BMA

Focus on GP quality indicators

General Practitioners Committee

June 2018



Background

The Quality and Outcomes Framework (QOF) was introduced into the new GMS contract in 2004, following negotiations between the Department of Health and the General Practitioners Committee (GPC). QOF is a pay-for-performance scheme, which provides practices with funding for completing specific activities that are considered to represent good quality of care, or outcomes that are in line with best clinical evidence. The introduction of QOF represented a radical to the GMS contract in the UK and has since been viewed with interest by other health services across the world.

In 2009, the National Institute for Health and Care Excellence became responsible for developing a menu of recommended indicators based on an explicit evidence-based process. This menu was then used to inform negotiations between the GPC and NHS Employers (on behalf of NHS England) on changes to QOF. Following the imposition of the GP contract in April 2013, it was decided that the negotiations and contracts with regards to QOF would be separate for the devolved nations. In Scotland, as of 1 April 2016 QOF has been dismantled, the remaining points retired and the funding has been moved to global sum. In Wales, a new approach was trialled in 2017/18 where the clinical QOF domain was divided in to active and inactive QOF, with inactive indicators to be reviewed by practices at GP cluster meetings. In recognition of workload pressures, for 2018/19, active QOF was further reduced to only disease register and two flu indicators, while the cluster network domain was simplified to require attendance at 5 cluster meetings during the year. Northern Ireland is maintaining the QOF due to the workload and workforce imbalance, to have stability for practices.

Further information and guidance about QOF is available on the QOF guidance page.

The following principles relating to the QOF were agreed by the negotiating parties[1]:

- 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 for 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 e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

Under the QOF, practices are awarded points, each attracting a payment, for recording specific activities or outcomes described in a set of indicators. The number of points varies by indicator. Some indicators support a practice-level activity, e.g. being able to identify a list of patients with a particular condition, and others enable the practice to focus on a proportion of patients who have received a component of clinical care or who have achieved a particular outcome. For the latter, the practice receives points on a sliding scale between a lower and upper threshold according to the proportion of relevant patients recorded as receiving the care or achieving the outcome.

[1] 2016/17 General medical services - Quality and outcomes framework guidance

When QOF was first introduced, there were around 140 indicators with a total of 1050 points; in 2006 it was reduced to 1000 points and remained constant until 2013/14 when it was reduced to 900 as part of an imposed contract change[2]. The following year the QOF negotiation had been separated in to the different nations, and in England, the number of indicators were, as part of a negotiated agreement, significantly reduced to 77, with 559 points available. This remains the current size of QOF in England for 2018/19.

In Wales there are currently 253 active points; this is comprised of the disease register and flu indicators from the clinical domain (53 points) alongside a simplified cluster network domain reduced to one indicator (200 points). As in 2017/18, practices will still receive payment for the inactive indicators based on their achievement points used for payment in the 2016/17 financial year. In Northern Ireland, the number of points available remains at 547, whereas in Scotland all remaining 659 points were retired in 2017 as part of wider negotiated changes completed in 2018. A list of the annual QOF changes is available in the Appendices.

The QOF originally covered some activities (and their associated funding) that were required under the previous contractual arrangement together with additional funding to support more structured long term condition management and data recording linked to this. It consisted of a Clinical Domain, Additional Services (e.g. cervical screening), Organisational Indicators, and Patient Experience (e.g. Patient Survey) indicators, and subsequently in England some Public Health Indicators were introduced, and a Quality and Productivity Domain was in place from 2011/12 to 2013/14. The clinical areas covered by QOF prioritise common disease areas causing significant morbidity or mortality where the main responsibility for care is in general practice, and where there is evidence of health benefits arising from intervention in a primary care setting.

Payments and practice income

When QOF was first introduced, the pound per point per practice with an average weighted population (calculated through Contractor Population Index (CPI)) was £77.50, rising to £127.29 for 2010/11, and then to £130.51 in 2011/12. The CPI is calculated each year as set out in section 2.18 of the SFE (contractors' list divided by the national average list as taken at 1st Jan) and has always formed part of the QOF payment calculations. Changes to a practice's CPI are driven by changes to either/both the practice list and the national average list size. The value of individual QOF points is uplifted to offset this, however it may be that individual practice payments may increase or decrease based on relative prevalence changes in other practices nationally. It is worth noting that achievement over recent years has been stable and high. The QOF point value for 2018/19 is £179.26 in England, £172.88 in Wales and £162.12 in Northern Ireland.

In England, most general practices derive 12-15% of total practice income from QOF, and GMS and PMS practices receive about £685 million a year through QOF. Other income to practices comes from the capitation global sum (about £85 per patient per year) and payments for delivery of specific services. Payments are weighted by list size and measures of disease prevalence. QOF is therefore an essential part of practice funding which supports the employment of practice staff as well as the day-to-day activities of the practice.

[2] As part of the 2013/14 contract imposition, the GPC rejected the inclusion of some QOF indicators due to the services required not being universally available across the UK and due to the high workload implications. The Department of Health did not accept that the new indicators would have a profound impact on primary care workload or distort patient services.

Exception reporting and exclusions

Practices may record patients as 'exceptions', meaning that the patient is not included when calculating achievement. Exception reporting applies to all indicators where the achievement is determined by the percentage of patients receiving the specified level of care. These exceptions relate to registered patients who *would ordinarily be included in the indicator denominator, but who are excepted (i.e. removed from the denominator and numerator) by the contractor on the basis of the exception criteria*. This may be because the patient has recently registered with the practice, has a contraindication to the incentivised intervention, or actively refuses the intervention.

Exception reporting acts as a safeguard against clinical decisions being inappropriately affected by financial conflicts of interest, reduces overtreatment, and enables clinicians to deliver a greater degree of personalisation of care for patients, as well as fostering a decision-making partnership between patients and clinicians. Exception reporting only applies to the QOF year in which it was added and therefore the reason for exception reporting has to be reviewed annually.

Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group. Patients who are on the disease register or in the target group for the clinical area concerned, but not included in an indicator denominator for definitional reasons, are called "exclusions". For example, an indicator may refer only to patients of a specific age group, patients with a specific status or with a specific length of diagnosis, within the register for that clinical area.

Reviews of clinical indicators

There have been a number of problems and concerns highlighted in relation to QOF, such as:

- annual changes
- micromanagement
- impact of the doctor's agenda taking time away from the patient's agenda
- more activity required for the same amount of funding
- political interference relating to specific indicators, placing greater value on elements that could be measured against the aspects that are harder to quantify but important to patients
- concern from some disease specific groups that if their condition is not covered by QOF, practices would not focus on it
- increased awareness of multi morbidity and need to move away from a single disease focus
- rise in thresholds making it more difficult to achieve with the pressure then to over medicalise patients to hit targets
- the introduction of INLIQ and concerns about how this data is used.

As a result, reviews and research projects have been carried out about QOF to investigate these concerns, some of which are outlined below.

The Health Foundation review of indicators of the quality of care offered by practices in England[3] assessed if comparable indicators of the quality of primary care were sufficiently developed to be used to help practices improve quality, and whether such indicators help patients and carers gauge the quality of care their GP practice provides. The following recommendations were made:

[3] Dixon et al. Indicators of quality of care in general practices in England – independent review for the Secretary of State for Health. October 2015. Accessible at www.health.org.uk/publication/indicators-quality-care-general-practices-england

- Develop a small set of indicators that show information about what matters most to the public, health care professionals and those accountable for the quality of general practice

- Consolidate multiple existing websites currently sharing information about general practice quality, to meet the differing needs of health care professionals and the public

- Develop a national strategy for improving the quality of general practice and primary care that guides indicator development

- Provide support to those working in general practice about how to understand and use information to improve patient care.

The review also strongly advised against making a composite score out of selected indicators to indicate the quality of care overall in general practice, or for particular population groups.

In 2016, the University of Kent Policy Research Unit published a review of the evidence of effectiveness of QOF[4] in the context of a changing policy landscape. Their key findings were:

- Most QOF indicators are unlikely to promote the aims of the Five Year Forward View most relevant to primary care (better holistic care, integrated care or patient-centred care)

- QOF may motivate practices to maintain performance on QOF indicators, although these represent a limited, biomedical view of health and the quality of primary care

- It is not clear what would happen to the care if the current indicators were retired

- QOF may divert practices from other aspects of providing high quality of primary care and from prioritising those patients with the greatest needs

- There is no definitive evidence that QOF has an important impact on population health or emergency admissions.

One of the studies in the review was identified to have examined the impact of withdrawal of indicators, and it found that performance for lithium treatment monitoring remained stable for five years, although there was a small drop in influenza immunisations in patients with asthma. It also identified that there was no fall in performance after one year of follow up for the other withdrawn QOF indicators (although ongoing further research on long term impacts was being undertaken).

A systematic review published in the British Journal of General Practice[5] concluded that any replacement for QOF needs to consider the evidence of effectiveness of pay-for-performance in primary care, and the evidence of what motivates primary care professionals to provide high-quality care.

[4] Forbes et al. Review of the Quality and Outcomes Framework in England. Dec 2016. Accessible at: http://blogs.lshtm.ac.uk/prucomm/files/2017/02/Review-of-QOF-21st-December-2016.pdf

[5] Forbes et al. The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review. Br J Gen Pract September 2017. http://bjgp.org/content/early/2017/09/25/bjgp17X693077

Other sources of quality indicators in primary care

Although the main quality indicator currently in use in primary care is still the QOF, other sources of quality metrics are:

- NHS England - GP Patient Survey (GPPS)[6]
- NHS England - Friends and family test[7]
- Public Health England - General Practice profiles[8]
- Care Quality Commission (CQC) - GP Insight model (quantitative and qualitative data)[9]
- RCGP Quality improvement initiative[10]
- Local quality and performance schemes (see separate section below)

Although there is no universally accepted definition of 'quality', it is commonly thought to be about making healthcare safe, effective, patient-centred, timely, efficient and equitable[11]. The main purposes of indicators of quality of care are peer review and professional quality improvement, supporting the public to make choices, and increasing accountability. They have also increasingly been used by commissioners as a performance management tool.

In addition to direct feedback to individual practices from patients, there are two nationally determined methods used in general practice to gauge the public's views about their healthcare, namely the GP Patient Survey and the Friends and family test. The GP Patient Survey is run by Ipsos MORI on behalf of NHS England and establishes how people feel about their practice, and provides a dataset relating to patient experience. The Friends and family test is a feedback tool that shows how patients view their GP and NHS services. Some of the results of these surveys are used to provide information to allow patients to compare practices (see NHS Choices). The Primary Care Web Tool is a confidential web tool allowing professionals to compare performance, including the General Practice Outcomes Standards (GPOS) and General Practice High Level Indicators.

The King's Fund, in its paper *Commissioning and contracting for integrated care*, identified the most common high level contractual outcomes, which include:

- patient experience and satisfaction with services
- early detection and intervention, to support people to recover and stay well
- support people to manage their condition and increase involvement in decision making
- improved patient outcomes (including survival rates)

In England, the Care Quality Commission (CQC) examines quality and uses 'Characteristics of Ratings' to determine the rating awarded to each of the five key question areas (safety, effectiveness, care, responsive to people's needs, well-led, and QOF outcomes are used to make judgements in some of these areas. The CQC also looks at how services are provided to people in specific population groups and a final overall rating for the practice is then aggregated from these five ratings.

[6] www.england.nhs.uk/statistics/statistical-work-areas/gp-patient-survey/
[7] www.england.nhs.uk/fft/
[8] https://fingertips.phe.org.uk/profile/general-practice
[9] www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices
[10] www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx
[11] The Institute of Medicine definition www.health.org.uk/publication/quality-improvement-made-simple

Payment for performance schemes and local variation

Payment for performance schemes refer to payment arrangements where providers are financially rewarded for doing specific tasks and achieving high performance or quality. In some cases, there has been a focus on clinical audits as the key performance measure, but there are several others, such as performance benchmarking, 'plan do study act' and process mapping. Performance benchmarking is where key performance indicators (KPIs) are used as part of a comparison process to raise awareness of required local and national performance targets and act as drivers for quality improvements.

One approach taken by some commissioners to measure quality and performance which can be linked to outcome measures is to use *local quality score cards* or *dashboards*. Most areas have continued with QOF and developed a quality dashboard to review performance of their health, care and support model, such as the Cornwall outcome framework[12], the Tower Hamlet Quality and Performance Framework[13], the Outcomes Based Commissioning contract (providers deliver services through "provider alliances") in Croydon[14] and the Bolton Quality Contract (extra funding in return of four quality standards)[15].

There are some areas, however, which have designed their own quality and outcome measures, e.g. Somerset, being the first locality to move away from QOF and to introduce their own Somerset Practice Quality Scheme (SPQS)[16] in 2014. Other areas with wholesale changes to QOF include the Aylesbury Primary Care Development Scheme[17] and the Dudley Quality Outcomes for Health[18], which have both focused on delivering specific aspects of care quality, directing practices towards patient centred care, through a gateway based on putting in place processes for Aylesbury and specific incentives in Dudley.

It is worth noting that in many of the examples of localised schemes additional funding to the allocated QOF has been invested by the local CCG and additional expectations are sometimes required of practices involved.

In Scotland, QOF was replaced in 2016 by a system of clusters, which requires a representative of each practice in an area to meet with their peers to discuss aspects of quality that they think are relevant. *Improving Together* offers an alternative route to continuously improve the quality of care that patients receive by facilitating strong, collaborative relationships across GP clusters and localities. The intention is to support learning, developing and improving together for the benefit of local communities. The NHS Circular outlines how clusters have been established and what they will be expected to do. Further details are available in the 2018 GMS Contract Framework in Scotland.

In Wales, QOF was temporarily suspended due to winter pressures both in 2017 and 2018. In recognition of these long-term and seasonal pressures in the system, a new approach was trialled in 2017/18 where the clinical QOF domain was divided into active and inactive QOF; the 18/19 agreement saw the further reduction of active clinical QOF to disease registers and flu indicators.

[12] www.cornwall.gov.uk/health-and-social-care/public-health-cornwall/joint-strategic-needs-assessment-jsna/outcome-frameworks/

[13] www.towerhamletsccg.nhs.uk/downloads/about/performance/Quality%20Framework%20for%202016-18.pdf

[14] www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx

[15] www.boltonccg.nhs.uk/media/1300/bolton-quality-contract-2015-16.pdf

[16] www.somersetlmc.co.uk/somersetpracticequalityscheme

[17] www.aylesburyvaleccg.nhs.uk/wp-content/uploads/2015/06/GPFV-plan-May-2017-FINAL.pdf

[18] www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2016/05/Dudley-CCG-Outcomes-for-Health-Indicators-Final.pdf?b3cb5a

Practices are expected to undertake peer review of the inactive indicators within meetings of their GP clusters, which is reflected in the cluster network domain.[19]

The cluster network domain (CND) was introduced in Wales in April 2014 to 'strengthen the ability of GP cluster networks as active agents for change in the delivery of local care'[20] by incentivising practices to engage with their work through the award of QOF points. Indicators required the development of practice development plans, assisting in development of cluster plans and annual reports, and to participate in a suite of nationally determined clinical priority pathways. However, feedback from practices suggested that the CND requirements were too prescriptive and did not allow clusters to mature and respond to local health priorities. Anecdotally, we heard that this focus on QOF achievement at cluster meetings disengaged non-medical members of the multidisciplinary cluster team. As a result, from 2018/19, the cluster network domain itself has been simplified to a single indicator requiring practices to engage with five cluster meetings during the year.

The long-term future of QOF in Wales will be considered as part of the Welsh GMS contract review in the lead up to April 2019, which includes a workstream which specifically considers the concept of 'quality' within general practice**.**

Future of QOF and quality indicators

In 2017, members of the GPC UK Conference of LMCs had an extensive debate about the future of QOF, following which they passed a motion which called for evolution of QOF rather than radical change. This was because QOF has shown quality improvements and provides good data, but there was also an acknowledgement of the potential consequences of radical change in England in the context of proposals to develop accountable care organisations which could remove QOF funding from practice contracts and require locally determined targets instead. It also called for continued funding for existing QOF indicators as well as new funding when they are introduced. The conference motion reads:

'That conference believes:
(i) that disinvestment from QOF is no longer desirable as QOF has shown quality improvements and provides good data
(ii) that evidence based chronic disease management is an important form of general practice funding and needs to be maintained
(iii) that GPC England should develop and agree with government a revised QOF which should be evidence based and clinically relevant
(iv) that indicators should have clinically appropriate timeframes for data collection.
That successful indicators should not be retired, and that new indicators should attract new funding when they are introduced.'

QOF review

As part of the 2017/18 GMS contract negotiations, it was agreed that there would be a review of QOF, led by NHS England. The review brought key stakeholders together to review current evidence on QOF and other incentive schemes, with the intention of delivering proposals on the future of QOF, such as keeping the current system, changing the current system or implementing a new system. The GPC has highlighted, and NHS England agrees, that a significant proportion of QOF

[19] www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-wales/contract-agreement-wales
[20] www.wales.nhs.uk/sites3/Documents/480/QOF%202014%20-%2015%204%20April%20v1%20%282%29.pdf

funding is core income for practices and is an essential resource used for the employment of practice staff, and is already committed to delivering important practice activities.

The review is expected to conclude in May 2018, and NHS England will then publish a report. Any changes to QOF that NHS England propose in the future following public discussion of the review's findings will be subject to negotiations as usual with GPC England.

Analysis and aims of GPC England

As seen above, there are a multitude of indicators available that purport to measure quality of care in general practice. Our aim is to ensure any contractual requirements support the delivery of high quality, holistic general practice services, using the best available evidence of effectiveness in a primary care context. As part of this process GPC would seek to identify problems with any proposed indicators or changes to the framework, in order to mitigate any adverse effects, both on practices and patients. Maintaining the stability of practices and enhancing the doctor/patient relationship and quality of care provision that QOF has enabled, are also important priorities.

In redesigning QOF, or implementing other systems to measure and support quality care, a number of potential adverse consequences and indicator problems need to be considered:

- The administration of the indicators may take up clinical or managerial time.
- For practices unable to achieve the set targets, perhaps because of factors beyond their control such as their particular patient demographic, there could be reputational difficulties, problems with staff morale, loss of trust between doctors and patients, falling list sizes resulting in decreased funding, and exacerbation of recruiting difficulties.
- For practices scoring well, and who are therefore perceived to be delivering better care than others, increased numbers of patients could put strain on services resulting in falling quality of care.
- Concentration on identified measures of performance can lead to less attention being paid to other areas, and a decrease in consultation time spent on the patient's perceived agenda.
- Few measures of performance outside QOF have exception reporting facilities. If the indicators at any stage have payments linked to them, either directly or indirectly, this facility is essential to meet ethical requirements and to reduce the risk of over-medicalisation and inappropriate treatment being provided, particularly to vulnerable patients and those with multi morbidity.
- For many indicators, the level achieved by a hypothetical perfect practice will not be at either extreme, but at some point in the middle of the threshold range, which is unknown. Even a practice achieving this level may be offering poor care at the level of the individual patient.
- Patients, in addition to suffering the consequences of the above points, may suffer adverse events if the pressure to treat to a quality target is not in their individual best interest.

Most intended measures of quality are in fact measures of difference, so are meaningless without an answer to the question, 'different to what?'. There are also limitations to the GP performance data – the main datasets used are incentive-based metrics (QOF) and prescribing data (may be difficult to determine performance). In the Nuffield Trust briefing, Transforming general practice: what are the levers for change?, it is argued that a minimum dataset for general practice is urgently required. Another problem highlighted is that data in primary care is patchy and not linked at national level.

LMC conference voted to retain and improve QOF but did not support any further disinvestment from the current system. Any changes to QOF therefore need to support sustainability and professionalism within general practice, and support practices in providing holistic patient-centred care, while providing quality assurances to commissioners and NHS England. Changes to the system should focus on reducing bureaucracies, remove the remaining small number of indicators that have limited evidence basis or clinical support, enable greater flexibility to be able to tailor care for patients with complex multi-morbidity and support practices in peer-review and quality improvements.

Given the current climate of high workload, it is understandable why the profession wants contractual and financial stability, and to retain the best of QOF, namely a limited set of clinically relevant, evidence based and professionally agreed indicators of good quality care. We believe appropriate changes could be introduced to provide a quick and safe solution to the cumbersome workload associated with some elements of QOF, allowing GPs to concentrate on holistic, patient-centred care rather than bureaucratic processes. The outcome of any changes should be to decrease unnecessary workload, maintain or improve the quality of care provided to patients, and maintain the current level of essential funding to practices and to general practice as a whole.

We would suggest that the criteria for which any proposed changes in QOF should be measured against are:

- Increased likelihood of improved patient outcomes
- Decreased likelihood of iatrogenic patient harms
- Stability of practice income/work
- Appropriate data collection
- Improved individualisation of care
- Acceptable to patients, patient groups, NHS organisations and politicians

Sources of information

Quality and Outcomes Framework guidance BMA

Quality and Outcomes Framework guidance NHS Employers

Review of the Quality and Outcomes Framework in England
University of Kent Policy Research Unit 2016

Indicators of quality of care in general practices in England (An independent review for the Secretary of State for Health) Health Foundation 2015

Quality improvement guide for general practice Royal College of General Practitioners 2015

How the NHS in England compares to other countries in publishing selected transparency metrics
Department of Health 2015

A guide to quality improvement methods Healthcare Quality Improvement Partnership 2015

Transforming general practice: what are the levers for change? Nuffield Trust 2015

Capitation: a potential new payment model to enable integrated care Monitor/NHS England 2014

Commissioning and contracting for integrated care King's Fund 2014

Quality improvement made simple Health Foundation 2013

Care Quality Commission (CQC)

NHS Digital QOF business rules and data collection

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Appendix 1 – Annual QOF changes England

Year	Main QOF contract changes: England
2004/05	First year of nGMS contract and QOF
2005/06	Second agreed year of nGMS with QOF point value increase
2006/07	166 QOF points redistributed including removal of 50 access points > 1000 points. PBC, Access, C+B and IT DESs introduced
2007/08	Withdrawal from negotiations
2008/09	58 QOF points used for 48hour access target measured though national patient survey.
2009/10	Reallocation of 72 points and changes to QOF prevalence, removing square rooting.
2010/11	Minimal change
2011/12	QOF 48hr access targets removed, QP indicators introduced
2012/13	QOF 2 new domains and QP A+E introduced
2013/14	Imposed contract changes: QOF thresholds and indicator changes. Timing reduced from 15 to 12 months
2014/15	QOF reduced to 559: 238 points to global sum, 100 QP points + risk profiling DES used to create admission avoidance DES
2015/16	QOF: no new indicators, amend AF & dementia, end CKD, MI
2016/17	No QOF changes
2017/18	No QOF changes
2018/19	No QOF changes

Appendix 2- Annual QOF changes Scotland

Year	Main QOF contract changes: Scotland
2004/05	First year of nGMS contract and QOF.
2005/06	Second agreed year of nGMS with QOF point value increase.
2006/07	Amendments made to 9 clinical indicator groups, addition of 8 clinical areas and removal of 50 access points.
2007/08	Minimal change.
2008/09	58 QOF points used for 48hour access target measured though national patient survey.
2009/10	Reallocation of 72 points and changes to QOF prevalence, removing square rooting.
2010/11	Minimal change.
2011/12	Reallocation of 92 points, QOF 48hr access targets removed, QP indicators introduced.
2012/13	Reallocation of 71 points, QOF 2 new domains and QP A+E introduced.
2013/14	Transferral of 77 points from QOF to the Global Sum, leaving 923 QOF points available. Introduction of 3 new domains.
2014/15	Transferral of 259 points from QOF to Global Sum, leaving 659 QOF points available.
2015/16	Minimal change.
2016/17	Transferral of remaining 659 QOF points to Global Sum, meaning QOF no longer exists in Scotland.
2017/18	-
2018/19	-

More information on the changes can be found here: www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/Revisions-To-QOF.asp

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Appendix 3 – Annual QOF changes Wales

Year	Main QOF contract changes: Wales
2004/05	First year of nGMS contract and QOF
2005/06	Second agreed year of nGMS with QOF point value increase
2006/07	166 QOF points redistributed including removal of 50 access points > 1000 points. Wales-only DES for Access, Learning Disabilities, Mental Health and IM&T DES (focused on data quality)
2007/08	Withdrawal from negotiations
2008/09	58 QOF points used for 48hr access target measured though national patient survey. Health Boards 'must offer' at least one enhanced service (extended hours, asylum seekers, care homes, diabetes)
2009/10	Reallocation of 72 points and changes to QOF prevalence, removing square rooting. Enhanced services menu wording changed to 'may offer'
2010/11	Minimal change
2011/12	QOF 48hr access targets removed, QP indicators introduced
2012/13	QOF 2 new domains and QP A+E introduced
2013/14	Direct negotiation with Welsh Government. Upper payment thresholds increased due to high achievement. A&E attendance indicators discontinued and value transferred to global sum (31 points); indicators in organisational domain (78.5 pts) discontinued to fund new indicators.
2014/15	Reduction of QOF to 669 points: retirement of patient exp domain and indicators within clinical domain. 300 points transferred to global sum. Cluster network domain (CND) introduced as 'local service development domain' worth 160 points to incentivise practices to work together.
2015/16	Two-year agreement on Welsh GMS contract. Reduction of QOF to 567 points (102 point value into Global sum). Adjustment of indicator value, two new indicators on AF; new Flu indicators. continuation of cluster development domain (remaining at 160 points)
2016/17	No change. QOF suspension January – March 2017 in light of winter pressures. Flu + CND remain.
2017/18	Clinical domain split into active (202 points) & inactive (165 points) indicators. Inactive indicators not measured and paid at 16/17 achievement, to be peer reviewed within clusters. CND expanded to 200 points, reconfigured to include new national priority areas and to reward completion of sustainability framework and information governance toolkits. QOF suspension repeated January – March 2018. Flu + CND remain.
2018/19	Clinical domain reduced to two flu indicators and disease registers only (53 points). CND reconfigured to one indicator mandating attendance at 5 cluster meetings (worth 200 points). Pending review of long-term future of QOF, all other indicators inactive and practices will receive payment based on 16/17 achievement levels.