a progressive NHS, QOF ideally needs indicators that function earlier in the progress of disease, in prevention. The future also surely lies in a framework that is constantly evolving to include ongoing effective health promoting indicators.

New national and local policy initiatives, such as Quality Accounts and quality/balance scorecards are making increased use of indicators and benchmarking them against other information. It is quite possible that this is only a beginning in making more use of this rich data drawn from the QOF which is intended to improve patient experience and the quality, performance and productivity of clinical care.

Disclaimer

This Primary Care Contracting document is currently in final draft form and is still to undergo the full quality assurance process. It is being released in draft form at this stage to invite comment from PCTs and their QOF assessors as users of the document.

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Acknowledgements

PCC would like to thank a number of contributors whose own work has contributed to some of the content and also those who have given their time in reviewing this management guide for its accuracy and usefulness to subscribers. They include:

- Jo Abbott (Specialist Nurse)
- Robin Carlisle (Cons PH)
- Cheryl Cowley, NHS Connecting for Health
- Niki Jakeman, Contracts Manager, Wiltshire PCT
- Alan Payne, NHS Connecting for Health
- Dr. Mark Strong HSMC, Birmingham
- Marcus Williamson (Analyst)
- Julie Wilkinson, Head of Clinical Governance, NHS Bedfordshire

In Volumes 2 and 3 of the QOF Management Guide which are currently awaiting publication, we would also like to thank external members of a dedicated focus group for their time and expert guidance on the final publication. The members of this group are:

- Dr. Andrew Black, GP in Herefordshire PCT region
- Dr. John Derry GP and Professional Medical Adviser, Thames Valley Primary Care Agency
- Dr. Dave Jeffery, Former GP and now full time Primary Care Data Quality Manager, Herefordshire PCT.
- Dr. Paddy Twomey GP and Medical Secretary, Lincolnshire Local Medical Committee
- Patricia Cordery Service Manager - Beckenham & Penge
Annex

The main source materials for this guide are

- The latest “official” QOF and GMS contract guidance
- The West Midlands QOF Guide 2009/10
- The business rules and business rules explained
- Ten top tips
- Establishing accuracy, a QOF assessors guide
- SFE
- The NHS Code of Practice on Confidentiality
- Confidentiality and Disclosure of Information Code of Practice
- QMAS guidance
- Exception reporting guidance