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Publication, Part of Quality and Outcomes Framework

Quality and Outcomes Framework, 2021-22

Official statistics

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England

Geographical Granularity:
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Date Range:
01 Apr 2021 to 31 Mar 2022

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Integrated Care Boards

Integrated Care Boards (ICBs) were established as statutory bodies from 1st July 2022, consequently this publication no longer presents data at CCG and STP level. From July 2022 onwards, data will be aggregated to Sub ICB Location, and ICB level. For further information on these changes please see Related Links.

1 July 2022 00:00 AM

Summary

The objective of the Quality and Outcomes Framework (QOF) is to improve the quality-of-care patients are given by rewarding practices for the quality of care they provide to their patients, based on several indicators across a range of key areas of clinical care and public health. This publication provides data for the reporting year 1 April 2021 to 31 March 2022 and covers all General Practices in England that participated in QOF in 2021-22.

Due to the impact of the COVID-19 pandemic on activity in general practice, payment protection has been applied to the QOF service and may affect QOF activity and/or its recording for the following years:

• 2021-22 QOF service – practices were advised in December 2021 that payment protection would be applied.

• 2020-21 QOF service - practices were advised at the beginning of the reporting year that payment protection would be applied.

NHS England and Improvement published information about the implementation of QOF payment protection in the Guidance for General Medical Services Contract document for 2020-21 and in a letter to practice for 2021-22.

Achievement and Personalised Care Adjustment (PCA) data have been re-introduced to the Excel summary tables for the 2021-22 reporting year.

GP practices have been mapped to their respective PCNs, Sub ICB Locations , ICBs and Regions using reference data current on 7 July 2022. This mapping has been applied to data for both the current and previous reporting year.

Key Facts

6,470 practices included in the 2021-22 publication

Participation in QOF is voluntary, though participation rates are very high, with coverage of 97.5% this year.

QOF recorded prevalence rates

Hypertension (14.0%), depression (12.7%) and obesity (9.7%) had the highest QOF recorded prevalence rates.

Changes in QOF recorded prevalence

Obesity had the greatest change in QOF recorded prevalence, which was 2.8 percentage points higher than in 2020-21.

(Note - 2020-21 prevalence rates have been recalculated using data for practices included in QOF 2021-22 only)

Average practice achievement score

582.4 was the average practice achievement score (out of a maximum of 635).

Proportion of practices achieving maximum score

1.5% of practices achieved a maximum score of 635 points, compared with 6.2% of practices in 2020-21 who achieved a maximum score (567 points).

New Indicator group

Vaccination and Immunisation was introduced this year with 8.1% of practices achieving a maximum score of 64 points.

Value of a QOF point

A QOF point had a value of £201.16, an increase of 3.2% compared to 2020-21.

Personalised care adjustment rates

Depression indicator group had the highest personalised care adjustment (PCA) rate at 18.9%. Blood Pressure had the lowest PCA rate at 0.7%.

Interactive Tool

Interactive data visualisation

This dashboard shows Quality and Outcomes Framework (QOF) Achievement, Prevalence and Personalised Care Adjustment (PCA) rate from GP practice to national level, by indicator group.

Give us your feedback on this publication

We'd love to know what you think of this publication, including how you use it, and any ideas for improvement

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Resources

QOF 2021-22: Prevalence, achievement and personalised care adjustments at regional and national level

XLSX 337 KB

QOF 2021-22: Prevalence, achievement and personalised care adjustments at ICB level

XLSX 4 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments at Sub ICB Location level

XLSX 2 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, cardiovascular group, at GP practice level

XLSX 18 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, respiratory group, GP practice level

XLSX 6 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, lifestyle group, GP practice level

XLSX 4 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, high dependency and other long-term conditions group, GP practice level

XLSX 12 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, mental health and neurology group, GP practice level

XLSX 10 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, musculoskeletal group, GP practice level

XLSX 3 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, fertility, obstetrics and gynaecology group, GP practice level

XLSX 3 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, vaccination and immunisation group, GP practice level

XLSX 2 MB

QOF 2021-22: Prevalence, achievement and personalised care adjustments, quality improvement group, GP practice level

XLSX 1 MB

QOF 2021-22: Achievement at practice level, all domains

XLSX 5 MB

QOF 2021-22: Personalised care adjustments at practice level, all domains

XLSX 6 MB

QOF 2021-22: Indicator definitions

XLSX 54 KB

QOF 2021-22: Raw data .csv files

ZIP 15 MB

Pre-Release Access List

PDF 110 KB

Related Links

- Guidance for General Medical Services Contract document
- Letter to practice 2021-22
- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs
- NHS England - GP Contract
- GMS contract Statement of Financial Entitlements
- General Practice Specification and Extract Service (GPSES)
- Calculating Quality Reporting Service (CQRS)
- NHS.UK Health A to Z

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Main findings

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Main findings

Introduction to the QOF

The Quality and Outcomes Framework (QOF) was introduced as part of the General Medical Services (GMS) contract on 1 April 2004. The QOF is an incentive payment scheme (not a performance management tool) which aims to improve patient care by rewarding practices for the quality of care they provide. This quality is assessed using achievement against a range of indicators across a number of key areas in clinical care and public health. A key principle of the QOF is that indicators should be based on the

best available research evidence.

In QOF 2021-22, 72 indicators were included across the following groups (age groups specified where applicable):

- Asthma (6+)
- Atrial fibrillation
- Blood pressure
- Cancer
- Care of people with learning disabilities
- Cervical screening (25-64)
- Chronic kidney disease (18+)
- Chronic obstructive pulmonary disease
- Dementia
- Depression (18+)
- Diabetes mellitus (17+)
- Early cancer diagnosis
- Epilepsy (18+)
- Heart failure
- Hypertension
- Learning disabilities
- Mental health
- Non-diabetic hyperglycaemia (18+)
- Obesity (18+)
- Osteoporosis (50+)
- Palliative care
- Peripheral arterial disease
- Rheumatoid arthritis (16+)
- Secondary prevention of coronary heart disease
- Smoking
- Stroke and transient ischaemic attack
- Vaccination and immunisation (0-2; 4-5; 79-80)

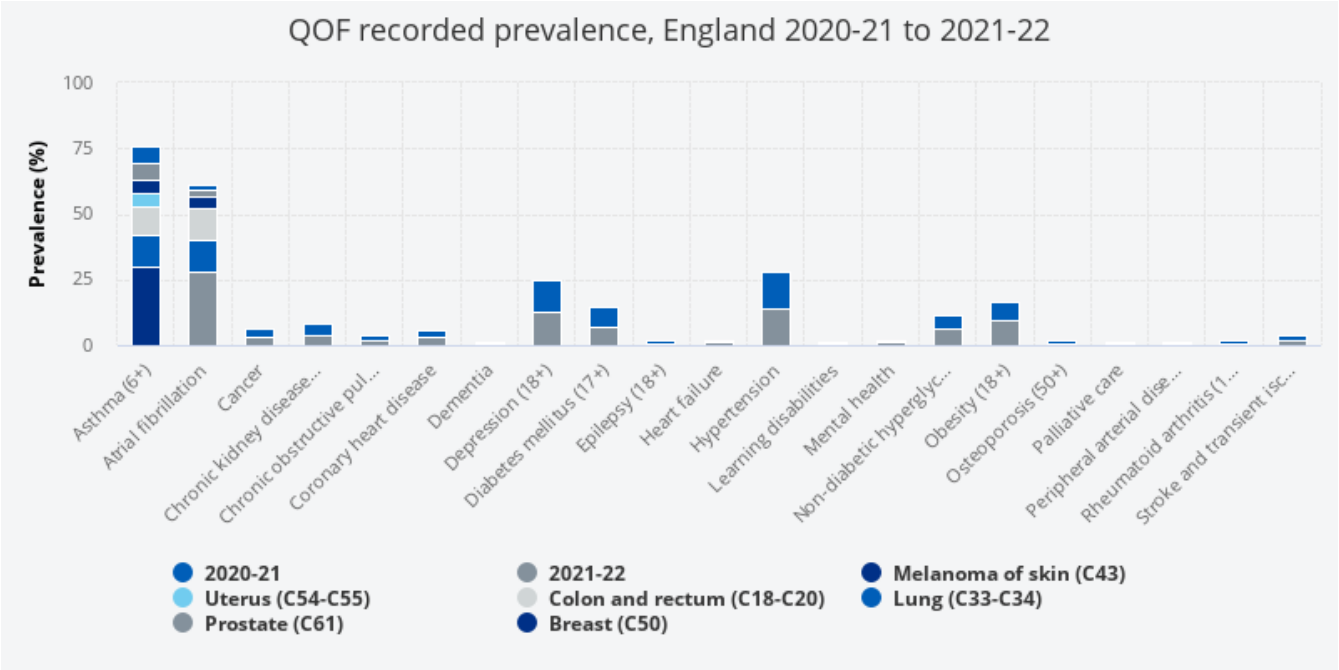
Due to the impact of the COVID-19 pandemic on activity in general practice, QOF implementation was changed for the 2020-21 reporting year; the majority of QOF indicators were income protected (i.e. payments were made to practices irrespective of activity recorded for indicators in that year). Payment protection continues to be in place for QOF 2021-22. Further information on the income protection measures applied to QOF can be found on the NHS England and Improvement website.

QOF recorded prevalence

The highest QOF recorded prevalence rates were for hypertension (14.0%), depression

(12.7%) and obesity (9.7%).

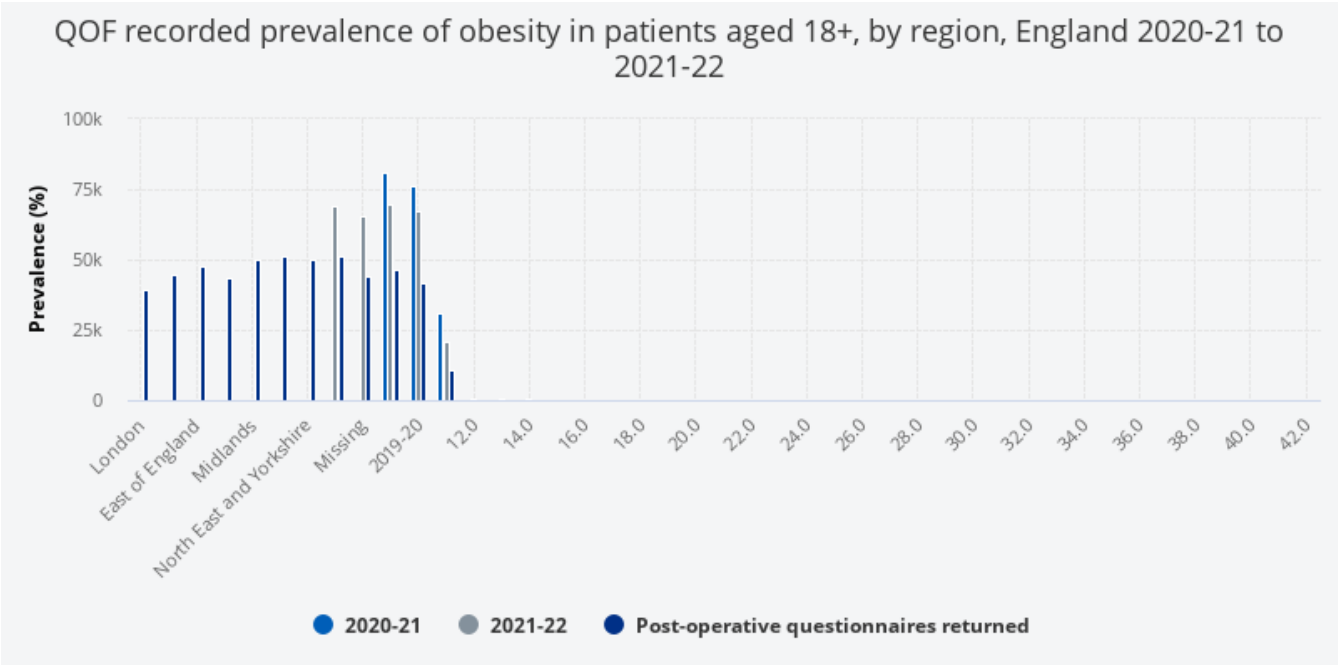
Overall, the greatest change in QOF recorded prevalence was for obesity, which increased from 6.9% in 2020-21 to 9.7% in 2021-22.



Download the data for this chart QOF recorded prevalence, England 2020-21 to 2021-22

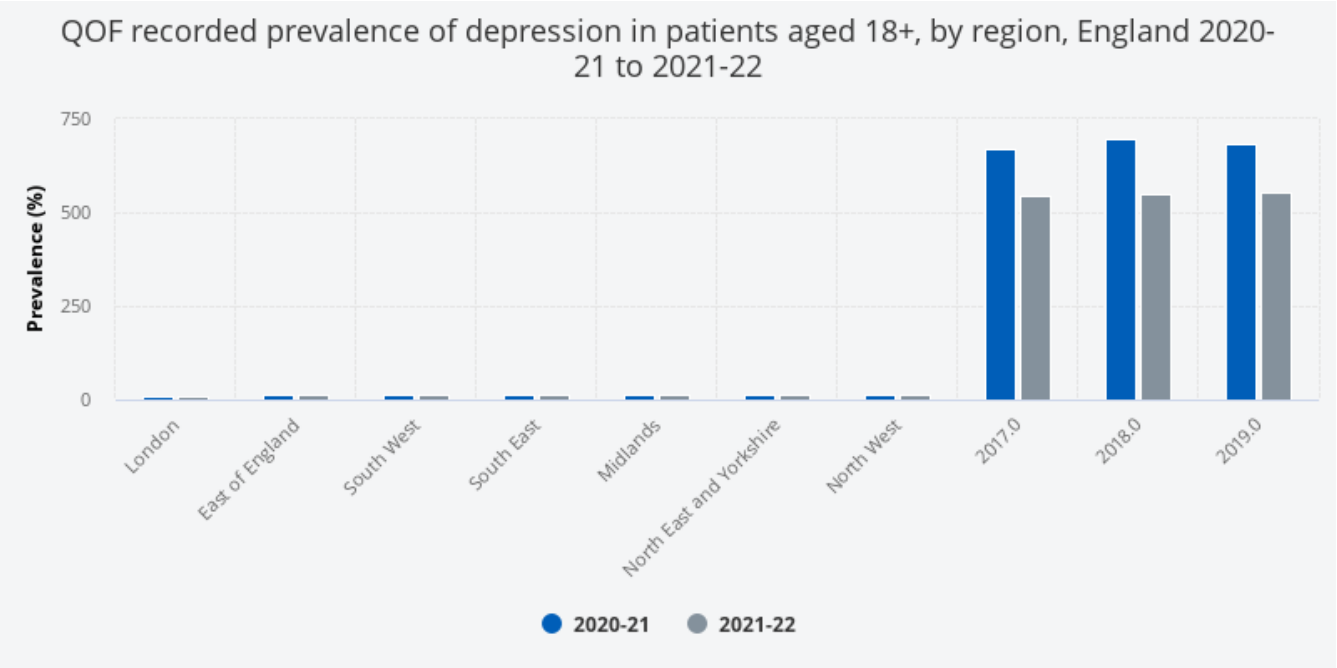
The increase in QOF recorded prevalence of obesity is likely to be due to the increase in face-to-face consultations after the pandemic; in order to be included on the obesity register, a patient must have a BMI of 30 or more recorded in the 12 months up to and including the reporting period end date.

This increase in QOF recorded prevalence is demonstrated across all regions in England.



Download the data for this chart QOF recorded prevalence of obesity in patients aged 18+, by region, England 2020-21 to 2021-22

The QOF recorded prevalence of depression exhibits the greatest range by region, with the lowest rate in London (9.0%) and the highest rate in the North West (15.5%).



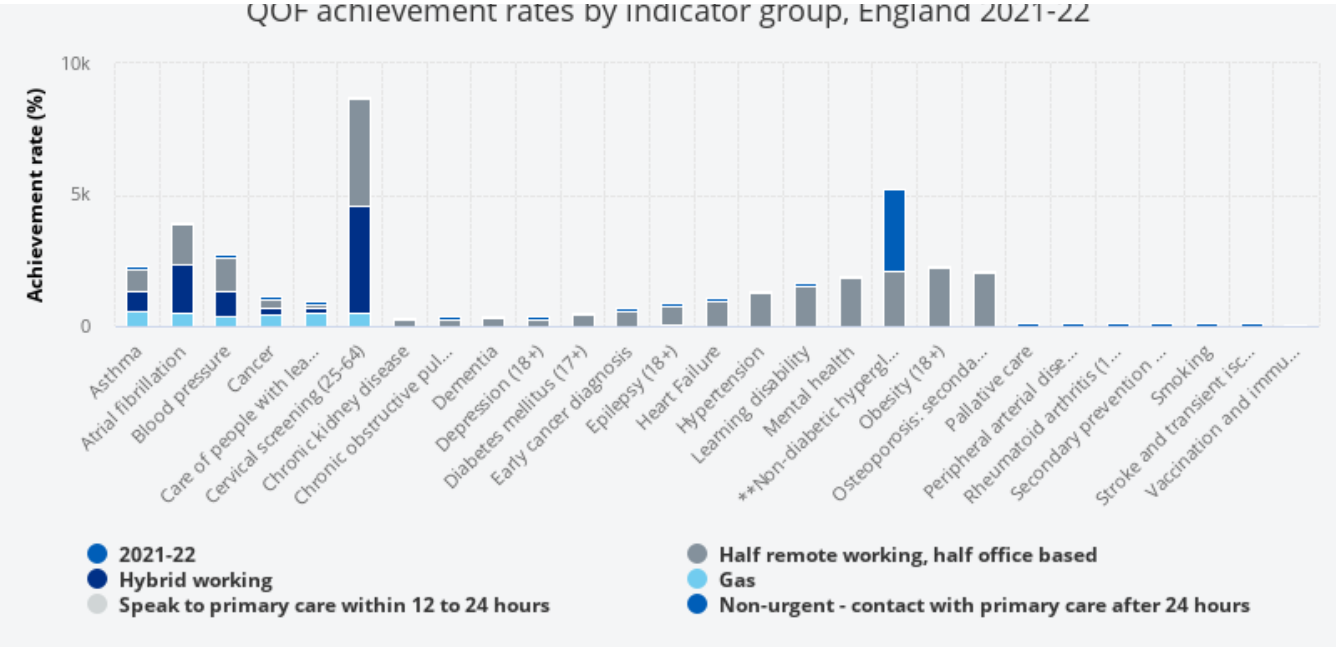
Download the data for this chart QOF recorded prevalence of depression in patients aged 18+, by region, England 2020-21 to 2021-22

Note: prevalence rates for 2020-21 have been recalculated using only those practices for which data are available for both reporting years.

Achievement

QOF achievement refers to the percentage of available QOF points attained. Points are associated with each indicator, and each indicator specifies a level of clinical care. A threshold is set in respect of the provision of this clinical care to patients on the relevant QOF register - for many indicators, a practice must provide the specified clinical care to 90% of patients on the relevant register in order to achieve the full points available for the indicator. Further details are available in the technical annex.

In 2021-22, overall achievement ranged from 52.2% for the vaccination and immunisation indicator group, to 100.0% for the cancer, care of people with learning disabilities, early cancer diagnosis and obesity indicator groups.

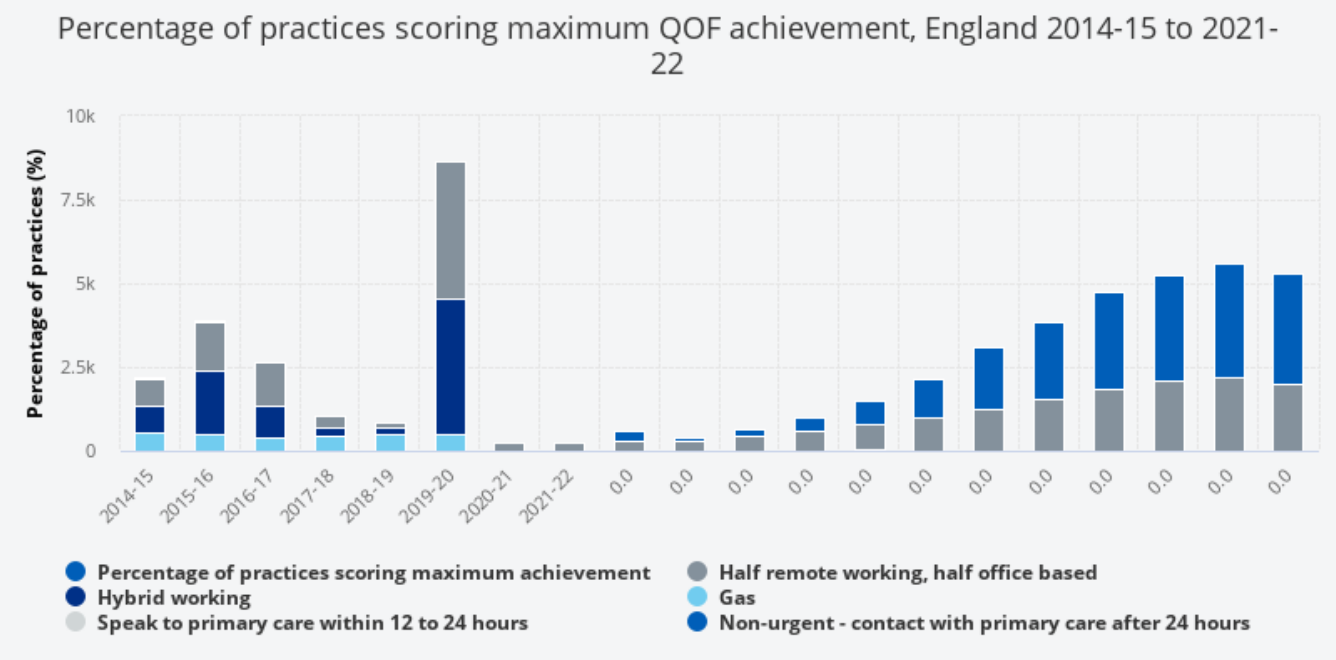


Download the data for this chart QOF achievement rates by indicator group, England 2021-22

***Non-diabetic hyperglycaemia (NDH) indicator group has a 0 (zero) points allocation which is reflected in the chart.*

The average total achievement score for GP practices in 2021-22 was 582.4 (out of a maximum of 635).

The proportion of practices achieving the maximum score decreased to 1.5% in 2021-22, from 6.2% in 2020-21.



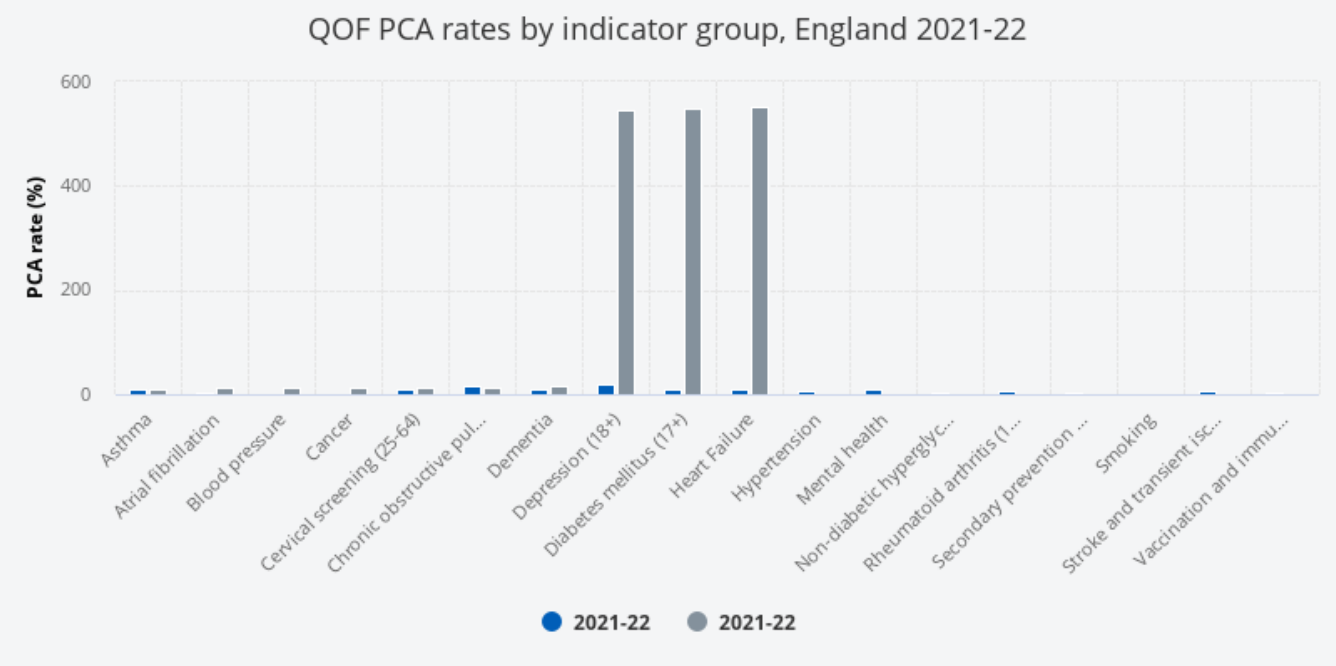
Download the data for this chart Percentage of practices scoring maximum

QOF achievement, England 2014-15 to 2021-22

Personalised care adjustments

Personalised care adjustment (PCA) rates reflect the percentage of patients who are not included when determining QOF achievement. Examples of PCAs include patient refusal of treatment, GP advice that two types of treatment should not be administered simultaneously, or a patient registration or diagnosis occurring within three months of the end of the reporting year (full details are available in the technical annex).

The Depression indicator group had the highest PCA rate (18.9%), whilst the blood pressure indicator had the lowest (0.7%).



Download the data for this chart QOF PCA rates by indicator group, England 2021-22

Related Links

- Guidance for General Medical Services Contract document
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- General Practice Specification and Extract Service (GPSES)
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- NHS.UK Health A to Z

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Technical annex

Technical annex

QOF background

The Quality and Outcomes Framework (QOF) was introduced as part of the General Medical Services (GMS) contract on 1 April 2004. The objective of QOF is to improve the quality of care patients are given by rewarding GP practices for the quality of care they provide to their patients and is therefore, an incentive payment scheme, not a performance management tool.

A key principle is that QOF indicators should be based on the best available research evidence. Participation by GP practices in QOF is voluntary, though participation rates are very high, with most Personal Medical Services (PMS) practices taking part.

The QOF contains five main components, known as domains, these are:

- Clinical
- Public health
- Public health - additional services
- Public health - vaccination and immunisation
- Quality improvement

Each domain consists of a set of achievement measures, known as indicators, against which GP practices score points according to their level of achievement.

The indicators included in the current reporting year are detailed in the accompanying 'Indicator definitions' file (available on the publication homepage) and details of changes to indicators by year are shown in the relevant section of this document.

QOF information from previous years has been published by NHS Digital and is available

at https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data, and via an online search function at https://qof.digital.nhs.uk/.

General Practice Extraction Service (GPES)

QOF data was collected from GP practices by GPES. GPES is a centrally managed service that extracts information from GP IT systems for a range of purposes at a national level. The GPES relays data to CQRS.

Calculating Quality Reporting Service (CQRS)

CQRS calculates achievement and payments on quality services, including the Quality and Outcomes Framework (QOF), as well as Enhanced Services (ESs) and some other clinical services (e.g. health checks).

Summary of changes for 2021-22

The following changes have been implemented in 2021-22:

- A new vaccination and immunisation domain consisting of four indicators. Three of these indicators focus on routine childhood vaccinations and one on the delivery of shingles vaccinations.
- The reintroduction of three indicators focused on patients with a serious mental illness in relation to uptake in all six elements of the SMI physical health check.
- A new indicator focused on cancer care has been introduced and amendments made to the timeframe and requirements for the cancer care review indicator.
- The four flu indicators have been retired.
- The date of diagnosis has been amended to ‘on or after April 2021’ for the asthma, heart failure and COPD diagnostic indicators.
- To account for the impact of the COVID-19 pandemic on care, the Learning Disabilities and Supporting Early Cancer Diagnosis Quality Improvement modules are to be repeated in their intended format (prior to amendments for the refocusing of QOF in September 2020) with some slight modifications to account for the impact of the pandemic on care.

The total points available to practices is 635 and all payments will be subject to prevalence and list size adjustments.

Additional information can be found in NHS England » Update on Quality Outcomes Framework changes for 2021/22

PMS practices

PMS practices can negotiate local contracts with their commissioning organisations for

the provision of all services. PMS practices may also participate in QOF, and they may either follow the national QOF framework or become part of local QOF arrangements.

PMS practices with local contractual arrangements are included in the published QOF information, and in the figures presented in the report.

Where PMS practices use the national QOF, their achievement (in terms of the maximum QOF points available) is subject to a deduction (approximately 100 points) before QOF points are turned into QOF payments. This is because many PMS practices already have a chronic disease management allowance, a sustained quality allowance and a cervical cytology payment included in their baseline payments.

GMS practices do not receive such payments but receive similar payments through QOF. To ensure comparability between GMS and PMS practices, the QOF deduction for PMS practices ensures that they do not receive the same payments twice.

As the report covers QOF achievement and not payments, all QOF achievement shown is based on QOF points prior to PMS deductions. This is to allow comparability in levels of achievement –where GMS and PMS practices have maximum QOF achievement, both are regarded as having achieved the maximum points.

Level of detail

There is no patient-specific data in CQRS because it is not required to support the QOF.

For example: GPES captures aggregate data on patients with coronary heart disease and on patients with diabetes, but it is not possible to identify or analyse information about individual patients and therefore not possible to identify the number of patients with both diseases.

QOF data extraction and validation

QOF data is extracted from CQRS and in years prior to 2019-20 was processed and then passed to external regional local office representatives for validation.

The following validation rules are applied to the data sequentially for each GP practice:

1. The total number of points achieved by a GP practice was less than or equal to the total number of QOF points that can be achieved for indicators which require a manual response (usually ‘yes’ or ‘no’) only.
2. The GP practice closed before 1 April in the year of publication and this closure was recorded in the NHS Digital reference data before 1 July in the year of publication.
3. The GP practice status in NHS Digital reference data on 31 March of the reporting period was not equal to ‘A’ (Active).
4. The number of registered patients at the GP practice was not available for any of the 3 months prior to 31 March of the reporting year.

The first validation rule that excludes a GP practice is recorded as the reason for exclusion from the publication, although a GP practice may fail more than one validation rule. Details of GP practices excluded for these reasons can be found in the PRACTICE_VALIDATION_OUTCOMES .csv which is part of the publication.

Practice list sizes

QOF data published for years from 2015-16 by NHS Digital uses GP practice list sizes on 1 April immediately following the reporting year end (31 March). In the context of this publication, these list sizes are used as the basis for the calculation of raw clinical prevalence.

Prior to 2015-16, GP practice list sizes on 1 January of the reporting year were used. These figures are still used in CQRS for list size adjustments in QOF payment calculations.

The sum of the GP practice list sizes for the GP practices included in the QOF publication can be found in the Data quality annex which is part of this publication. This number may contain duplicate patients where a patient has moved GP practice during the financial year; this is due to time lags in updates to organisation reference data.

GP practice mappings

Primary Care Networks (PCNs) were introduced into the National Health Service in England as part of the NHS Long Term Plan, published in January 2019, and form the building blocks of Integrated Care Systems. A PCN consists of a group of GP practices working together with a range of local providers (pharmacy, mental health, social care, community, and voluntary sector), serving a population of at least 30,000 and not tending to exceed 50,000. They build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. PCNs have been included as a mapped GP practice geography from 1 April 2020.

On 1 July 2022 Integrated Care Boards (ICBs) were established as statutory bodies, consequently this publication will no longer present data at CCG and STP level. From July 2022 onwards, data will be aggregated to Sub ICB Location, and ICB level. For further information on these changes please see the following links:

- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs

GP practices have been mapped to their respective PCNs, Sub ICB Locations, ICBs and Regions using reference data current on 7 July in the year of publication. This mapping has been applied to data for both the current and previous reporting year; this should be borne in mind when making comparisons between years (please see the section ‘Comparing QOF data over time’).

Suppression

Suppression has been applied to the PRACTICE_PCA_EXCL.csv. Where a GP practice's disease register for an indicator is comprised of between 1 and 4 patients, all PCA and exclusion counts for the indicators in that indicator group have been suppressed. Where an indicator group is not based on a disease register, this suppression has been applied where the relevant practice list size is comprised of between 1 and 4 patients. All suppressed values have been replaced by '*'.

For this suppression to be effective, all instances of PCA or exclusion counts of 0 are now included in this file.

Definitions

There is a distinction between:

- Numbers of patients on disease registers for QOF indicator groups.
- Numbers of patients relevant to specific indicators within these indicator groups.
- Numbers of patients relevant to specific indicators who are included in the indicator denominator when measuring QOF achievement.

Registers

Most indicator groups have an associated disease register (e.g. the atrial fibrillation indicator group is based on a register of patients with atrial fibrillation).

Some conditions do not have a disease register (e.g. the blood pressure indicator group is based on a count of those who have had their blood pressure taken, which is not a disease register).

The information systems which underpin QOF hold the numbers of patients on each of these registers, for each participating GP practice.

Indicator denominators, exclusions and personalised care adjustments (PCAs)

Indicator ***denominators*** are the numbers of patients from the appropriate disease register who are counted for QOF achievement against a specific QOF indicator.

Indicator numerator is the number of those in the denominator who meet the specific indicator success criteria.

Differences between an indicator denominator and the number on a register can be due

to indicator definition.

Patients who are on the disease register, but not included in the indicator denominator for definitional reasons, are referred to as ***exclusions***. Some indicators refer to subsets of patients on a disease register e.g. they may only refer to patients who smoke. In this instance, any non-smoking patient on the disease register is *excluded*.

Differences between an indicator denominator and the number on a register not due to indicator definition, but rather due to individual circumstances, are referred to as ***PCAs***. PCAs relate to patients who are on the disease register, and who would ordinarily be included in the indicator denominator. However, they are omitted from the indicator denominator because they meet at least one of the specified PCA criteria (these are detailed under 'Background to PCA reporting').

The normal relationship between registers, denominators, exclusions and PCAs is therefore:

Register = Denominator + Exclusions + PCAs

QOF achievement data

Reference to ‘QOF achievement’ often refers to the percentage of available QOF points achieved. If a GP practice achieves the full QOF points, it has achieved 100% of the points available and may be said to have 100% achievement across the whole QOF.

The level of achievement for certain elements of QOF can be expressed in the same way. A GP practice achieving all QOF points available for indicators in the clinical domain can be said to have 100% clinical achievement even though it may not have 100% achievement overall.

GP practices achieve the maximum QOF points for most indicators (especially clinical indicators) when they have delivered the maximum threshold to achieve the points available.

For many indicators, a GP practice must provide a certain level of clinical care to 90% of patients on a specific clinical register to achieve the maximum points.

Underlying achievement (net of PCAs)

Underlying achievement (net of PCAs) data is provided in the spreadsheets associated with the report. Since a GP practice can deliver the required care to fewer than 100% of its patients (often around 90%) 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 PCAs) for specific indicators.

Underlying achievement (net of PCAs) presents the indicator numerator as a percentage

of the denominator and is calculated as:

Underlying achievement net of PCAs = (Indicator numerator / Indicator denominator) * 100

Percentage of patients receiving the intervention

Underlying achievement (net of PCAs) does not account for all patients covered by an indicator, as it takes no account of "PCAs" (patients to whom the indicator applies, but who are not included in the indicator denominator according to agreed PCA criteria).

Percentage of patients receiving the intervention gives a more accurate indication of the rate of the provision of interventions as the denominator for this measure covers all patients the indicator applies to, regardless of PCA status (i.e. indicator PCAs and indicator denominator). This measure is calculated as follows:

Percentage of patients receiving the intervention = (Indicator numerator / (Indicator denominator + indicator PCAs)) * 100

Percentage of patients receiving the intervention figures are not covered in the main report, but are presented in the excel tables at national, regional, ICB, Sub ICB Loc and GP practice level.

Points achieved as a percentage of QOF points available

It is not always possible for GP practices to achieve all the points available in QOF. Therefore, NHS Digital produces a further measure of GP practice achievement. This measure takes account of instances where GP practices cannot achieve points because they have no patients relevant to an indicator and can be found in the achievement tables at GP practice level.

For example: if in a given financial year there are 559 QOF points available and 45 of these points are for asthma indicators but the GP practice does not have patients on their asthma register (no patients meeting the established criteria), then it would not be possible to achieve any of the points allocated to the asthma indicators.

Therefore, even if the GP practice achieved all other points available they would only be able to attain 91.9% overall achievement (points achieved / points available) * 100.

In these circumstances, the standard 'points achievement' measure may not be representative and may result in a GP practice's achievement apparently declining from one year to the next where they have patients on a register in one year but none in the next year.

To represent GP practice points achievement more fairly, NHS Digital calculates adjusted

maximum points achievable for each GP practice, effectively removing points from the calculation denominator where **both** of the following conditions apply:

- the GP practice does not have any patients in the indicator denominator
- the GP practice has reported no PCAs for the indicator denominator

The indicator denominator plus indicator PCAs must equal zero. This ensures adjustment of maximum points achievable where there are patients on the relevant disease register (PCAs are included in the disease register, but not in the relevant denominator), who have not received the interventions.

For example: if in a given financial year there are 559 QOF points available and 45 of these points are for asthma indicators but the GP practice does not have patients on their asthma register then points available would be QOF points available minus the 'unachievable' asthma points.

In this case, the difference between the GP practice's *'points achievement'* and *'points achieved as a percentage of QOF points available'* would be as follows:

Points achievement = (Points achieved / All QOF points) * 100

91.9% = (514 / 559) * 100

Points achieved as percentage of QOF points available = (Points achieved / QOF points available) * 100

100% = (514 / 514) * 100

'Points achieved as a percentage of QOF points available' figures are calculated for overall achievement and can be found in the achievement tables.

QOF prevalence data

QOF registers are constructed to underpin indicators on quality of care, and they do not necessarily equate to prevalence as defined by epidemiologists.

Prevalence figures based on QOF registers may differ from prevalence figures from other sources because of coding or definitional issues.

It is difficult to interpret year-on-year changes in the size of QOF registers, as a gradual rise in QOF prevalence could be due partly to epidemiological factors (such as an ageing population) or to increased case finding and recording. Other factors in interpreting information on specific registers include:

- Some clinical areas have 'resolution codes' to reflect the nature of diseases. Others, such as the cancer register, do not.
- Some indicator groups for which there is a disease register are based on a specific

age group (see table below). Prevalence for these indicator groups is calculated using a sub-set of the patient list size relating to the equivalent age group.

Indicator groups with a disease register that are age-specific

Domain	Indicator group	Age group (years)
Clinical	Asthma	6+
Clinical	Chronic kidney disease	18+
Clinical	Depression	18+
Clinical	Diabetes mellitus	17+
Clinical	Epilepsy	18+
Clinical	Non-diabetic hyperglycaemia	18+
Clinical	Osteoporosis	50+
Clinical	Rheumatoid arthritis	16+
Public health	Obesity	18+

Many patients are likely to suffer from co-morbidity (diagnosed with more than one clinical condition in QOF clinical domain). Robust analysis of co-morbidity is not possible using QOF data because it is collected at an aggregate level for each GP practice.

There is no patient-specific data in CQRS which captures aggregated information for each GP practice on patients with coronary heart disease and on patients with diabetes, but it is not possible to identify or analyse patients with both of those diseases.

Some disease registers have more specific definitions extending beyond a patient having a record of the relevant condition. For example, to be on the asthma register, patients need a diagnosis of asthma and a prescription for an asthma drug within the year. Full register definitions can be found in the 'Indicator definitions' file.

The number of patients on indicator registers in the clinical domain can be used to calculate recorded disease prevalence, expressing the number of patients on each register as a percentage of the number of patients on GP practices' lists, as described below:

Disease prevalence = (Number of patients on clinical register / Number of patients on GP practice list) * 100

Where age-specific registers are used, disease prevalence can be calculated as:

Disease prevalence = (Number of patients on clinical register / Number of patients in relevant age band on GP practice list) * 100

QOF PCA data

PCA reporting rates reflect the percentage of patients who are not included when determining QOF achievement and are presented for applicable indicators in QOF. For the NHS Digital QOF publication, there is a distinction between patients who are PCA-reported, and those whose non-inclusion in an indicator denominator is for definitional reasons ('exclusions').

PCAs

Personalised care adjustments can be applied to patients for a number of specified reasons and are usually the result of a patient or a GP decision at a personal level.

Examples of PCAs could be patient or carer refusal of treatment, a patient cancels or does not attend a consultation appointment, or a GP's advice that two types of medication or treatment methodology should not be administered simultaneously.

PCAs are only measured at indicator level, not condition level, as a patient could be omitted from more than one indicator within a condition but would be counted more than once if these omissions were summed.

Exclusions

These are usually due to the type of patient and can be considered as non-inclusion in a denominator due to indicator definition e.g. all men are excluded from the cervical screening indicator, which is a female only measure. This affects the denominator and is not shown in this publication.

Background to PCA reporting

Patient PCA reporting applies to those indicators in the QOF where level of achievement is determined by the percentage of patients receiving the specified level of care. The GMS 2019-20 contract Section 6: Personalised care adjustment contains the following:

"As of 1 April 2019, exception reporting is being replaced with a Personalised Care Adjustment (PCA). This will allow practices to differentiate between the following

reasons for adjusting care and removing a patient from the indicator denominator:

- *unsuitability for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy*
- *patient choice, following a shared decision-making conversation*
- *the patient did not respond to offers of care – recording of this will change to capture actual invitations sent to patients*
- *the specific service is not available (in relation to a limited number of indicators only)*
- *newly diagnosed or newly registered patients, as per existing rules.*

As with exception reporting applying a PCA to the patient record will remove that patient from an indicator denominator if the QOF defined intervention has not been delivered. It will not result in patients being removed from the disease register or other target population.

The associated changes to data recording and extraction should result in a redistribution of coding work away from year-end and provide better information about why patients are not receiving interventions.

Principles when considering whether a PCA applies to an individual patient practices are reminded that:

- *the duty of care remains for all patients,*
- *the decision to apply a PCA should be based on clinical judgement, informed by patient preferences, and underpinned by shared decision-making principles, with clear and auditable reasons coded or entered in free text on the patient record,*
- *there should be no blanket PCAs: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set and this decision reviewed on a regular basis.*

In each case where a PCA is applied then in addition to what needs to be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the reason for the adjustment is fully recorded in a way that can facilitate both safe and effective patient care and audit of the patient record.

Personalisation of care can occur for the following reasons which are listed in the order in which they will be extracted in the business rules:

1. *The investigative service or secondary care service is unavailable (where relevant to the indicator).*
2. *Intervention described in the indicator is clinically unsuitable.*
3. *The patient has chosen not to receive the intervention described in the indicator.*
4. *The patient has not responded to invitations for the intervention described in the indicator (a minimum of two invitations for the intervention in the preceding 12 months, except for the cervical screening indicators. where women should receive a total of three invitations for screening).*
5. *The patient has registered with the practice or has been newly diagnosed with the*

condition of interest in the preceding 3 months and has not received the defined clinical measurements e.g. blood pressure measurement.

6. *The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards e.g. blood pressure control within target levels.*

It is recognised that patients may meet more than one of these criteria and in these circumstances all reasons for PCA should be recorded in the patient's record. However, as a patient can only be acknowledged as having a PCA once within the Business Rules for a given indicator, they will be allocated to the first criterion they meet in the hierarchy listed above. For example, where a patient is recorded as having registered with the practice in the preceding 3 months and has also chosen not to receive the intervention described in the indicator, they would be identified in the Business Rules as having chosen not to receive the care.

The hierarchy listed above seeks to prioritise clinical judgement and patient choice over other criteria. Applying this hierarchy consistently in the Business Rules in conjunction with the recording changes support better attribution of the reason for care being personalised, allowing for more meaningful conversations between clinicians, commissioners, and regulators."

Calculation of PCA rates

For each indicator in the clinical domain, the PCA rate is calculated as follows:

PCA rate = (Number of PCAs / Number of PCAs + indicator denominator) ∗ 100

The recorded number of PCAs is expressed as a percentage of the number of patients on a disease register who were qualified to be part of the indicator denominator i.e. not counted as *PCAs* for definitional reasons.

Manual submissions

A small number of GP practices who participate in the QOF make manual submissions to CQRS or are otherwise unable to make an electronic submission of PCA data. For this small number of GP practices, no PCA data is available. To maintain consistency with the report annexes, which are based on aggregated data from individual GP practices, they are included in the overall PCA calculations.

This has the impact of slightly reducing the PCA rates (because there are no *indicator PCAs* for these GP practices in the calculation numerator, but their *indicator denominator* data is included in the calculation denominator). The impact of this is minimal, less than 1.0% of data submitted at GP practice level.

PCA data as extracted from CQRS

Information captured by CQRS relating to PCAs and exclusions cannot be amended on the CQRS system. CQRS is primarily a system to support QOF payments, and PCA reporting is recorded as part of that process. CQRS was not designed to deliver specific management information about PCA reporting but does allow summary information on the levels of PCA reporting to be generated. This information is the basis for this publication and is presented at GP practice level in the PRACTICE_PCA_EXCL csv.

CQRS does not allow a presentation of PCAs broken down by each of the six personalisations outlined above. There are three reasons for this:

- CQRS uses an internal set of PCA ID codes that do not map directly into the six PCA reporting criteria in the SFE; rather, these PCA ID codes relate to PCA reporting coding 'clusters' in QOF business rules, often specific to individual QOF indicators. Fewer than nine of the criteria in the SFE may apply to an indicator.
- CQRS reporting functionality does not make a distinction between PCA reporting and definitional exclusions – both types of omission from indicator denominators are included on reports available to CQRS users.

Caveats and data limitations

The CQRS system was established as a mechanism to support the calculation of GP practice QOF payments. It is not a totally comprehensive source of data on quality of care in GP practices, but it is potentially a rich and valuable source of information for healthcare organisations, analysts and researchers, providing the limitations of the data are acknowledged.

Levels of QOF achievement will be related to a variety of local circumstances and should be interpreted in the context of those circumstances. Users of the published QOF data should be particularly careful in undertaking comparative analysis.

The following points have been raised by local healthcare organisations in consultation with NHS Digital:

Prevalence and achievement

- The ranking of GP practices based on QOF points achieved, either overall or with respect to areas within QOF, may be inappropriate. QOF points do not reflect GP practice workload issues (e.g. around list sizes and disease prevalence), that is why GP practices' QOF payments include adjustments for such factors.
- Comparative analysis of GP practice-level or Sub ICB Location-level QOF achievement (or prevalence) may also be inappropriate without taking account of the underlying social and demographic characteristics of the populations concerned. The delivery of services may be related, for instance, to population age/sex, ethnicity or deprivation characteristics that are not included in QOF data collection processes.

- Information on QOF achievement, as represented by QOF points, should also be interpreted with respect to local circumstances around GP practice infrastructure. In undertaking comparative or explanatory analysis, users of the data should be aware of any effect of the numbers of partners (including single handed GP practices), local recruitment and staffing issues, issues around GP practice premises, and local IT issues.
- Users of the data should be aware that different types of GP practice may serve different communities. Comparative analysis should therefore take account of local circumstances, such as numbers on GP practice lists of student populations, drug users, homeless populations, and asylum seekers.
- Analysis of co-morbidity (patients with more than one disease) is not possible using QOF data as it is collected at an aggregate level for each GP practice. For example, CQRS captures aggregated information for each GP practice on patients with coronary heart disease and on patients with asthma, but it is not possible to identify or analyse patients with both diseases.
- Information held in CQRS, and the source for the published data, is dependent on diagnosis and recording (case finding) within GP practices using GP practices' clinical information systems.
- Measuring the quality of care is not a simple process. Within the clinical domain, QOF does not cover every clinical condition, and only describes some aspects of the care for the clinical areas that are included. However, QOF does provide valuable information (for instance on prevalence, cholesterol levels and blood pressure) on a scale unavailable before 2004-05 and provides a measure of improvement in the delivery of care.

PCAs

An important aim of QOF is to encourage appropriate and high-quality clinical care for key long-term conditions. Potentially, PCA reporting could influence the level of financial reward to GP practices.

The availability of high-level information on PCA reporting provides an indication of the variations in PCA rates that are found between specific indicators, and between NHS organisational areas.

It is also important to emphasise some of the limitations of the available data. These include GP practices missing from the analysis; the derivation of PCA counts; and the potential for amendments to indicator denominators not mirrored by changes to counts of PCAs.

Additionally, care should be taken when interpreting high level analysis in the context of local primary care service delivery, notably in terms of the numbers of patients associated with relatively high or low PCA rates. Sub ICB Locations will have access to more detailed local information, and knowledge of local circumstances, to enable unusual levels of PCA reporting to be investigated further.

Comparing QOF data over time

1. Achievement and Personalised Care Adjustment (PCA) data have been re-introduced to the Excel summary tables for the 2021-22 reporting year. Payment protection has been applied to the QOF service and may affect QOF activity and/or its recording for the following years:

- 2021-22 QOF service – practices were advised in December 2021 that payment protection would be applied.
- 2020-21 QOF service - practices were advised at the beginning of the reporting year that payment protection would be applied.

When comparing QOF data between these years, users should be aware that practices were advised that payment protection would be applied at different times during the year.

In years prior to this payment protection was not implemented. NHS England and Improvement published information about the implementation of QOF payment protection; for the 2020-21 reporting year this can be found in the Guidance for General Medical Services Contract document, and for the 2021-22 reporting year this can be found in a letter to practice.

2. The tables for QOF 2021-22 present data from both the current reporting year and the previous reporting year. The aggregated (i.e. non-GP practice level) figures presented for the previous year in this release will not match those published last year, as all figures have been recalculated using GP practice level data that can be mapped to current NHS geographies.

3. An additional indicator specific PCA has been added to indicator AST006 consequently this indicator is not comparable with previous years.

QOF formulae

Summary of formulae applied to raw QOF data

Measure	Formula
Prevalence	(register / number of patients on practice list) * 1(
Prevalence - age-specific	(register / number of patients in age band on prac
Achievement percentage	(number of points achieved / 559) * 100

Measure	Formula
Maximum achievement points available	sum of points available for indicators where (indic denominator > 0)
Adjusted achievement percentage	(number of points achieved / maximum achieveme
Underlying achievement score (net of PCAs)	(indicator numerator / indicator denominator) * 1
Percentage of patients receiving the intervention	(indicator numerator / (indicator denominator + P
PCA rate	(number of PCAs / (number of PCAs + indicator de

CSV metadata

ACHIEVEMENT

Data Item	Description
PRACTICE_CODE	GP practice code
INDICATOR_CODE	Unique code that identifies each indicator. The characters a of the string identify which group the indicator belongs to belongs to the Atrial Fibrillation group.
MEASURE	Defines the value type
VALUE	Count of the measure

MAPPING_INDICATORS

Data Item	Description
INDICATOR_CODE	Unique code that identifies each indicator. The characters the string identify which group the indicator belongs to e to the Atrial Fibrillation group.
INDICATOR_POINT_VALUE	Number of points a practice gains from achieving the indi
GROUP_CODE	Diagnostic or disease group code to which an indicator(s)
GROUP_DESCRIPTION	Diagnostic or disease group description to which an indic
DOMAIN_CODE	Domain code to which a group or groups belong.
DOMAIN_DESCRIPTION	Domain description to which a group or groups belong.
PATIENT_LIST_TYPE	A defined age groups against which an indicator is measu

MAPPING_NHS_GEOGRAPHIES

Data Item	Description
NAT_ONS_CODE	Country Office of National Statistics code - nine-character
NAT_CODE	Country code.
COUNTRY	Name of country.

REGION_ODS_CODE	Commissioning Region Organisational Data Service code - created by the Organisation Data Service within NHS Digit identify organisations across health and social care.
REGION_ONS_CODE	Commissioning Region Office of National Statistics code - code.
REGION_NAME	Commissioning Region name.
ICB_ODS_CODE	Integrated Care Board Organisational Data Service code - i created by the Organisation Data Service within NHS Digit identify organisations across health and social care.
ICB_ONS_CODE	Integrated Care Board Office of National Statistics code - code.
ICB_NAME	Integrated Care Board name.
SUB_ICB_LOC_ODS_CODE	Sub Integrated Care Board Location Organisational Data S unique code created by the Organisation Data Service witl used to identify organisations across health and social care
SUB_ICB_LOC_ONS_CODE	Sub Integrated Care Board Location Office of National Sta character GSS code.
SUB_ICB_LOC_NAME	Sub Integrated Care Board Location name.
PCN_ODS_CODE	Primary Care Network Organisational Data Service code - i created by the Organisation Data Service within NHS Digit identify organisations across health and social care. There equivalent.
PCN_NAME	Primary Care Network name.
PRACTICE_CODE	GP practice code.
PRACTICE_NAME	GP practice name.

MAP_PCAS_EXCL_CAT_TO_INDICATOR

Data Item	Description
INDICATOR_CODE	Unique code that identifies each indicator. The characte of the string identify which group the indicator belong

	belongs to the Atrial Fibrillation group.
PCA_EXCL_NAME	Name of the PCA or Exclusion
PCA_EXCL_SHORT_NAME	Shortened name of the PCA or Exclusion
PCA_EXCL_DESCRIPTION	Full description of the PCA or Exclusion
TYPE	Personalised Care Adjustment or Exclusion
GENERAL_SPECIFIC	Applies to PCAs only and indicates if the PCA is used acr specific to an indicator.
PCA_CATEGORY	Category which prompted the patient's omission - more found in the Technical Annex.

PCA_CATEGORY_DESCRIPTION	Full description of the PCA category.

ORGANISATION_REFERENCE

Data Item	Description
PRACTICE_CODE	Unique code that identifies each indicator. The character of the string identify which group the indicator belongs belongs to the Atrial Fibrillation group.
REVISED_MAXIMUM_POINTS	Maximum points it is possible for a practice to achieve. T from the maximum points available as a practice may be arrangements - more information can be found in the Te

PRACTICE_PCA_EXCL

Data Item	Description
PRACTICE_CODE	GP practice code
INDICATOR_CODE	Unique code that identifies each indicator. The characters a the string identify which group the indicator belongs to e. the Atrial Fibrillation group.
PCA_EXCL_NAME	Name of Personal Care Adjustments or Exclusions.
TYPE	Personal Care Adjustment or Exclusion

COUNT	Number of PCAs or Exclusions

PRACTICE_VALIDATION_OUTCOMES

Data Item	Description
PRACTICE_CODE	GP practice code
VALIDATION_RULE	Rule which prompted the practice's omission - more inform found in the Technical Annex.
RULE_DESCRIPTION	Short description of the validation rule, a full description c Technical Annex.

PREVALENCE

Data Item	Description
PRACTICE_CODE	GP practice code

GROUP_CODE	Disease group code to which an indicator belongs.
REGISTER	Patients on an indicator group register
PATIENT_LIST_TYPE	A defined age groups against which an indicator is measur
PRACTICE_LIST_SIZE	Patients registered at a GP practice

Related Links

- Guidance for General Medical Services Contract document
- Letter to practice 2021-22
- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs
- NHS England - GP Contract
- GMS contract Statement of Financial Entitlements
- General Practice Specification and Extract Service (GPSES)
- Calculating Quality Reporting Service (CQRS)

- NHS.UK Health A to Z

Last edited: 21 September 2022 4:17 pm

Previous Chapter
Main findings

Next Chapter
Data quality annex

Data quality annex

Please note: The outbreak of Coronavirus (COVID-19) in the last quarter of 2019-20 has led to unprecedented changes in the work and behaviour of GP practices and consequently data in this publication may have been impacted.

As such, caution should be taken in drawing any conclusions from the data without due consideration of the circumstances both locally and nationally as of 31 March 2020 and we would recommend that any use of this data is accompanied by an appropriate caveat.

The tables for QOF 2021-22 present data from both the current reporting year and the previous reporting year for prevalence, achievement and PCAs more information can be found below under Coherence and comparability.

Relevance

The Quality and Outcomes Framework (QOF) covers 20 clinical, 5 public health and 2 quality improvement aspects of GP practice activity and represents one of the richest sources of information from primary care. QOF data is collected primarily to support payments to GP practices. QOF information is valuable for many secondary uses.

Some aspects of the NHS Digital published QOF information are also presented by the Care Quality Commission, NHS.UK, and other information dissemination routes.

Accuracy and reliability

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.

QOF data for this release was downloaded on 1 July 2022, and so include all adjustments up to 30 June 2022.

Following validation, the published QOF dataset includes data for 6,470 practices. In the 2021-22 reporting year 6,638 practices eligible for QOF were open and active at some point; this gives a coverage of 97.5%.

Considerations for 2021-22 data

The following changes have been implemented in 2021-22:

- A new vaccination and immunisation domain consisting of four indicators. Three of these indicators focus on routine childhood vaccinations and one on the delivery of shingles vaccinations.
- The reintroduction of three indicators focused on patients with a serious mental illness in relation to uptake in all six elements of the SMI physical health check.
- A new indicator focused on cancer care has been introduced and amendments made to the timeframe and requirements for the cancer care review indicator.
- The four flu indicators have been retired.
- The date of diagnosis has been amended to ‘on or after April 2021’ for the asthma, heart failure and COPD diagnostic indicators.
- To account for the impact of the COVID-19 pandemic on care, the Learning Disabilities and Supporting Early Cancer Diagnosis Quality Improvement modules are to be repeated in their intended format (prior to amendments for the refocusing of QOF in September 2020) with some slight modifications to account for the impact of the pandemic on care.

The total points available to practices is 635 and all payments will be subject to prevalence and list size adjustments.

Additional information can be found in https://www.england.nhs.uk/gp/investment/gp-contract/

Validation exercise

QOF is extracted from CQRS and in years prior to 2019-20 was processed and then passed to external regional local office representatives for validation.

In 2019-20 following the abolition of regional local offices and after consultation with NHS England this validation process was integrated into an automated process carried out by NHS Digital to ensure consistency of approach and outcome.

The validation process for the current year excluded:

106 practices where the total number of points achieved was less than or equal to the total number of QOF points that can be achieved for indicators which require a manual response only.

0 practices which closed before 1 April 2022 and this closure was recorded before 1 July 2022.

2 practices which did not have a status of 'A' (Active) on 31 March 2022.

0 practices where the count of registered patients was not recorded in the 'Patients registered at a GP practice' publication in any of the 3 months prior to 31 March 2022.

The first validation rule that excludes a GP practice is counted as the reason for exclusion from the publication, although a GP practice may fail more than one validation rule. Details of GP practices excluded for these reasons can be found in the PRACTICE_VALIDATION_OUTCOMES csv which is part of the publication.

Timeliness and 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 NHS England.

The extract of QOF data for this publication was made from CQRS on 1 July 2022. This delay after the financial year-end maximises the number of practices whose achievement is signed-off, whilst still allowing publication in September.

Accessibility and clarity

QOF publications are available on the NHS Digital website at Quality and Outcomes Framework

Included is a summary of the main findings, technical annex, FAQ annex and data quality annex. Information at GP practice, Sub ICB Location, ICB, regional and national levels are presented in Excel workbooks, and the underlying ('raw') data is available in .csv files which can be found on the publication homepage.

We also provide an online database which allows users to view detailed information about practices in a more visual format.

Where NHS Digital data is reused, NHS Digital should be clearly acknowledged as the data source. Please see Terms and conditions for more information.

Coherence and comparability

QOF information is collected primarily to support QOF payment calculations under GMS contracts, and this data collection is (for clinical information) based on detailed coded business rules. QOF clinical registers may not match disease definitions used by epidemiologists and may not cover all ages. As a result, QOF indicators may not be defined in the same way as similar measures from other sources.

It is 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 and/or the business rules associated with them can change from year to year. Levels of achievement and personalised care adjustments (formerly exceptions) rates therefore may not be directly comparable each year.

Achievement and Personalised Care Adjustment (PCA)

Achievement and PCA data have been re-introduced to the Excel summary tables for the 2021-22 reporting year. Payment protection has been applied to the QOF service and may affect QOF activity and/or its recording for these years:

- 2021-22 QOF service – practices were advised in December 2021 that payment protection would be applied.
- 2020-21 QOF service - practices were advised at the beginning of the reporting year that payment protection would be applied.

When comparing QOF data between these years, users should be aware that practices were advised that payment protection would be applied at different times during the year.

In years prior to this payment protection was not implemented. NHS England and Improvement published information about the implementation of QOF payment protection; for the 2020-21 reporting year this can be found in the Guidance for General Medical Services Contract document, and for the 2021-22 reporting year this can be found in a letter to practice.

Changes to NHS geographies

On 1 July 2022 Integrated Care Boards (ICBs) were established as statutory bodies, consequently this publication will no longer present data at CCG and STP level. From July 2022 onwards, data will be aggregated to Sub ICB Location, and ICB level. For further information on these changes please see the following links:

- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs

GP practices have been mapped to their respective PCNs, Sub ICB Locations , ICBs and Regions using reference data current on 7 July in the year of publication. This mapping has been applied to data for both the current and previous reporting year; this should be borne in mind when making comparisons between years (please see the section 'Comparing QOF data over time' in the Technical annex).

Introduction of suppression

Suppression was introduced in 2021-22 and applied to the PRACTICE_PCA_EXCL.csv. Where a GP practice's disease register for an indicator is comprised of between 1 and 4 patients, all PCA and exclusion counts for the indicators in that indicator group have been suppressed. Where an indicator group is not based on a disease register, this suppression has been applied where the relevant practice list size is comprised of between 1 and 4 patients. All suppressed values have been replaced by '*'.

For this suppression to be effective, all instances of PCA or exclusion counts of 0 are now included in this file.

Overview of year-on-year changes

2004-05 and 2005-06

QOF was introduced in 2004-05, the same indicator set was used in 2005-06. In 2004-05 and 2005-06 GP practices were able to achieve a maximum QOF score of 1,050 points.

2006-07 and 2007-08

From April 2006 a revised QOF was introduced, including new clinical areas, and revising some clinical indicators. The revised QOF continued to measure achievement against a set of evidence-based indicators but allowed a maximum possible QOF score of 1,000 points.

2008-09

Changes were made at the start of 2008-09.

- The introduction of two new indicators in the Patient Experience domain. The new indicators, PE7 and PE8, were derived from the results of the national GP Patient Survey, and rewarded GP practices for providing 48-hour appointments (PE7) and advanced booking (PE8). These two new indicators were worth a total of 58.5 QOF points, and their introduction coincided with the removal of some indicators (or points associated with indicators)

Maximum possible QOF score remained at 1,000 points.

2009-10 and 2010-11

Changes made at the start of 2009-10 and remained in force for 2010-11 included:

- The introduction of new indicators in the existing heart failure, chronic kidney disease, depression, and diabetes clinical indicator sets
- The introduction of two new indicators under a new cardiovascular disease (primary prevention) clinical indicator set
- The removal of some patient experience indicators; changes to contraception indicators within the Additional Services domain of the QOF
- Various changes to the points values of some QOF indicators

Maximum possible QOF score remained at 1,000 points.

2011-12

Changes at the start of 2011-12 included:

- The introduction of new indicators in the epilepsy, learning disability and dementia clinical indicator sets
- The introduction of a new set of indicators measuring quality and productivity.
- Twelve indicators were retired across a range of sets
- Twenty-two indicators were replaced, either due to changes to indicator wording or coding/business logic changes
- Five indicators had changes to point values or thresholds.

Maximum possible QOF score remained at 1,000 points

2012-13

Changes at the start of 2012-13 included:

- The retirement of seven indicators (including five from the Quality and Productivity area), releasing 45 points to fund new and replacement indicators.
- Nine new NICE recommended clinical indicators introduced, including two new clinical areas (Peripheral arterial disease and Osteoporosis) and additional smoking indicators.
- Three new organisational indicators for improving Quality and Productivity which focused on accident and emergency attendances.
- Sixteen other indicators were replaced, either due to changes to indicator wording or coding/business logic changes or to changes to point values or thresholds.

Maximum possible QOF score remained at 1,000 points.

2013-14

Changes at the start of 2013-14 included:

- The indicator codes have all been reset and re-ordered, starting with 001 for each set of indicators to reflect the flow of processes.

- Thirty-eight indicators were retired which included the organisational domain
- A new public health domain was introduced (including a subset of additional services indicators), with some existing indicators reallocated to this new domain.
- Twelve new indicators were introduced which included a new public health measure: blood pressure and a new clinical condition: rheumatoid arthritis.
- Thirteen indicators have been replaced along with changes to the wording where necessary, which was mainly changing 'GP practice' to 'contractor'.
- There was of the end-of-year overlap for most indicators by changing the indicator timeframe from 15 to 12 months or 27 to 24 months.

Maximum possible QOF score available changed to 900.

2014-15

Changes at the start of 2014-15 included:

- Two domains retired: the quality and productivity domain and the patient experience domain.
- Three indicator group retired: hypothyroidism, child health surveillance and maternity.
- Twenty-six individual indicators retired from within conditions that are still measured in QOF.
- No new indicators or indicator groups have been added this year.
- Minor changes to indicators have resulted in new indicator numbering. Epilepsy now has only one indicator (the presence of a register). Learning disability has had the age restriction removed and is no longer for those aged 18 or over. Blood Pressure has also changed its age restriction from age 40 or over to age 45 or over.

Maximum possible QOF score available remained at 900.

2015-16

Changes at the start of 2015-16 included:

- Total number of indicators fell from 81 to 77 with some indicators being retired or replaced.
- The number of points assigned to some indicators has been changed but the number of points available in each domain has remained the same.
- No changes to the number of indicator groups
- Minor changes to indicators' wording, timeframe or maximum available points have resulted in new indicator numbering. This affects the dementia; chronic kidney disease and obesity indicator groups as follows:
    - DEM002 and DEM003 are now numbered DEM004 and DEM005 respectively, due to changes in the wording and points for DEM002, and changes in the timeframe for DEM003.
    - CKD001 is now numbered CKD005 following a change in wording

- OB001 is now numbered OB002 following a change in the age group to which the indicator applies

Maximum possible QOF score available changed to 559 points

2016-17-18

- No changes to the number of points available, or the number or definition of indicators for 2016-17 or 2017-18, as compared to 2015-16.

Maximum possible QOF score available remained at 559 points

2018-19

Changes at the start of 2018-19 included:

- Clinical codes used to define the learning disabilities register changed meaning the register (and associated recorded disease prevalence) is not comparable with previous years. The indicator ID has changed from LD003 to LD004 as a result, although the description remains the same.

Maximum possible QOF score available remained at 559 points

2019-20

Changes at the start of 2019-20 included:

- A new quality improvement domain (worth 74 points) was introduced, broken down to indicator groups prescribing safety and end of life care
- Nineteen new indicators were introduced 15 within existing conditions (worth 101 points) and 4 in new domain
- One indicator group retired: contraception.
- Twenty-eight individual indicators retired (worth 175 points), from within conditions that are still measured in QOF.
- Personalised care adjustments (PCAs) replaced exceptions more information can be found in the technical annex.

Maximum possible QOF score available remained at 559 points

2020-21

Changes at the start of 2020-21 included:

- A new non-diabetic hyperglycaemia indicator group in the Clinical domain (worth 0 points) was introduced.
- Fourteen new indicators were introduced 13 within existing conditions (worth 70 points) and 1 in the new indicator group.
- One indicator group retired: cardiovascular disease - primary prevention containing 1 indicator worth 10 points.

- Thirteen individual indicators retired (worth 151 points), from within conditions that are still measured in QOF.
- A new age qualifier 6 years and over applied to the asthma register.

Maximum possible QOF score available has increased to 567 points

2021-22

Change at the start of 2021-22 included:

- One new domain, Public health – vaccination and immunisation containing one new indicator group (Vaccination and immunisation) comprising of four new indicators worth a total of 64 points.
- Five new indicators were introduced within existing conditions (worth 0 points).
- Five individual indicators were retired (worth 42 points), from within conditions that are still measured in QOF.
- Eleven existing indicators had their points allocation changed from last year.

Maximum possible QOF score available increased to 635 points.

Specific issues and caveats concerning the interpretation of QOF data are covered in the Technical annex.

Assessment of user needs and perceptions

During each publication cycle, data quality is assessed by the NHS Digital collection and publication teams, and where queries arise, data suppliers are contacted to validate and confirm data submissions.

Customer feedback is regularly solicited through QOF publication feedback or comments can be sent via:

Email: enquiries@nhsdigital.nhs.uk

Telephone: 0300 303 5678

Performance, cost and respondent burden

QOF data downloaded from CQRS by NHS Digital is a secondary use of the data.

The primary use of the QOF data is to support QOF payments to GP practices.

No increased respondent burden.

Confidentiality, transparency and security

Published QOF information is derived from the data available via CQRS. Users of CQRS (appropriate individuals from practices and Sub ICB Loc) can monitor their own QOF information on a continuous basis throughout the year. In addition, they have access to reports which provide the same level of information as that which is published by NHS Digital.

QOF publications are subject to risk assessments concerning disclosure. No personal identifiable data has been identified in this year's QOF. Standard NHS Digital protocols around information governance are followed in the production of QOF publications.

The data contained in this publication are Official Statistics. The code of practice is adhered to from extraction of the data to publication:

https://uksa.statisticsauthority.gov.uk/about-the-authority/uk-statistical-system/types-of-official-statistics/

Please see links below to the relevant NHS Digital policies:

Statistical Governance Policy:

https://digital.nhs.uk/data-and-information/find-data-and-publications/publications-supporting-user-documents

Freedom of Information:

https://digital.nhs.uk/article/253/Freedom-of-Information

Related Links

- Guidance for General Medical Services Contract document
- Letter to practice 2021-22
- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs
- NHS England - GP Contract
- GMS contract Statement of Financial Entitlements
- General Practice Specification and Extract Service (GPSES)

- Calculating Quality Reporting Service (CQRS)
- NHS.UK Health A to Z

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Frequently asked questions

Frequently asked questions

QOF 2021-22

What is in the latest QOF publication?

Why do Sustainability and Transformation Partnerships (STPs) and Clinical Commissioning Groups (CCGs) no longer exist?

Why have Achievement and Personalised Care Adjustment (PCA) data have been re-introduced to the Excel summary tables for the 2021-22 reporting year?

Has suppression been applied to the QOF data for the 2021-22 reporting year?

Can I compare prevalence, achievement and PCA data for 2021-22 with achievement and PCA data for 2020-21?

Background

What is QOF?

Where does the data come from? / What is CQRS?

What is in QOF? What are 'domains'?

How do CQRS / QOF data relate to GP practice payments?

Previous years and future changes

Where can I find QOF data for previous years?

Can I have QOF indicator information for years prior to 2004-05?

How is 2021-22 QOF different from previous years?

What changes are planned for next year's QOF?

How do I complain about QOF indicators or suggest changes to the QOF?

Business rules

What are QOF business rules? Where can I find them?

PCAs

Why do the PCA .csv files contain less data than I expected?

Where can I find information on QOF PCA reporting?

Why are PCA reporting figures published by NHS Digital different from the figures in CQRS reports?

We only applied PCA codes to a very small number of patients, but our published PCA rate is very high. Why is this?

GP practice information

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

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

I do not agree with the published QOF information for my GP practice

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Achievement

Why do the achievement .csv files contain less data than I expected?

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

What does 100% achievement mean?

What is 'underlying achievement (net of PCAs)'? What is 'percentage of patients receiving the intervention'?

Are all GP practices supposed to reach, or try to reach, 100% QOF achievement?

What if a GP practice does not have any patients on a register?

Prevalence

What disease prevalence information is available from QOF?

What prevalence figures are shown and how are they calculated?

How do I get a count of the number of patients who smoke?

Do QOF prevalence figures differ from prevalence figures published elsewhere?

What GP practice list sizes are used in calculating prevalence rates?

Are there issues with prevalence for specific clinical areas?

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

Register information

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

Can I have figures for specific conditions from the Mental Health register, e.g. for schizophrenia, separately?

Comparison

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

Further data and re-use of data

What is QOF data used for?

Can I re-use or publish QOF data?

Where can I find information on QOF for Scotland, Wales and Northern Ireland?

How can I obtain a list of GP practice names and addresses?

CQRS data

I have a problem with my GP practice's data in CQRS reports

Where can I find information on QOF payments to GP practices?

Related Links

- Guidance for General Medical Services Contract document
- Letter to practice 2021-22
- NHS England - ICBs in England
- Organisation Data Service (ODS) - ICBs
- NHS England - GP Contract
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