GIG CYMRU NHS WALES

Perfformiad a Gwella
Performance and Improvement

Quality Outcomes Framework

Learning Report

September 2025

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Introduction

Quality in healthcare in NHS Wales is underpinned by the Duty of Quality, which came into effect in April 2023 as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Duty of Quality applies to all staff (clinical and non-clinical roles) in NHS Wales as well as to Welsh Ministers in their health-related functions. The Duty includes 12 Health and Care Quality Standards providing a structure on which to implement the Duty of Quality whether at national policy level or by service providers.

To achieve its aim of ensuring a system-wide focus on quality, the Duty requires NHS Wales organisations to establish effective Quality Management Systems (QMS) that focus on learning and are driven by their Boards. NHS Wales Performance and Improvement published a report sharing learning and insights to date on developing a QMS within NHS Wales. One of the key findings focused on the importance of system-level measures for quality to provide internal and external assurance and identify and monitor organisational improvements. The report highlighted evidence-based research and experience which shows that high-performing health systems use system-level safety and quality measures to:

- Foster a culture of quality and safety, grounded in predictability and reliability.
- Enable organisations to learn and direct their quality and safety improvements at 'whole-system level'
- Shift from audit-based approaches to time-series data, using data for learning rather than judgment.
- Provide assurance to boards and external stakeholders that population needs are being met.
- Guide improvement and inform learning.

Additionally, healthcare services in Wales are guided by the strategy A Healthier Wales (2018) and the subsequent publications of A Healthier Wales: our Plan for Health and Social Care (2024) and Improving Performance Together: Priority Delivery Actions for Better Health and Care 2025-2026 (2025). These support the drive to develop measures to ensure improvement activity is focussed on outcomes. Alongside this, two existing frameworks support and guide the NHS in Wales:

- NHS Wales Planning Framework 2025 to 2028 – outlines the Cabinet Secretary's strategic priorities and delivery expectations.

- NHS Wales Performance Framework 2025-2026 – outlines performance measures which reflect the strategic priorities in the Planning Framework along with a set of enabling measures.

In Summer 2024, the Welsh Government requested the development of a national suite of outcome measures aligned with the Health and Care Quality Standards 2023. While there is a Public Health Outcomes Framework for Wales, there is no national Quality Outcomes Framework (QOF) for the healthcare system. Data is central to an effective QMS and a QOF serves as a key enabler to demonstrate whether care is being delivered in line with national standards. Outcome measures provide both local and national assurance, and identify and monitor areas for improvement, with operational / process measures throughout the organisation cascading from the QOF through to the point of care delivery.

The purpose of the QOF is to focus on improving quality, experience and outcomes for service users – aligned to the definition of quality in the Duty of Quality: 'continuously, reliably, and sustainably meeting the needs of the population that we serve'. It focuses on harm avoidance with a lens on the greatest harms to enable behaviour change and to support benchmarking within Wales and outside.

Development of the QOF was based on the following design principles, adapted from IHI's Whole System Measures 2.0 for the Welsh context (principally the alignment and the adaptability principles).

- **Balance**: The set of measures will address the six quality domains of the Quality Standards in phase 1 and prescriptive measures that address the six enabler domains will form phase 2. In addition, the measure set should balance the current need of the system and the possible future direction of the system. The set of measures will be multi-professional, multi-system and multi-purpose.

- **Prudent**: To maintain a systems perspective, a small set of measures is required – no more than 20. If there are too few measures, significant dimensions will be overlooked; if there are too many, the measures cease to have targeted value in providing strategic guidance to system leaders.

- **Alignment**: The set of measures should build on learning locally, nationally and internationally and align to the Quality Standards. They will be a combination of existing and aspirational measures, and where appropriate, proxy measures will be used initially whilst aspirational measures are developed. The measures should support both the Duty of Quality and Duty of Candour as well as the national strategic programme and networks of the NHS Wales Performance and Improvement.

- **Immediate usefulness**: The measures need to be useful to health system leaders and boards to drive improvement in quality outcomes, and reduce avoidable harm and unwarranted variation as part of a quality management system. The measures will offer the opportunity for benchmarking. The measures, as a set, will combine leading and lagging indicators to ensure they focus on both the prevention and detection of harm. The set of measures must be captured and reported using real-time data for improvement.

- **Co-production**: To achieve the most robust set of measures, input will be leveraged from health system multi-professional clinical leaders, quality improvement professionals, measurement experts, national advisors, and experts in patient- and family-centred care.

- **Adaptability**: The phase 1 set of measures that map to the Quality domains (STEEEP) will be prescriptive but allow for local flexibility. They will also include high level measures that are presently of high importance (and may be population or service specific) and will therefore need to be periodically revisited to ensure the measures remain viable and relevant. Over time, other measures may need to come to the forefront. Prescriptive phase 1 measures will be introduced in shadow form for year 1, with organisations determining their own evidence against the six enabler domains. Phase 2 will co-produce the prescriptive measures for the enabler domains.

A guiding position was agreed of stratification of data by age, gender and ethnicity wherever possible.

Part 1: Methods used to develop the Quality Outcomes Framework

Existing research and existing knowledge influenced our method for developing the QOF, including previous efforts in Wales to develop system-level measures in 2007-2008.

The QOF is aligned to the Health and Care Quality Standards (fig. 1), with measures being developed against each standard. The first phase of development focused on the six domains of quality, also known as STEEEP – Safe, Timely, Effective, Efficient, Equitable, Person centred.

Figure 1: Health and Care Quality Standards

Defining the areas of measurement for the QOF

It was recognised that a vast body of research exists on outcome measures therefore scoping focused on review and analysis of high-performing national and international healthcare systems along with selected key white papers and frameworks including:

- Aneurin Bevan University Health Board, UK (organisational QOF in development)
- North East and North Cumbria Integrated Care Board, UK
- Leeds Teaching Hospitals NHS Trust, UK
- Surrey & Sussex NHS Trust, UK
- East London NHS Foundation Trust, UK
- NHS England 2023/24 priorities, UK
- Healthcare Improvement Scotland: Indicators about the quality of care (under review), UK

- Jönköping County Council, Sweden
- Greater Baltimore Medical Center, USA
- Cincinnati Children's, USA
- System Level Measures (QuIP, Wales, WG, 2006)
- IHI Whole System Measures (2007)
- IHI Whole System Measures 2.0 (2016)
- Centers for Medicare & Medicaid Services: Hospital measures
- Agency for Healthcare Research and Quality (AHRQ) Quality Indicators

This revealed a wide range of approaches. Some organisations such as Greater Baltimore Medical Centre and Jönköping County Council identified around 10 key measures, while others like North East and North Cumbria Integrated Care Board and Leeds Teaching Hospitals NHS Trust identified over 30 measures. While our scoping covered a mix of healthcare settings and frameworks, some key themes emerged such as access, patient and service user experience, incidents, mortality and workforce along with disease-specific measures particularly around cancer.

These themes influenced the development of the QOF, along with a review of existing measurement frameworks in Wales – NHS Wales Planning Framework, NHS Wales Performance Framework and Public Health Outcomes Framework. We were very aware of the design principle of Alignment and the aim to include a combination of existing and aspirational measures.

In addition, it was recognised throughout the development of the QOF that it would be an iterative process, continually developing and reviewing measures and adapting the QOF accordingly.

By reviewing a number of existing frameworks in the UK and internationally, in addition to existing measurement frameworks in Wales, it became clear that multiple measures could fit within the QOF. To aid co-design of the QOF, NHS Wales Performance and Improvement established both a QOF Advisory Group and a national QOF Stakeholder Group.

The QOF Advisory Group was a small group which consisted of key representatives from the Medical Director, Nurse Director and Therapies Director Peer Groups and advised on content development.

The QOF Stakeholder Group was a larger group which included representatives from a range of professional groups and national organisations in Wales including:

- Executive Medical Directors Peer Group
- Executive Directors of Nursing Peer Group
- Directors of Therapies Peer Group
- Chief Operating Officer Peer Group
- Directors of Planning & Performance Peer Group
- Clinical Advisory Group
- National organisations including:
    - Public Health Wales
    - Digital Health and Care Wales
    - NHS Wales Shared Services
    - Health Education and Improvement Wales
    - Joint Commissioning Committee
    - Llais (representing the patient and public voice)
- NHS Wales Performance and Improvement
- Welsh Government

This resulted in a group of approximately 35 participants.

Both groups were supported by a QOF Management Group with members selected from NHS Wales Performance and Improvement to lead the QOF project. The Management Group had final accountability and responsibility for developing the QOF, considering all the feedback from across the Welsh healthcare system.

Method for developing the QOF

The initial aim was to follow the modified Delphi method used by IHI's Whole System Measures 2.0 to develop the QOF. This method was used for the first meeting of the Stakeholder Group when it met to review the initial draft of the QOF which consisted of one concept and a selected areas of measurement for each of the six domains of quality (STEEEP) in the Health and Care Quality Standards. The Stakeholder Group used small breakout groups to discuss the proposed concepts and areas of measurement. Members then voted on each concept and ranked the proposed areas of measures.

After collating feedback from the breakout groups, and informed by wider group discussion, it became clear that the idea of a concept for each domain was unnecessary. The structure of the QOF was redeveloped and agreed as:

Quality Standard ⟹ Areas of measurement ⟹ Individual measures

Further feedback from the Stakeholder Group and discussion with the Advisory Group suggested that the voting process was not considered suitable. It was agreed that members of the Stakeholder Group needed to have further discussions with their colleagues and other professional groups and individuals who could contribute to the QOF and this did not lend itself to a restricted voting process.

Following the first Stakeholder Group workshop, and discussion with the Advisory Group, a small project technical group was formed to begin scoping potential measures for the areas of measurement collated from existing frameworks in Wales and other organisations using themes identified during scoping. A high-level set of criteria was used to initially sift the measures (see Appendix 1).

The revised draft of the QOF included draft areas of measurement for each domain of quality (STEEEP) and examples of potential measures. It was shared with the Advisory Group and a further Stakeholder Group workshop was held to review and further iterate the draft.

The aim of the second Stakeholder Group workshop was to gain agreement on the draft areas of measurement. Small breakout groups discussed the draft focusing on what works well, is there anything missing and should anything be removed. Discussion within the groups revealed that more time was needed to gain consensus on the areas of measurement before potential measures could be considered. This is where our learning to 'go slow to go fast' was gained and adopted as a fundamental ethos for our way of working going forward.

Scoping of potential measures by the project technical group continued and the Advisory Group helped to refine the proposed areas of measurement, ensuring the framework was co-produced, relevant, and supported across the system.

Further minor iterations of the draft QOF continued and engagement with expert groups began identifying some potential individual measures. It became clear that there were gaps in availability of measures for some areas of measurement and that a full set of individual measures would not be identified by the end of phase one. This added weight to the QOF being an evolving document firmly positioned in the reality of the existing healthcare system. It also enabled the inclusion of some ambitious outcome measures which the system would work towards developing in the long term.

The QOF measures are also linked to the national improvement programme, Safe Care Partnership (SCP). SCP phase 2 formally launched in May 2024 and aims to continuously, reliably and sustainably improve the quality, safety and outcomes of care for the people of Wales. Four national safety priority workstreams were identified, three of which are leading the development of outcomes measures for areas of measurement aligned to the Safe standard: acute deterioration, deconditioning and infections.

The QOF for the six domains of quality can be found in Appendices 2 and 3. A summary of the process and method can be found in Appendix 4.

Limitations of the methodology

We recognise that the methodology used to develop the QOF was rooted in a realistic assessment of the healthcare system in Wales and adapted for that context. Similar to Whole Systems Measures 2.0, limitations around potential bias in measures, potential bias in participants, potential for undue influence and need for further development of measure specification were all acknowledged.

However, we do not believe that this should inhibit the ongoing work to further develop, iterate, refine and implement the QOF. These measures are seen as a good representation of the scope and scale of the Welsh healthcare system and all support the definition of quality to 'continuously, reliably, and sustainably meeting the needs of the population that we serve'. The QOF is both practical and ambitious towards the aim of quality healthcare services.

Part 2: Implementation of the QOF

Expectations of use

Initial milestones for implementation of the QOF include:

- **October 2025 - 13 measures launched**

These initial QOF measures will be supported by longitudinal data and are expected to be included in Board-level reporting from this date. Their use will support assurance of service quality and help identify areas for strategic improvement. While these measures already exist within other frameworks, their inclusion in the QOF will provide a consolidated view against the Quality Standards.

- **October 2025 – National Assurance Integration**

QOF measures will form part of national quality assurance oversight across organisations and the health system.

For organisations and teams, expectations of use can be summarised as follows:

1. **Welsh Government** - include the QOF in their performance and assurance meetings with NHS Wales organisations, using the opportunity to drive the focus towards improving quality and outcomes for the population.

2. **NHS Wales Chief Executives and Executive Teams** - begin developing their own organisational QOF, based on the national QOF, with cascading measures to assure their Board of the quality of services. Use the QOF to focus conversations towards identifying strategic improvement efforts, all as part of an organisational QMS. Understand that the QOF is the minimum set of measures they should consider; which other measures from their planning and performance data could they review in addition to key measures from lower tiers of the organisation? Organisations are encouraged to use QOF measures to inform and support 'always on' reporting and summarise their progress with the QOF in their Annual Quality Report (requirement of the Duty of Quality).

3. **NHS Wales Organisational Boards** – use the QOF to inform their questions of their Executive Teams exploring organisational quality.

Digitisation of the QOF

As part of the development and delivery of the QOF, we established a digital enablement workstream to oversee and manage the digitisation of the QOF measures. We agreed early in the development of the QOF that the national quality and safety signalling system known as Beacon is the best opportunity for digitisation of the QOF measures. Beacon is a well-established quality and safety dashboard which is extensively used across the healthcare system, including board reporting within health boards and trusts, at Integrated Quality, Planning and Delivery (IQPD) meetings and by NHS Wales Performance and Improvement to provide quality and safety assurance across the system. It will provide visibility of QOF measures alongside a wider range of specialty-specific metrics.

We undertook a scoping exercise to identify the acquisition, data standards and data flow requirements for each of the QOF measures. We are able to schedule the digitisation of each QOF measure based on:

- Complexity of the acquisition process
- Data standard requirements
- Data flow requirements (e.g. manual versus automated)

As a result, the QOF measures have been clustered into three key groups:

1. Those that are already in existing dashboards data sets across the healthcare system and can be easily acquired, have gone through data

standards processes and have an automated data flow – 14 measures identified in this category.
2. Those that are more complex to acquire or may need to go through data standards processes prior to being published in Beacon – five measures identified in this category.
3. Those measures that are aspirational and will require significant work to establish them – seven measures identified in this category.

The first 13 measures have been acquired, developed for inclusion in Beacon and are scheduled to go live on 1 Oct 2025 (see appendix 3).

To accommodate the QOF metrics into Beacon, some background restructuring of the Beacon dashboards has taken place. The restructure provides an opportunity for the triangulation of QOF measures with the wider quality and safety data held within the Beacon signalling system.

We are scheduled to start work on the second group of measures in October 2025 once the first group of measures has gone live.

Part 3: Challenges and learning so far

- Design principles are essential but the most challenging to uphold was ensuring that 'measures already exist'. Accept that depending on the maturity of the system, some measures do not exist and will need to be developed with the right people.
- It became clear that equity was not just a standard in its own right but also became a guiding principle across all measures. It was agreed that as a default all data would be stratified by age, gender and ethnicity wherever possible.
- Accept that many professionals will want to see their specialty reflected in a national QOF – while some specialties which are a specific priority for NHS Wales are included, the QOF is primarily aimed at gaining a broad understanding of the quality of the whole system. Cascading measures within organisations can then focus more directly on specific specialties.
- Engagement and co-design of the areas of measurement with stakeholders was truly valuable but requires sufficient time and commitment to ensure true representation. Linked to this, collaboration with specialist expert groups is crucial for identifying appropriate indicators.

- It was acknowledged that some measures would need to align to national safety improvement priorities that are of immediate concern and recognised that these will change over time. For Wales, the QOF has to be iterative while individual measures are developed and we accept it will need to be continually reviewed and iterated to ensure its relevance and utility.
- Developing a QOF is not a standard, linear process – adopting the ethos of 'go slower to go faster' proved to be a valuable mindset. In hindsight, the initial timeline for development and completion of the QOF was unrealistic, so be prepared for a long-term, evolving process with learning along the way.
- Positioning the QOF as part of the national effort to improve quality and develop a QMS helped gain traction and alignment. The opportunity to align QOF measures with national areas of strategic important has enhanced the value of the QOF.
- Working collectively as NHS Wales Performance and Improvement and being able to draw internally on the dual perspectives of improvement and assurance has strengthened development of the QOF.
- In hindsight, we would have benefited from starting to scope the measures earlier – focusing on the availability of potential existing measures and ascertaining if those which do not exist can be sourced from existing data collected.

We recognised that public involvement was lacking in initial development of the QOF and should be addressed in future phases. To maximise impact, it would be beneficial to actively encourage stakeholders to engage both within their organisations and with the wider public.

Conclusion

As NHS Wales continues to operate within an ever-complex system, the Quality Outcomes Framework will support a more consistent, system-wide approach to quality. Development of the QOF has been informed by research and learning from high-performing healthcare systems both nationally and internationally. It is designed to provide a clear and consistent picture, both locally and nationally, to support the identification, monitoring, and learning of quality and safety improvement priorities, as part of a Quality Management System (QMS) approach.

We believe that using these measures will enable system-wide improvement and lead to better health and improved experience of care for the people of Wales.

Appendix 1: Technical Group – high-level set of criteria for initial sift:

The Technical Group reviewed the areas of measurement and proposed measures using an initial high-level set of criteria:

1. Does the area of measure meet the QSOF Design Principles?
2. Does it support the definition of the Quality Domain?
3. Is the measure attributable to the NHS provider?
4. Will the measure have a significant impact on patient's health?
5. Is this a high-level system level measure?
6. Is background info available for this measure?

The selected measures were then reviewed using principles developed by the Public Policy Institute for Wales (2015) (used to determine the indicators for the Well-Being of Future Generations Act and the Public Health Outcomes Framework). It was also noted if the potential measures are reported in an existing framework.

Appendix 2: Quality Outcomes Framework – Areas of Measurement

Quality Standard	Area of Measurement
Safe	Mortality
	Patient safety incidents
	Infections
	Deconditioning
	Deterioration
	Safeguarding
Timely	Access to care
	Transitions of care
Effective	Population health
	Early years
	Patient-reported outcome measures
Efficient	Advanced/future care planning
	Sustainability
	Early intervention
Equitable	Healthy life expectancy
	Equity of access
	Equitable communication
Person-centred	Staff experience and engagement
	Experience of care
	Patients as partners

Appendix 3: Quality Outcomes Framework Phase 1 Measures (from 1 October 2025)

Quality Standard	Area of measurement	Measure name	Operational definition	Data collection plan
Safe	**Mortality**	**RAMI (Risk Adjusted Mortality Index) 2023**	Numerator: Total deaths for included spells Denominator: Total expected deaths for included spells Exclusions: Any episode in the spell with a COVID-19 diagnosis of U07.1 or U07.2 in a primary or secondary position, those spells are excluded from the model Type: Index Orientation: Lower is better	Where the data is stored: NDAP GCP (National Data Analytics Platform - Google Cloud Platform) Who owns the data: CHKS (Central Health Knowledge System) How the data is collected: CHKS API Frequency: Refreshed monthly Duration: Ongoing Exclusions: None
Safe	**Mortality**	**Crude mortality**	Numerator: Spells with Discharge Method=4 (death) Denominator: Total spells excluding well babies Exclusions: None Type: Percentage Orientation: Lower is better	Where the data is stored: NDAP GCP Who owns the data: CHKS How the data is collected: CHKS API Frequency: Refreshed monthly Duration: Ongoing Exclusions: None

Safe	**Safeguarding**	**Safeguarding Adults – Level 1 training**	Numerator: Number of staff who have completed the 'Safeguarding Adults - L1 training' competency within the Core Skills and Training Framework Denominator: Total staff (includes all staff groups) Exclusions: None Type: Percentage Orientation: Higher is better	Where the data is stored: NDAP GCP Who owns the data: HEIW How the data is collected: Extracted from the NHS Wales WFP Dashboard Frequency: Monthly Duration: Ongoing Exclusions: None
Safe	**Patient Safety**	**Never Events reported to NHS Wales Performance and Improvement**	Numerator: Number of Never Event classification National Reportable Incidents (NRIs) reported to NHS Wales Performance and Improvement Denominator: NA Exclusions: Rejected/down-graded NRIs Type: Volume Orientation: Lower is better	Where the data is stored: RL Datix Who owns the data: NHS Performance and Improvement How the data is collected: Extracted from the RL Datix Incident Reporting tool though the 'all listing' report Frequency: Monthly Duration: Ongoing Exclusions: Rejected/down-graded NRIs

Safe	**Deconditioning**	**Percentage of discharges on each D2RA pathway 0, 1, 2, 3 or no pathway allocated**	Numerator: 1- Number of patients discharged in a whole calendar month 2- All adults 18 and above (on admission) 3- Inpatients (Patient classification '1' (ordinary admission)with a LOS > = 1 day i.e. where the patient has remained in hospital until midnight the day following admission) 4- Admission method (Elective or Emergency) Split: • Split by D2RA Pathway on Discharge: Pathway '0', Pathway '1', Pathway '2', Pathway '3' or 'No Pathway Allocated'. Denominator: Number of Discharges in a whole calendar month (per criteria set in Numerator). Exclusions: Day case admission, regular day admissions, regular night admission, women using delivery facilities only and not applicable (patient classification 2, 3, 4, 5 and 8), Admitting Episode of the Hospital	Where the data is stored: DTIV Shared Drive (to be moved to NDAP GCP ETA Sept-25) Who owns the data: Six Goals for Urgent and Emergency Care National Programme How the data is collected: Health Board D2RA submission return forms Frequency: Monthly Duration: Ongoing Exclusions: Velindre does not submit

			Provider spell where Treatment Function Codes in MH, Obs, Gynae, Maternity (CODES that start with 7 or 5), and patients that have died. Type: Percentage	
Safe	**Infections**	**Antibiotic prescribing rates - Antibacterial items per 1,000 STAR-PUs**	Numerator: All antibacterial items (BNF Code = 0501, BNF Name = 'Antibacterial drugs' Denominator: 1,000 specific therapeutic group age–sex related prescribing units (STAR-PUs) Exclusions: None Type: Rate Orientation: Lower is better	Where the data is stored: NDAP GCP Who owns the data: NWSSP How the data is collected: Server for Prescribing Information Reporting and Analysis (SPIRA)– NPI Reporting Tool (Tableau extract download) Frequency: Quarterly Duration: Ongoing Exclusions: None
Timely	**Access to care**	**12-month improvement trend in percentage of patients starting first definitive cancer treatment within 62**	Numerator: The number of patients who start their first definitive cancer treatment within 62 days of the date of suspicion of cancer, regardless of how they were referred (e.g., GP referral, screening, consultant upgrade)	Where the data is stored: NDAP GCP Who owns the data: DTIV/DHCW but same data is published through StatsWales Frequency: Monthly

		days from point of suspicion (regardless of the referral route), building towards national target of 80% by 31 March 2026	Denominator: The total number of patients who start their first definitive cancer treatment, where the clock started at the point of suspicion of cancer, regardless of referral route Exclusions: None Type: Percentage Orientation: Higher is better	Duration: Ongoing Exclusions: None
Timely	**Access to care**	**Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date**	Numerator: The number of ophthalmology R1 (R1 = risk of irreversible harm or significant patient adverse outcome) appointments attended within their clinical target date or within 25% beyond their clinical target date Denominator: The total number of ophthalmology R1 appointments attended Exclusions: None Type: Percentage Orientation: Higher is better	Where the data is stored: Objective Connect Who owns the data: Welsh Government, General Ophthalmic Services (WGOS) How the data is collected: Eye Care Outcome monthly submission proforma by Welsh Government extracted through excel Frequency: Refreshed monthly Duration: Ongoing Exclusions: None

Effective	**Population health**	**Percentage of patients (aged 17 years and over) with diabetes who received all eight NICE recommended care processes**	Numerator: Registered diabetes patients (type 1 and 2) 17 years or older who have received all eight NICE recommended care processes (1. HbA1c measurement, 2. Blood pressure measurement, 3. Cholesterol measurement, 4. Serum creatinine measurement, 5. Urine albumin-to-creatinine ratio, 6. Foot examination, 7. Body mass index measurement, 8. Smoking status recording) within the last 12 months Denominator: Total registered diabetes patients (type 1 and 2) aged 17 years or older Exclusions: None Type: Percentage Orientation: Higher is better	Where the data is stored: Primary Care information Portal Who owns the data: DHCW How the data is collected: Primary Care information Portal - All Wales Diabetes Module Frequency: Refreshed monthly Duration: Ongoing Exclusions: None
Efficient	**Sustainability**	**Agency spend as a percentage of total pay bill**	Numerator: Agency spend as the total cost of Agency staff (Invoiced payment) Denominator: Total pay bill as all Pay elements including Contracted cost, Bank cost and Agency Exclusions: None Type: Percentage Orientation: Lower is better	Where the data is stored: NDAP GCP Who owns the data: HEIW How the data is collected: Extracted from the NHS Wales WFP Dashboard Frequency: Monthly Duration: Ongoing Exclusions: None

Equitable	**Communication**	**People's Experience Survey - Were you able to communicate in your preferred language? (%)**	Numerator: Total 'Always' or 'Usually' response answers to question 'Were you able to communicate in your preferred language?' Denominator: Total response answers to question 'Were you able to communicate in your preferred language?' Exclusions: None Type: Percentage Orientation: Higher is better	Where the data is stored: NDAP GCP Who owns the data: CIVICA How the data is collected: CIVICA API Frequency: Monthly Duration: Ongoing Exclusions: None
Person-centred	**Experience of care**	**People's Experience Survey – how would you rate your overall experience?**	Numerator: Total response scores to question 'Using a weighted scale of 0 – 10 where 0 is very poor and 10 is very good, how would you rate your overall experience?' People's Experience Survey Denominator: Total response answers to question 'Using a weighted scale of 0 – 10 where 0 is very poor and 10 is very good, how would you rate your overall experience?' from People's Experience Survey Exclusions: None Type: Average score Orientation: Higher is better	Where the data is stored: NDAP GCP Who owns the data: CIVICA How the data is collected: CIVICA API Frequency: Monthly Duration: Ongoing Exclusions: None

Person-centred	**Patients as Partners**	**People Experience Survey – Were you involved as much as you wanted to be in decisions about your care?**	Numerator: Total 'Always' or 'Usually' response answers to question 'Were you involved as much as you wanted to be in decisions about your care?' Denominator: Total response answers to question 'Were you involved as much as you wanted to be in decisions about your care?' Exclusions: None Type: Percentage Orientation: Higher is better	Where the data is stored: NDAP GCP Who owns the data: CIVICA How the data is collected: CIVICA API Frequency: Monthly Duration: Ongoing Exclusions: None

Appendix 4: Step-by-Step Process for Developing a QOF

1. **Review Existing Research and Knowledge**
    - Consider previous efforts like Wales's 2007-2008 system-level measures.
    - Align QOF with Health and Care Quality Standards, focusing on six STEEEP domains (Safe, Timely, Effective, Efficient, Equitable, Person-centred).

2. **Define Measurement Areas**
    - Scope existing outcome measures from high-performing national and international healthcare systems.
    - Analyse key frameworks and white papers from relevant organisations.
    - Conduct thematic analysis.

3. **Review Relevant Welsh Frameworks**
    - Include NHS Wales Planning, Performance, and Public Health Outcomes Frameworks.
    - Ensure alignment and include both existing and aspirational measures.

4. **Establish Governance Groups**
    - Form a QOF Advisory Group with key clinical directors to advise on content.
    - Form a QOF Stakeholder Group (~35 members) from diverse professional and national organisations to co-design the QOF. Or within an organisation, a QOF Stakeholder Group from diverse directorates, departments and stakeholders.
    - Create a QOF Management Group with accountability for final development.

5. **Initial Development Using Modified Delphi Method**
    - Present initial draft.
    - Stakeholder Group discusses concepts in breakout groups and votes on measures.

6. **Iterative Feedback and Redesign**
    - Stakeholder members consult colleagues for broader input.
    - Form a small technical project group to scope and sift potential measures using defined criteria.
    - Share revised drafts with Advisory and Stakeholder Groups for further review.

7. **Second Stakeholder Workshop**
    - Focus on agreeing areas of measurement rather than measures.

- Identify areas where more time needed to build consensus (utilise the "go slow to go fast" approach).

8. **Ongoing Refinement**
    - Project technical group continues to scope measures.
    - Advisory Group refines areas ensuring relevance and co-production.
    - Recognise gaps in available measures; accept QOF as an evolving framework including aspirational targets.
    - Link with National Improvement Programs.

9. **Finalise and Document**
    - Appendices provide the detailed QOF framework, measures, and process summary.