Data Quality Statement

Quality & Outcomes Framework (QOF), Achievement, Prevalence & Exceptions data
Introduction: The Health and Social Care Information Centre (HSCIC) publishes an annual report on the Quality and Outcomes Framework (QOF) Achievement, prevalence and exceptions data. Publications include statistical bulletins, detailed tables in Excel format and an online database. All are accessible online.

The QOF is a voluntary, indicator-based incentive scheme for GPs. The QOF consists of clinical and non-clinical indicators. Clinical information is available about GPs’ patients who are recorded as having specific chronic conditions.

The QOF allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores. Patients can be exception-reported from individual indicators if, for example, they do not attend appointments or where the treatment is judged as inappropriate by the GP (such as medication cannot be prescribed due to side-effects).

Data source & coverage The QOF is a component of GP practice contracts. Although voluntary, most practices in England participate in the QOF, therefore coverage is virtually 100 per cent. QOF information is collected in order to calculate QOF payments to GP practices as part of contracts.

The source of QOF information is the national QMAS system, delivered by the former NHS Connecting for Health, now part of the HSCIC. QMAS collects information about all practices in England that participate in the QOF.

A small number of practice codes are excluded from the QOF publications despite being in the QMAS dataset – these exclusions generally refer to practices that provide specialist services and which do not receive QOF payments. Sometimes such ‘practices’ are locally led services for specialist populations.

Accuracy: The accuracy of QOF information depends on:

- Clinical case finding by GPs – for example, information from QOF diabetes registers or about QOF diabetes indicators depends on people with diabetes being diagnosed.
- Clinical coding – for example, when patients are diagnosed with diabetes the quality of QOF data about people with diabetes depends on the GP practice maintaining accurate, and coded, clinical records.

As QOF information is used to calculate payments to GP practices means that practices’ clinical information system suppliers deliver systems to maximise QOF data recording and quality of coding. GP practices are similarly incentivised to ensure that patient records are accurate and up to date so that appropriate QOF information is collected by QMAS to calculate practice payments.

QOF information is used to calculate payments annually. The HSCIC uses a snapshot of QMAS data some months after financial year-end as the basis for QOF publications. Practices and Area Teams are advised to sign-off QOF achievement and payments at the end of June following year-end. In practice, many GP practices do not sign-off QOF payments with their ATs until after June. The HSCIC extracts data after the level of practice sign-off reaches a minimum threshold of 80 per cent, though depending of the timing of the extract the actual rate may be somewhat higher. Published QOF data included notes about later sign-off, or where QOF achievement was subject to sign-off. Such notes are
derived from a AT consultation exercise ahead of publication.

Before publication the HSCIC allows ATs access to the total QOF points for each of their practices, as held on QMAS at the point of extract. ATs are asked to advise the HSCIC of:

- Any subsequent changes to QOF achievement (where known).
- Any practices whose final points total is subject to sign-off.
- Any practice codes missing from the extract.
- Any practice codes that should not be included in the publication (for example services not receiving QOF payments).
- Notes on any practices whose QOF achievement should be viewed in context – for example practices whose lists are specialised and where not all QOF points can be achieved (university practices, asylum seeker services, services for the homeless, etc).

The HSCIC considers all comments received from ATs, and annotates data in the QOF publications where this aids interpretation.

**Relevance:**

Although limited in scope (covering 22 clinical areas, plus some non-clinical aspects of GP practice activity), the QOF represents one of the richest sources of information from primary care. Although collected primarily to support QOF payments, QOF information is valuable for many secondary uses:

- Department of Health – to inform policy and aspects of spending.
- Regions, Area Teams and CCGs – for monitoring, public health analysis (using clinical prevalence data for example), for commissioning, etc.
- GP practices – to assess performance in context.
- Healthcare researchers and by organisations interested in specific care areas (for example diabetes care).
- Public health observatories – especially for prevalence analysis.
- General public – reviewing local GP care information.

Some aspects of the HSCIC’s published QOF information is also presented by NHS Choices, NHS Comparators, and other information dissemination routes.

**Timeliness & Punctuality:**

QOF information relates to achievement over a financial year. QOF achievement can take some months after financial year-end to be agreed between practices and ATs. The HSCIC takes a QMAS extract three or four months after year-end (June/July) to maximise the numbers of practices whose achievement is signed-off, whilst still allowing publication in October.

**Coherence & Comparability:**

QOF information is collected primarily to support QOF payment calculations under GP contracts, and that data collection from practices is (for clinical information) based on detailed coded business rules.

QOF indicators may not be defined in the same way as similar measures from other sources. For example, the QOF definition of obesity may differ from that used by public health professionals.

Information on QOF clinical registers may not precisely match disease definitions used by epidemiologists. QOF registers for some diseases (eg diabetes) do not cover all ages.
It is extremely important to take account of QOF definitions (including coding contained in QOF business rules) before comparing QOF information with other data sources – for example comparing QOF disease prevalence with expected prevalence rates (based on public health models).

Individual QOF indicators or the business rules associated with them can change from year to year. Therefore levels of achievement and exceptions rates may not be directly comparable each year. Details regarding year-on-year changes to indicators are available on the NHS Employers website.

Specific issues and caveats concerning the interpretation of QOF data are covering the Technical Annex which accompanies the QOF publication.

Accessibility & Clarity:
QOF publications are accessible via the HSCIC internet as PDF documents. More detailed, local level information is provided in Excel format. The online database (http://www.qof.hscic.gov.uk/) allows users to view detailed information about practices in a more visual format.

Performance, Cost & Respondent Burden:
QOF information is collected primarily to support QOF payment calculations under GP contracts, and that data collection from practices is (for clinical information) based on detailed coded business rules.

The QOF data downloaded from QMAS by the HSCIC is secondary use of the data used to support QOF payments to GPs. The AT consultation exercise, which allows ATs to validate practice data ahead of the publication does place some burden on ATs. We estimate that validation may take two person-days to complete for some of the larger ATs. This is an increase from the burden when the exercise was undertaken by PCTs (as there are fewer ATs, covering more practices). We are exploring options for minimising this burden in future years. Participation in the validation exercise is voluntary.

Confidentiality, Transparency and Security
Published QOF information is derived from the national QMAS system. Prior to the closure of the system in July 2013, users of QMAS (appropriate persons from practices and commission organisations) could see QOF information on a continuing basis throughout the year; they also had access to reports which provide the same level of information that is published by the HSCIC.

QOF publications are subject to risk assessments around disclosure. However, no patient identifiable data is available from the QOF. Standard HSCIC protocols around information governance are followed in the production of QOF publications.