INFORMATION
ANALYSIS
DIRECTORATE

Quality and Outcomes Framework

2018-19

Quality and Outcomes Framework Statistics for Northern Ireland 2018/19

This bulletin summarises the fifteenth year of Quality and Outcomes Framework (QOF) achievement data from general practices, relating to the period from April 2018 to March 2019. There were no changes to the QOF in this period.

All data used in this bulletin is from the Payment Calculation and Analysis System (PCAS), a Northern Ireland (NI) IT system used by general practices to support the QOF payment process and is dated 1st April 2019.

Summary

- The average total QOF achievement of practices was 539.0 (98.5%), from a maximum available QOF total of 547.

- Of the clinical registers collected for QOF that measure actual disease prevalence, the highest prevalence was for Hypertension (13.79%) and the lowest was for Osteoporosis (0.33%).

- Across the domains, the average points achieved were:
    - Clinical: 374.1 (98.4%)
    - Public Health: 33.5 (95.6%)
    - Public Health (Additional Services): 13.6 (97.1%)
    - Patient Experience: 18.0 (100.0%)
    - Records & Systems: 99.9 (99.9%)

- Achievement data was received from 330 practices and data is reported on 323 practices[1]. The 323 practices received a total of £30.43 million, with an average award of £94,201 per practice.

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[1] An agreement regarding QOF achievement was in place between the HSCB and 7 practices in relation to issues which the HSCB recognised would impact on QOF achievement in 2018/19. These issues related to practice closures, dispersals and mergers and the subsequent impact on practices. These 7 practices are excluded from all analysis.

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1. Introduction

The figures in this bulletin are derived from PCAS, a Northern Ireland system that uses data from general practices to calculate individual practice's QOF achievement and payments. A full set of QOF data tables and a factsheet giving a full explanation of QOF can be found on the Department's website (www.health-ni.gov.uk) via the Statistics section provided by the Information and Analysis Directorate (IAD).

The 2018/19 QOF tables published by the Department use practice list sizes supplied to PCAS from the National Health Applications and Infrastructure Services (NHAIS), the national practice payments system, as at 1st January 2019; a more familiar term may be the 'Exeter Payment System'. These are the figures used in PCAS for the list size adjustments in final QOF payment calculations.

Data submitted on 31st March 2019 formed the basis for figures for the complete financial year April 2018 to March 2019. Any adjustments made by the Health and Social Care Board in the period April to June 2019 are included. This publication uses the most recent figures for each practice as at 30 June 2019 and reports on data both at a practice level and at Local Commissioning Group (LCG) level.

Patient Exceptions

Practices may exclude specific patients from data collected to calculate QOF achievement within clinical areas. The GMS Contract sets out valid exception criteria (e.g. newly registered patients, patients newly diagnosed with a condition, patients unsuitable for treatment & informed dissent). The Department publishes information on 2018/19 QOF exception reporting in a separate bulletin.

2. Disease Prevalence in the Quality & Outcomes Framework

An important feature of QOF is the establishment of registers from which the prevalence of various conditions can be calculated. There are a total of 22 individual domains within QOF, of which 15 can be used to calculate the prevalence of conditions within the population. There are no disease registers for the Patient Experience and Records & Systems domains. The Smoking register is excluded, as it does not allow prevalence to be derived but rather counts if the smoking status of these patients has been recorded and the registers for Palliative Care and Blood Pressure are excluded, as they are not disease prevalence registers. There are also no disease registers for the Public Health Additional Services domains of Cervical Screening and Sexual Health. Whilst the Depression register does not measure prevalence of depression, but rather new diagnoses of it, it has been retained in the collection of disease registers.

For the prevalence information published on the website, the Department has reported raw (unadjusted) disease prevalence – that is, the number on a disease register of a practice on 31st March 2019 as a proportion of its registered list at 1st January 2019. The figures presented are as submitted to PCAS, without any adjustment for known factors that might influence disease prevalence, such as the age structure of practice populations.

A report on 'Raw Disease Prevalence in Northern Ireland', a factsheet giving a more detailed explanation of how prevalence is used within the calculation for QOF payments and the 'Raw Disease Prevalence data for Northern Ireland' excel file are available from the DoH website (https://www.health-ni.gov.uk/articles/prevalence-statistics).

3. Content of the Quality & Outcomes Framework – changes in recent years

In 2015/16, the majority of the register-focused indicators of conditions in QOF were subsumed into the core funding for practices. The points previously allocated for practices keeping and maintaining a register for patients with Asthma (AST), Atrial Fibrillation (AF), Cancer (CAN), Chronic Obstructive Pulmonary Disease (COPD), Coronary Heart Disease (CHD), Dementia (DEM), Diabetes Mellitus (DM), Epilepsy (EP), Heart Failure (HF), Hypertension (HYP), Learning Disability (LD), Mental Health (MH), Obesity (OB), Osteoporosis (OST), Peripheral Arterial Disease (PAD), Rheumatoid Arthritis (RA), Sexual Health (CON) and Stroke and Transient Ischaemic Attack (STIA) were consequentially removed from the maximum QOF achievement, reducing it by 71 points.

There is no longer any financial incentive associated with keeping a register for the clinical areas listed above, as these register-focused indicators and their associated funding were subsumed into core funding. Registers for some clinical areas still exist if other indicators still assessed for QOF remain on the system (Asthma or CHD, for example), however the subsuming of registers for other conditions resulted in their complete removal in 2015/16 from the QOF assessment (Epilepsy, Learning Disabilities, Peripheral Arterial Disease and Obesity).

The majority of indicators remained unchanged in 2016/17, in terms of both definitions and points available. Only the Records & Systems domain saw changes to indicators, with the wording for all indicators being amended (although largely keeping the same meanings) and the points available for each indicator changing. However, the overall total points available for the Records & Systems domain remained unchanged at 100 points. Indicator RS006 was retired in 2016/17, but the points for it were incorporated into the changes to the points for the other Records & Systems indicators. There was therefore no change to the overall maximum QOF points available to practices (547).

With the retirement of RS006, there were a total of 63 indicators in the Quality & Outcomes Framework in 2016/17. From 2016-17 onwards, QOF has remained unchanged in terms of indicators, definitions and points.

Summary of domains

The QOF consists of 4 domains, each containing a range of areas described by key indicators. The indicators describe different areas of achievement. The domains and their constituent areas are:

- **Clinical domain.** 51 indicators in 15 areas: Asthma (AST), 3 indicators; Atrial Fibrillation (AF), 2 indicators; Cancer (CAN), 1 indicator; Secondary Prevention of Coronary Heart Disease (CHD), 4 indicators; Chronic Obstructive Pulmonary Disease (COPD), 5 indicators; Dementia (DEM), 2 indicators; Depression (DEP), 1 indicator; Diabetes Mellitus (DM), 10 indicators; Heart Failure (HF), 3 indicators; Hypertension (HYP), 1 indicator; Mental Health (MH), 6 indicators; Osteoporosis (OST), 2 indicators; Palliative Care (PC), 2 indicators: Rheumatoid Arthritis (RA), 3 indicators and Stroke and Transient Ischaemic Attack (STIA), 6 indicators. This domain has a maximum QOF achievement of 380 points (69.5% of the total).

- **Public Health (including Additional Services).** 6 indicators in 5 areas: Blood Pressure (BP), 1 indicator; Cervical Screening (CS), 1 indicator; Cardiovascular Disease – Primary Prevention (CVD-PP), 2 indicators; Sexual Health (CON), 1 indicator and Smoking (SMOK), 1 indicator. This domain has a maximum QOF achievement of 49 points (9.0% of the total).

- **Patient Experience.** 1 indicator in 1 area: Patient Experience (PE). This domain has a maximum QOF achievement of 18 points (3.3% of the total).

- **Records & Systems.** 5 indicators in 1 area: Records and Systems (RS). This domain has a maximum QOF achievement of 100 points (18.3% of the total).

4. Overall Achievement in the Quality & Outcomes Framework

4.1 Summary at Northern Ireland level

QOF achievement data for 2018/19 was received from 330 practices in Northern Ireland. Data is reported throughout this report on 323 practices[2]. Overall, 74 practices achieved the full 547 points, with an average QOF achievement of 539.0 points (98.5%) and a median QOF achievement of 544.2 points (99.5%).

Figure 1 shows the distribution of total QOF points achieved across all practices. The QOF points achieved axis (x axis) is the upper limit for the range so, for example, the bar labelled 547 shows the number of practices for which the total points achieved was more than 540 but less than or equal to 547, of which there were 229 in 2018/19.

Figure 1. Distribution of total points achieved by general practices
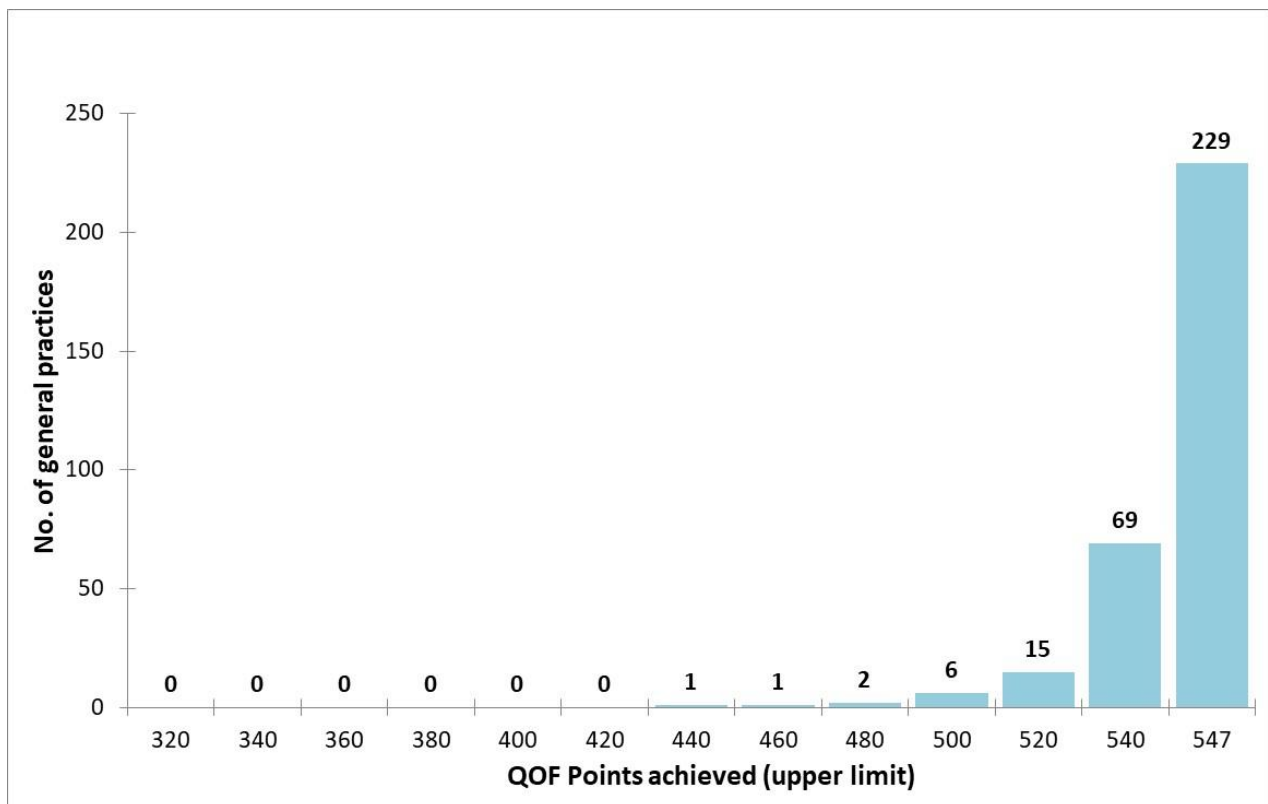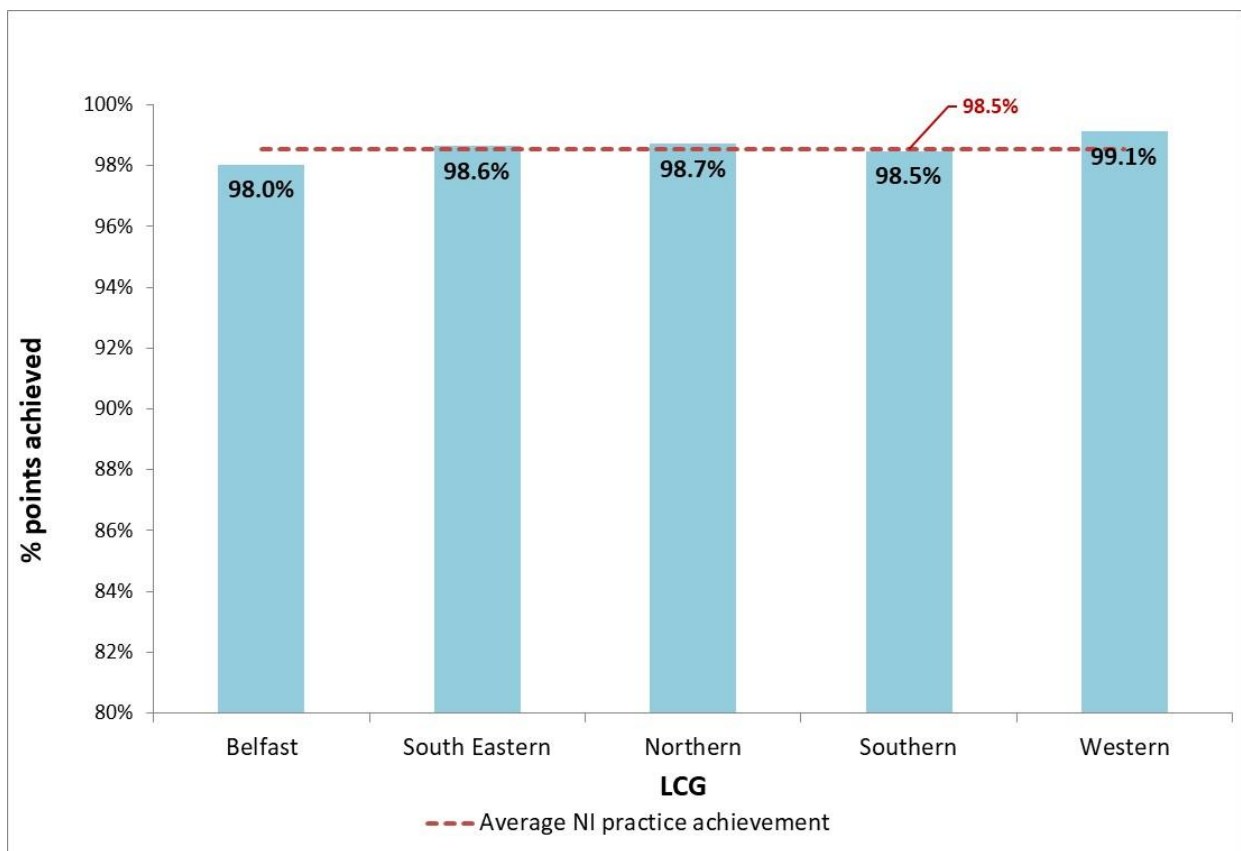

Source: PCAS, July 2019

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[2] An agreement regarding QOF achievement was in place between the HSCB and 7 practices in relation to issues which the HSCB recognised would impact on QOF achievement in 2018/19. These issues related to practice closures, dispersals and mergers and the subsequent impact on practices. These 7 practices are excluded from all analysis.

4.2   Summary at Local Commissioning Group (LCG) level

Figure 2 shows the average QOF achievement rate of practices in each LCG as well as the Northern Ireland average achievement rate. The average achievement rate at LCG level ranges from 98.0% (536.3 points) in the Belfast LCG to 99.1% (542.2 points) in the Western LCG, compared to the average Northern Ireland QOF achievement rate of 98.5% (539.0 points).   Section 6 looks at comparisons in achievement across the last five years of QOF by LCG.

Figure 2. Average QOF points achievement rate of practices in each Local Commissioning Group

4.3 Domain Level Achievement

The average points achieved by general practices in Northern Ireland in each domain are shown in Table 1.

Table 1. Average practice achievement in each QOF domain

Domain	Maximum points available	Average points achieved	Average points achieved as % of total available
Clinical	380	374.1	98.4%
Public Health	35	33.5	95.6%
Public Health – Additional Services	14	13.6	97.1%
Patient Experience	18	18.0	100.0%
Records & Systems	100	99.9	99.9%

Source: PCAS, July 2019

Note that each domain has a different number of indicators as well as a different number of points available.

Figure 3 shows the percentage of available points achieved in each domain in 2018/19. Section 6 looks at comparisons across the last five years of QOF for each domain.

Figure 3: Percentage of total points achieved in each domain
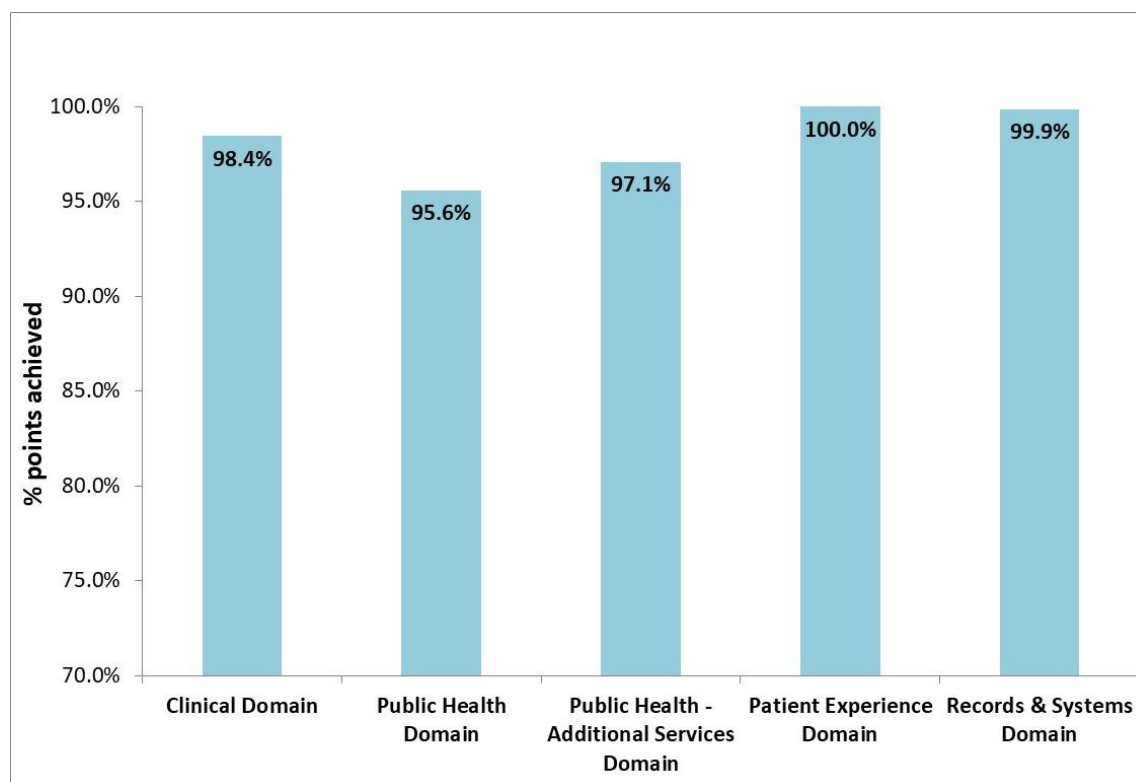
Source: PCAS, July 2019

4.3.1 Clinical and Public Health domains

Figure 4 shows the distribution of points achieved across general practices in the Clinical and Public Health domains (including Additional Service) combined. As shown, 300 practices (92.9%) each achieved over 400 QOF points for these domains combined. Of those 300 practices, 74 achieved the full 429 points available (380 from Clinical, 35 from Public Health and 14 from Public Health Additional Services). The average points achieved of practices in these combined domains was 421.2 (98.2% of the total available).

Figure 4. Distribution of points achieved in the Clinical and Public Health domains across practices in Northern Ireland

Source: PCAS, July 2019

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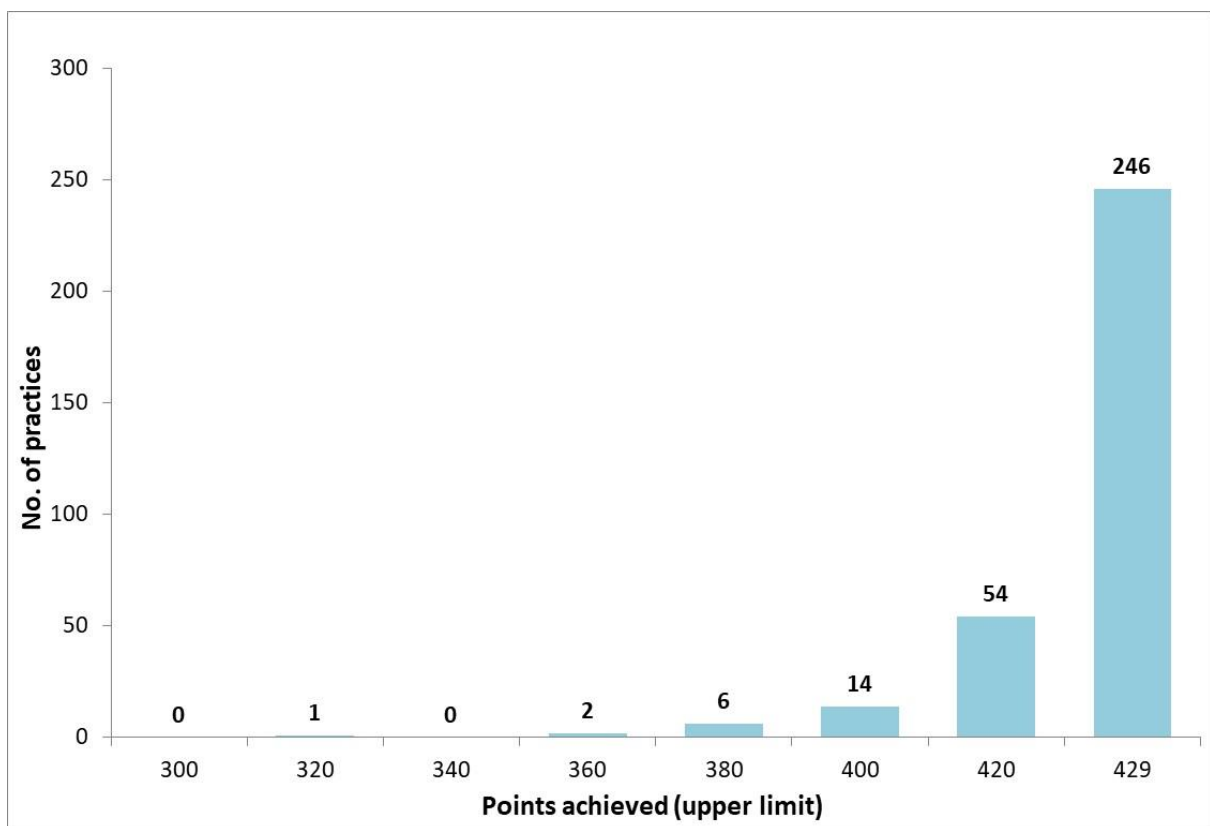
<u>Clinical domain and Public Health domain areas</u>

There are 15 areas in the Clinical domain and 3 areas in the Public Health domain (Blood Pressure, CVD-PP and Smoking), not including the Public Health – additional services indicators. Figure 5 shows the percentage of points achieved within each of these areas. There was no area in which all practices achieved maximum points; all except 3 practices achieved maximum points in the Atrial Fibrillation area. It is important to note that the number of indicators and points available is different for each disease area.

Figure 5. Percentage of points achieved in each clinical and public health area
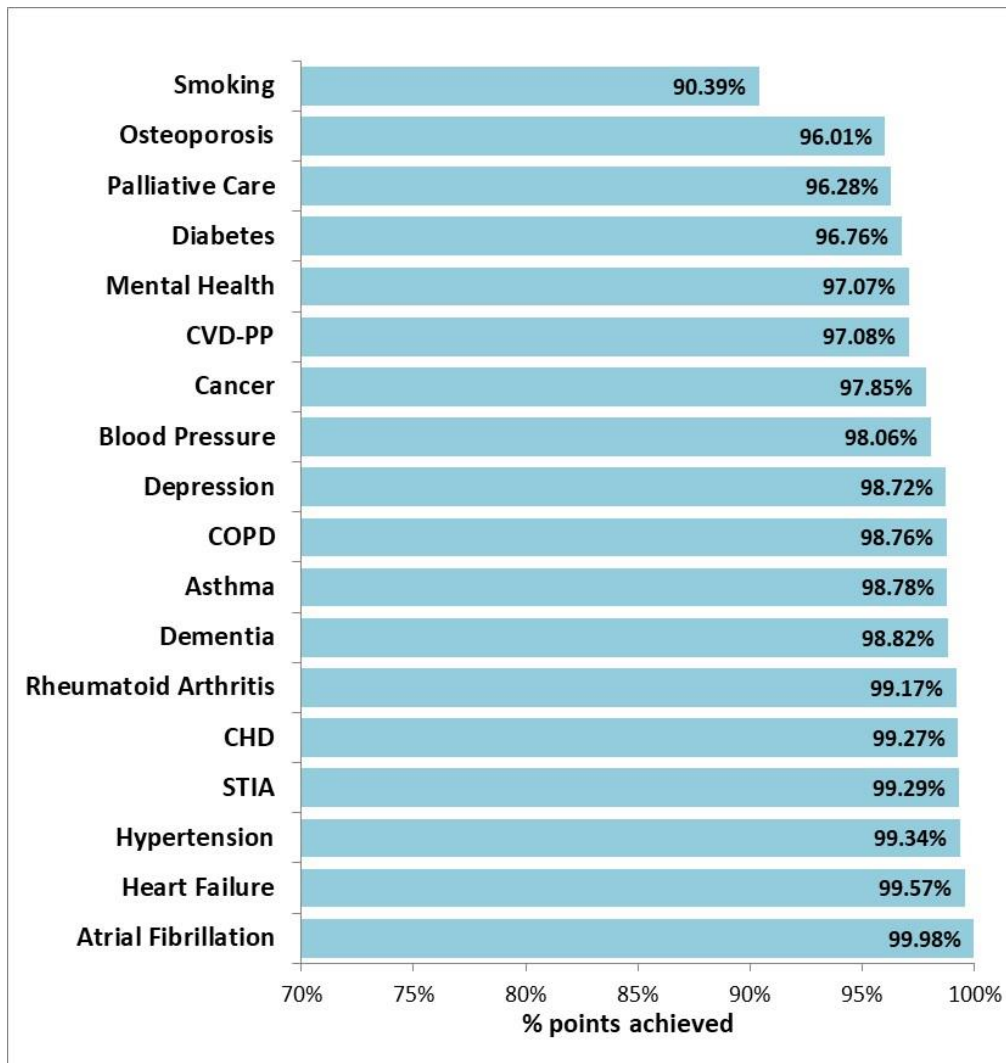
4.3.2 Public Health – Additional Services domain

Figure 6 shows the distribution of QOF points achieved across general practices in the Public Health – Additional Services domain (which consists of the two areas of Cervical Screening and Sexual Health, each with one indicator). A total of 300 practices (92.9%) achieved over 12 points for this domain, with 247 practices (76.5%) achieving the full 14 points available. On average, practices achieved 13.6 points.

Figure 6. Distribution of points achieved in the Public Health – Additional Services domain across practices in Northern Ireland
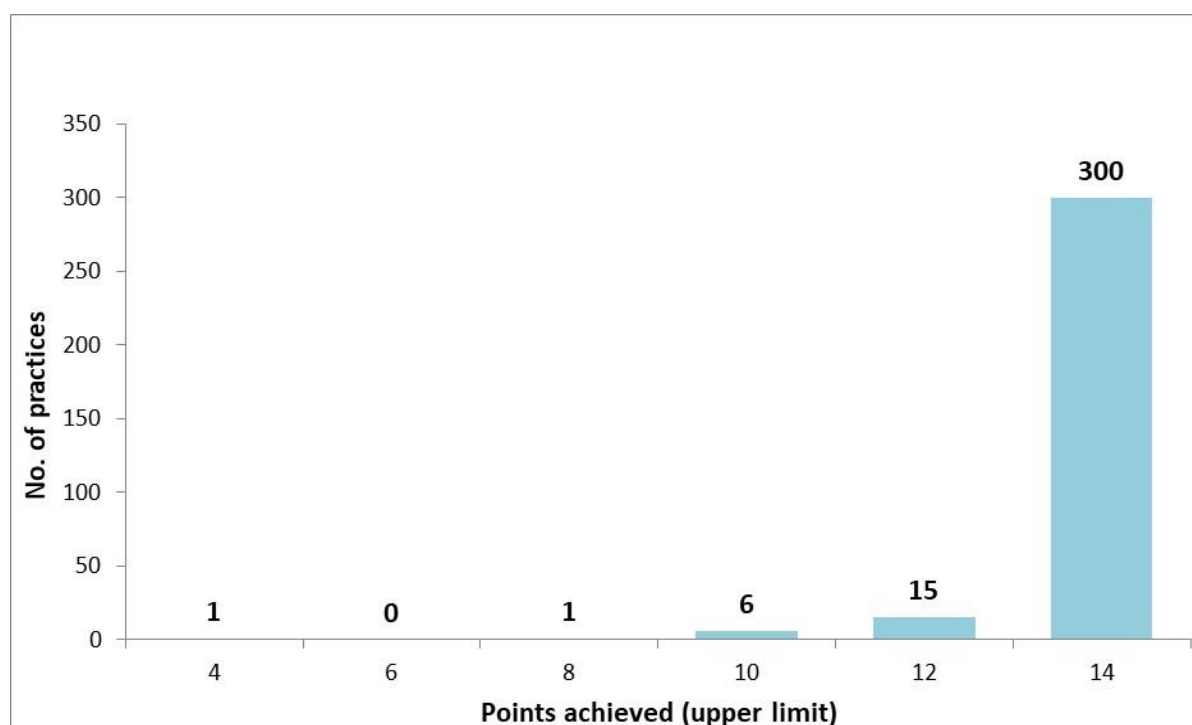
Table 2 shows that practices achieved an average of 96.8% of the available points for Cervical Screening and an average of 98.2% of the available points for Sexual Health; these clinical areas both had one indicator but different numbers of points available.

Table 2.   Total points available and achieved (Northern Ireland) for Public Health Additional Services

QOF Domain Area	Total points available	Total points achieved	% Points Achieved
Cervical Screening	3553	3438	96.8%
Sexual Health	969	952	98.2%

4.3.3 Patient Experience domain

The one indicator in this domain focuses on a survey of patients who have had contact with the practice within the last year. Practices may achieve either all 18 points or 0 points in this domain; all 323 practices received the full 18 points.

4.3.4 Records & Systems domain

A total of 5 indicators are in this domain, with a total of 100 points available. 321 practices achieved the full 100 points and 2 practices received 80 points.

4.4 QOF groups

In the absence of the 'Indicator Type' labels that the National Institute for Health and Care Excellence (NICE) have supplied in the past, the QOF indicators are presented instead using the 'QOF Groups' that were introduced by England to their QOF reports in 2013/14.

Table 3 shows achievement according to these QOF groups and table 4 lists the conditions within each of the QOF groups. Further information about the QOF indicators and their groups may be found in Annex B.

Table 3. Total points available and achieved (Northern Ireland) by QOF group

QOF Group	Number of Indicators	Total points available	Total points achieved	% Points Achieved
Cardiovascular	19	51,680	51,254	99.2%
Fertility, Obstetrics & Gynaecology	2	4,522	4,390	97.1%
High Dependency & other long-term conditions	13	27,455	26,576	96.8%
Lifestyle	1	3,230	2,920	90.4%
Mental Health and Neurology	9	20,672	20,297	98.2%
Musculoskeletal	5	7,429	7,306	98.3%
Respiratory	8	23,579	23,289	98.8%
Undefined group	6	38,114	38,074	99.9%

Table 4. QOF Group categorisations

QOF Group	Condition/Measure
Cardiovascular	Atrial Fibrillation Blood Pressure Cardiovascular Disease – Primary Prevention Coronary Heart Disease Heart Failure Hypertension Stroke and Transient Ischaemic Attack
Fertility, Obstetrics & Gynaecology	Cervical Screening Sexual Health
High Dependency & other long-term conditions	Cancer Diabetes Mellitus Palliative Care
Lifestyle	Smoking
Mental Health and Neurology	Dementia Depression Mental Health
Musculoskeletal	Osteoporosis Rheumatoid Arthritis
Respiratory	Asthma Chronic Obstructive Pulmonary Disease
Undefined group	Patient Experience Records & Systems

4.5   Prevalence summary

Table 5 shows the percentage prevalence for appropriate clinical registers within QOF. Prevalence Day moved from the 14th of February to the 31st of March in 2008/09, to bring it in line with National QOF Achievement Day. For the 2018/19 QOF year, prevalence was calculated using register counts at 31st March 2019 and total list sizes at January 2019.

QOF registers for 6 clinical areas have maintained a consistent definition since April 2004: Asthma, Cancer, CHD, Hypertension, COPD and STIA. A small change was made to the diagnosis codes for Diabetes Mellitus in 2006 regarding eligibility for the register.

A number of revisions to QOF occurred in April 2006, mostly affecting the clinical domain. A number of new clinical areas were introduced and revised definitions were implemented in some areas. No clinical areas were removed, but specific indicators within some clinical areas were redefined or removed and new indicators were introduced in some areas.

New registers were introduced in April 2006 for: Atrial Fibrillation, Chronic Kidney Disease, Dementia, Depression, Heart Failure, Heart Failure due to LVD, Learning Disabilities, Obesity, Palliative Care, Conditions assessed for Smoking and Conditions assessed for Depression screening.

From April 2006, the Mental Health register was redefined from 'those with severe long-term mental health problems who require and have agreed to regular follow-up' to 'people with schizophrenia, bipolar disorder and other psychoses'. For 2013/14 the register definition was expanded to include other patients on lithium therapy, and the register is therefore no longer fully comparable with previous years.

Further changes were implemented in April 2009, including the introduction of a new public health area, Cardiovascular Disease – Primary Prevention, and two new clinical areas were introduced in 2012/13 – Osteoporosis and Peripheral Arterial Disease.

New registers were introduced for the Rheumatoid Arthritis and Blood Pressure areas in 2013/14, though the Blood Pressure register was not reported on due to reporting errors in the raw data available from PCAS.

In 2014/15, registers for Hypothyroidism and Chronic Kidney Disease were retired alongside the rest of the indicators for those conditions. Changes to the Smoking domain left it with one indicator, resulting in the 'Conditions assessed for Smoking' register also retiring.

Table 5 presents the figures for those 15 domain registers which actually measure disease prevalence. As stated in Section 2, out of the total 22 individual domains within QOF, disease prevalence can be presented for 15 registers. The Depression register, while it does not measure prevalence of depression, but rather new diagnoses of it, has been retained in table 5. Note that there are 16 disease areas in Table 6, as the Heart Failure and Heart Failure due to LVSD prevalence figures are calculated from the same Heart Disease register.

Of the registers collected for QOF for which prevalence can be derived, Osteoporosis (using the full list) is the least prevalent (0.33%) and hypertension is the most prevalent (13.79%) amongst patients. A prevalence summary report and trend data is available on the DoH website via the Statistics section at: https://www.health-ni.gov.uk/articles/prevalence-statistics.

Table 5. QOF prevalence for Northern Ireland at 31st March 2019

Clinical disease area	Northern Ireland Prevalence for QOF payment purposes	*Northern Ireland prevalence where the register is limited to age-specific groups
Asthma	6.19%	
Atrial Fibrillation	1.98%	
Cancer	2.58%	
COPD	2.13%	
Coronary Heart Disease	3.73%	
CVD - Primary Prevention	2.55%	
Dementia	0.74%	
Depression* (population aged 18+)	8.56%	11.01%
Diabetes* (population aged 17+)	5.03%	6.37%
Heart Failure	0.92%	
Heart Failure due to LVSD	0.35%	
Hypertension	13.79%	
Mental Health	0.92%	
Osteoporosis* (population aged 50+)	0.33%	0.96%
Rheumatoid Arthritis* (population aged 16+)	0.64%	0.80%
Stroke & TIA	1.93%	

Source: PCAS, July 2019

To calculate the Adjusted Practice Disease Factors, which are used to weight QOF points in each clinical area for QOF payment purposes, the raw prevalence is derived by dividing the count of patients on the register for that clinical area by the total practice list (all ages). The register is age-specific for 4 of the clinical areas: Depression, Diabetes, Osteoporosis and Rheumatoid Arthritis and an age-specific prevalence rate is also shown in table 5, using the number of registered patients in the relevant age-band from that practice as the denominator.

The number of registered patients who are affected by more than one of these conditions cannot be estimated by simply adding the prevalence figures together, as many patients are likely to suffer from co-morbidity and may have been diagnosed with more than one of these conditions. For example, the prevalence in a practice of patients affected by AF and CHD cannot be calculated by summing the number of

patients diagnosed with each, as this would ignore the fact that some patients may have been diagnosed with both.

Criteria other than just diagnosis of a condition may apply for patients to be included on the register for a condition. For example, the cancer register refers to patients diagnosed after 1 April 2003; the diabetes register includes only patients aged 17 and over; and the asthma register includes only those with asthma who have been prescribed asthma-related drugs in the past 12 months. Full details of each register can be found in Annex D of the Statement of Financial Entitlement, available at: https://www.health-ni.gov.uk/publications/gp-contract-statements-financial-entitlements

5. Recommendations around the use of QOF data

The data collected for the Quality & Outcomes Framework provides some useful information for researchers and public health officials regarding disease prevalence and information about general practices. However, it is important to note the limitations of using QOF data to make further inferences and conclusions.

The following points should be noted:

- It may be inappropriate to use the data to make comparisons between practices in terms of the quality of care offered. For instance, the clinical disease areas chosen for the Quality & Outcomes Framework represent the minority of patients in Northern Ireland and therefore points achievement in these areas does not reflect the full workload of general practices.

- As the Quality & Outcomes Framework system takes into account practice list size and disease prevalence before calculating payment, comparing practices by isolating particular domain points achieved does not account for the full system of QOF.

- The data collected for the clinical domains on prevalence contains a count of patients on each register only, no patient details such as age or gender are held. It is essential to note that it is raw, unadjusted data that has been published, particularly when looking at comparisons at LCG level or practice level, which will not take account of the underlying social and demographic characteristics of the populations concerned.

- The PCAS system does not hold information on co-morbidity i.e. patients with more than one condition. Many patients are likely to have been diagnosed with more than one condition; therefore it is not correct to simply add prevalence figures together as this may result in double-counting and, consequently, an overestimation of combined prevalence.

- Prevalence figures will not be directly comparable across all years where definitions have been revised (see notes under paragraph 4.5). Changes to indicators will also affect achievement and so achievement may not be comparable across all years. Year-on-year comparisons are also difficult to interpret due to demographic reasons (e.g. ageing population) and improvement in case-finding and recording by practices.

- The achievement of each practice will be partly dependent on the number of points each practice aspired to, therefore not all practices will have commenced QOF from the same baseline and not all will have improved to the same extent. Standards of recording diagnoses and other administrative procedures may also differ between practices.

- Prevalence figures based on QOF registers may differ from prevalence figures from other sources because of coding or definitional issues. For example, to be included on the QOF diabetes register, patients need to be aged 17 or over, and the type of diabetes (1 or 2) must be specified by the practice. Patients with gestational diabetes are excluded from the register. Other sources may not be subject to such restrictions.

6. Comparisons with previous years

6.1 Changes for the 2018/19 year

As discussed in section 3, there were no changes to the Quality & Outcomes Framework this year. The full domains and their constituent areas and the points available for the 2018/19 year are summarised in Table 6. There were no changes to indicators or points and the total points available remained at 547.

Table 6. All QOF domains and their constituent areas, points available within each area for the 2018/19 year

Domain	Clinical Area	Indicators	Change from previous year	Points 2018/19
Clinical	Asthma	AST002	No Change	15
		AST003	No Change	20
		AST004	No Change	6
	Atrial Fibrillation	AF006NI	No Change	12
		AF007	No Change	10
	Cancer	CAN003	No change	6
	Coronary Heart Disease	CHD002	No change	17
		CHD003NI	No change	17
		CHD005	No change	7
		CHD007	No change	7

Domain	Clinical Area	Indicators	Change from previous year	Points 2018/19
Clinical	**Chronic Obstructive Pulmonary Disease**	COPD002NI	No change	5
		COPD003	No change	9
		COPD004NI	No change	7
		COPD005NI	No change	5
		COPD007	No change	6
	Dementia	DEM002	No change	15
		DEM003	No change	6
	Depression	DEP001NI	No change	21
	Diabetes Mellitus	DM002NI	No change	8
		DM003NI	No change	10
		DM004NI	No change	6
		DM006	No change	3
		DM007	No change	17
		DM008	No change	8
		DM009	No change	10
		DM010	No change	3
		DM012	No change	4
		DM015NI	No change	4
	Heart Failure	HF002NI	No change	6
		HF003	No change	10
		HF004	No change	9
	Hypertension	HYP002NI	No change	20
	Mental Health	MH002	No change	6
		MH003	No change	4
		MH007	No change	4
		MH008NI	No change	5
		MH009	No change	1
		MH010	No change	2

Domain	Clinical Area	Indicators	Change from previous year	Points 2018/19
Clinical	**Osteoporosis**	OST002	No change	3
		OST005	No change	3
	Palliative Care	PC001	No change	3
		PC002	No change	3
	Rheumatoid Arthritis	RA002	No change	5
		RA003NI	No change	7
		RA004	No change	5
	Stroke and Transient Ischaemic Attack	STIA003	No change	5
		STIA004NI	No change	2
		STIA005NI	No change	5
		STIA007	No change	4
		STIA008NI	No change	2
		STIA009	No change	2
Patient Experience	**Patient Experience**	PE001NI	No change	18
Public Health	**Blood Pressure**	BP002	No Change	15
	Cardiovascular Disease – Primary Prevention	CVD-PP011NI	No Change	5
		CVD-PP012NI	No Change	5
	Smoking	SMOK001NI	No Change	10
Public Health – Additional Services	**Cervical Screening**	CS002NI	No Change	11
	Sexual Health	CON003NI	No Change	3
Records & Systems	**Records & Systems**	RS001	No Change	10
		RS002	No Change	20
		RS003	No Change	20
		RS004	No Change	20
		RS005	No Change	30

6.2 Total points achieved by Local Commissioning Group

Achievement levels across the five LCGs in 2018/19 were similar to the high levels of achievement seen last year. Similar levels of achievement were shown across the LCGs, with the lowest achievement seen in the Belfast LCG (98.0%) compared to the highest achievement in the Western LCG (99.1%).

Achievement in 2016/17 was lower than usual as a result of the QOF holiday that practices were allowed to take in that year.

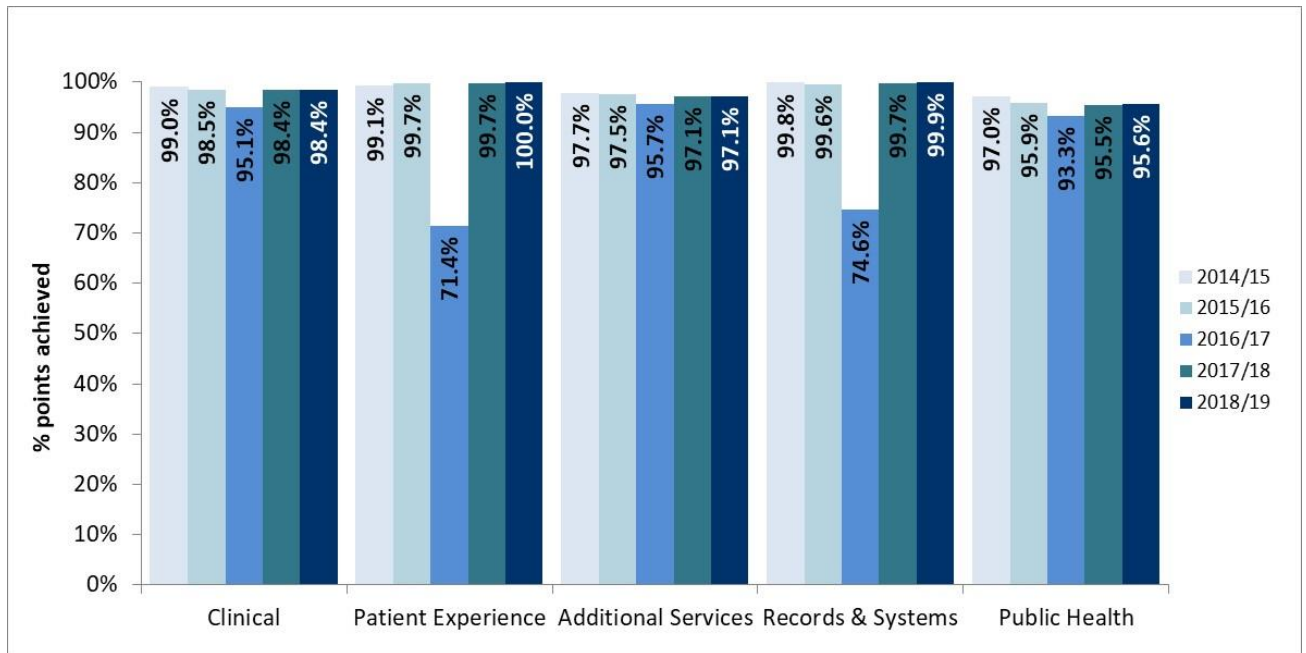**Figure 7. Percentage of total points achieved by practices in each LCG area 2014/15 to 2018/19**
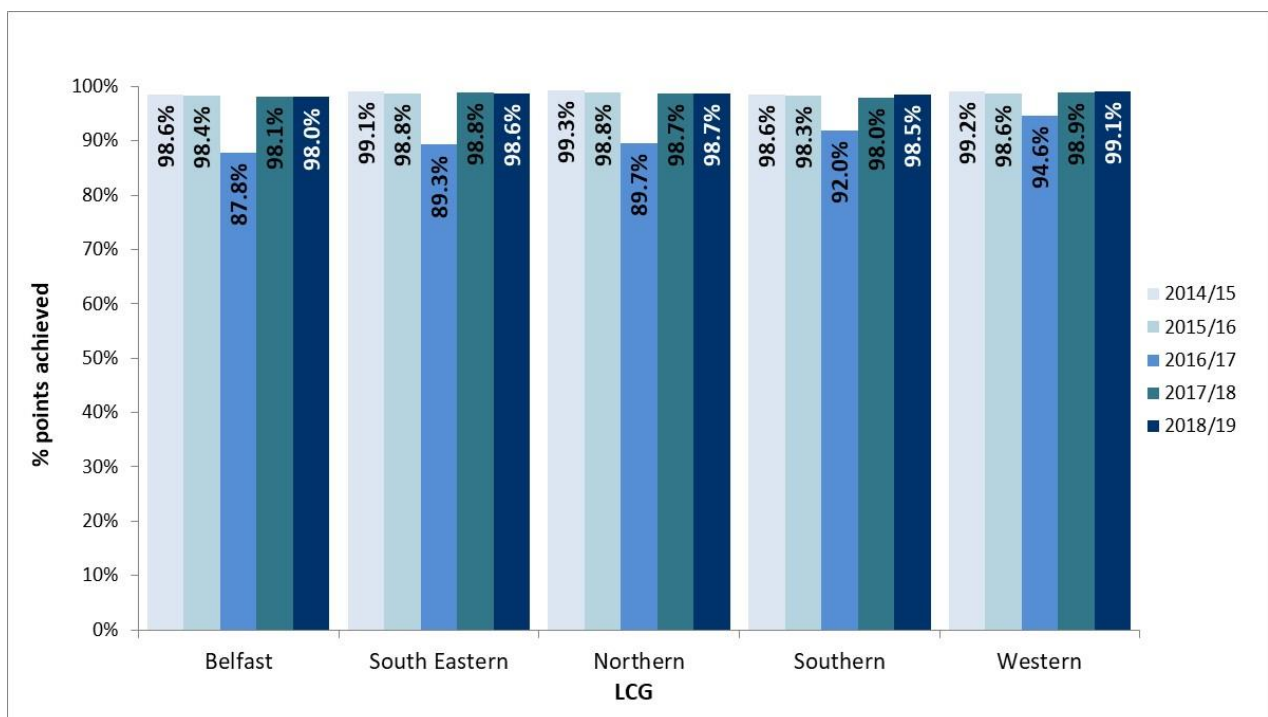
6.3 Domain achievement summary

All domains in 2018/19 have achievement levels comparable with earlier years; in 2017/18, levels were restored to pre-2016/17 levels and this has been maintained for 2018/19. Achievement in all domains was down in 2016/17 due to the confirmation by the Department in February 2017 that practices could take a QOF holiday. The impact of this was most pronounced in the Records & Systems and Patient Experience domains, due to the fact that practices complete the work for these domains closer to year end, whereas work for the other domains is ongoing throughout the year. The achievement in these two domains increased in 2017/18 to the high levels usually observed and has been maintained in 2018/19.

Figure 8. Percentage of points achieved by practices in Northern Ireland in each domain, 2014/15 to 2018/19

6.4 Clinical and Public Health domains

Figures 9a, 9b and 9c show the levels of QOF achievement for indicators within the Clinical and Public Health domains; levels of achievement notably increased in 2018/19 for hypertension, dementia, smoking and CVD-PP. There was little change in achievement levels for diabetes, depression, mental health, osteoporosis, rheumatoid arthritis and atrial fibrillation. There were slight decreases in all other areas.

Figure 9a. Percentage of points achieved by practices in Northern Ireland in each clinical domain area, 2014/15 to 2018/19
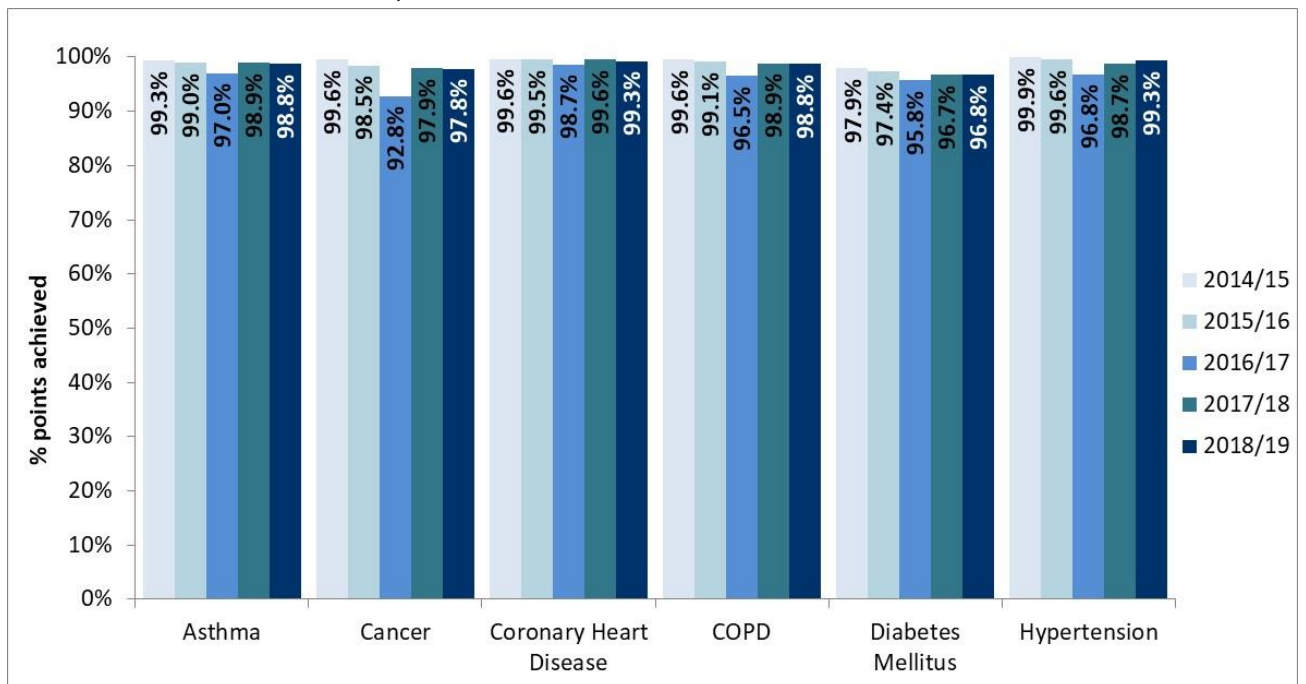
Source: PCAS, July 2019

Figure 9b. Percentage of points achieved by practices in Northern Ireland in each clinical domain area, 2014/15 to 2018/19
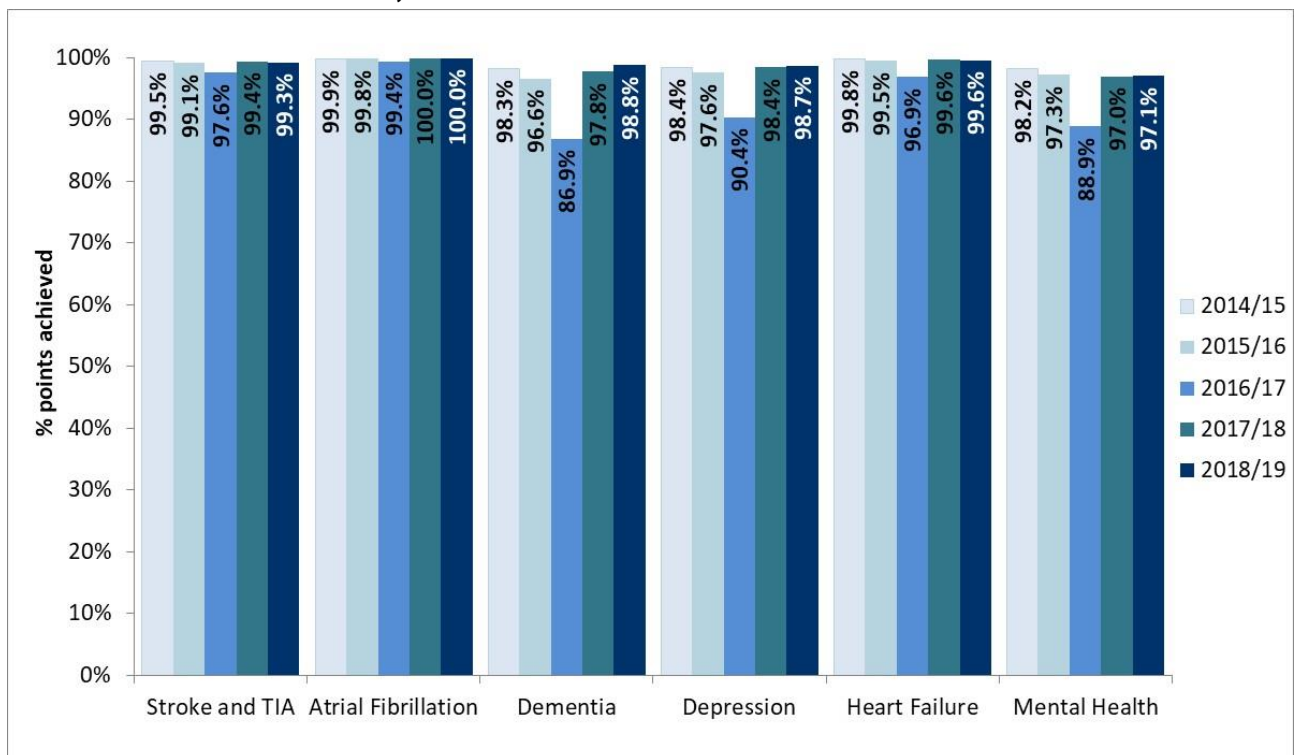
Source: PCAS, July 2019

Figure 9c. Percentage of points achieved by practices in Northern Ireland in each clinical domain area, 2014/15 to 2018/19
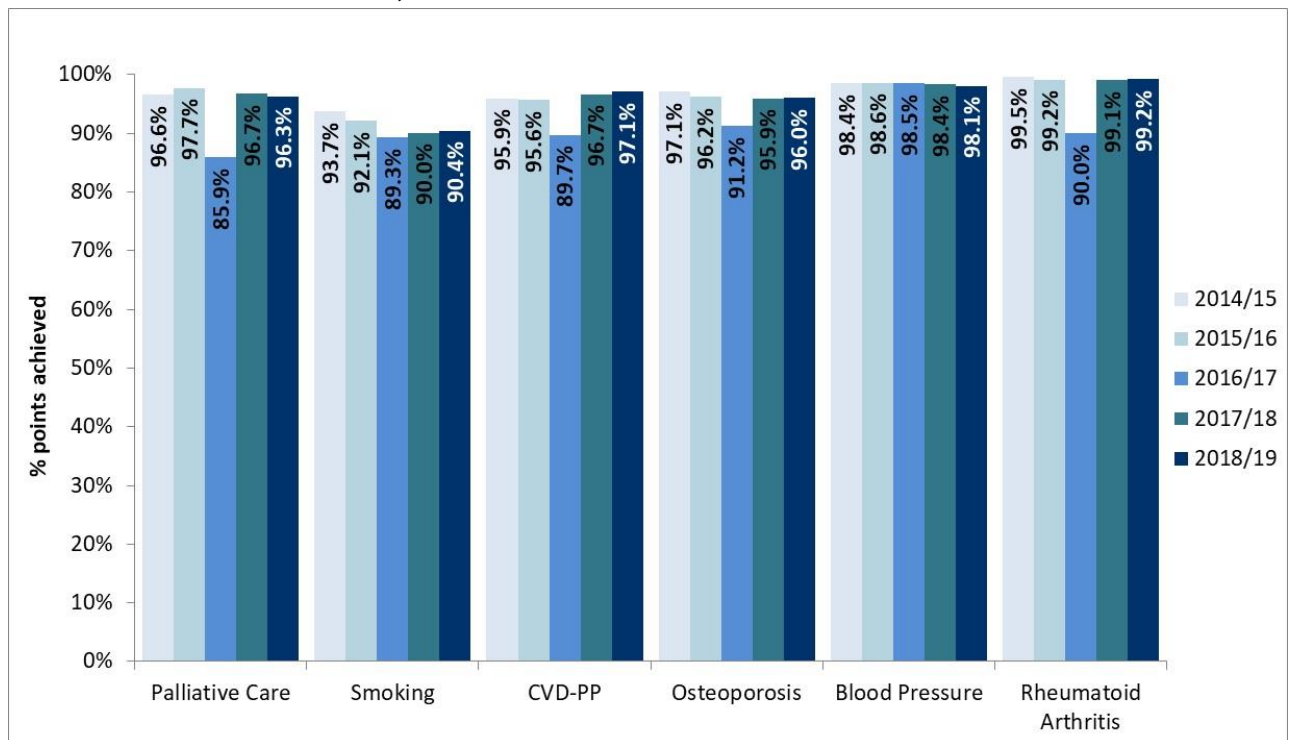
Performance in clinical domain areas is determined by achievement in individual indicators of that domain. For example, there was an overall achievement rate of 96.3% for the palliative care domain. However, within this domain, practices achieved 98.5% of available points for the PC001 indicator, which is the establishment and maintenance of a register of patients in need of palliative care/support. In comparison, practices overall achieved 94.1% of the available points for the PC002 indicator, which concerns the contractor having regular multi-disciplinary case review meetings relating to patients on the register.

6.5 Public Health – Additional Services domain

There was a small decrease in achievement for cervical screening, from 96.9% in 2017/18 to 96.8% in 2018/19, while achievement for sexual health increased slightly from 97.6% to 98.2%.

Figure 10. Percentage of points achieved by practices in Northern Ireland in each additional services domain area, 2014/15 to 2018/19
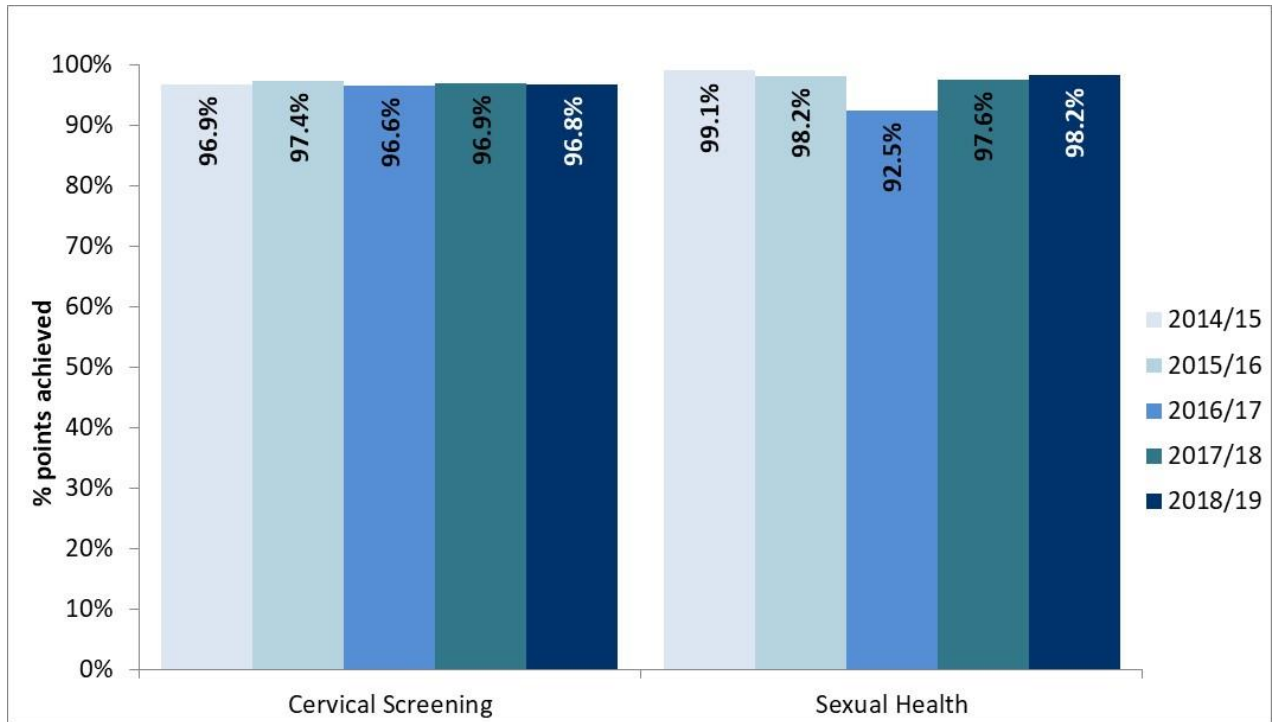
Source: PCAS, July 2019

6.6 Patient Experience and Records & Systems domains

Achievement in these 2 domains was historically always very high, at over 99% for both patient experience and records and systems. In 2016/17, achievement levels were impacted by the QOF holiday. In 2017/18, achievement levels rose again to 100% for patient experience and 99.9% for records and systems. These levels have been maintained in 2018/19.

Figure 11. Percentage of points achieved by practices in Northern Ireland in the Patient Experience and Records & Systems domains, 2014/15 to 2018/19
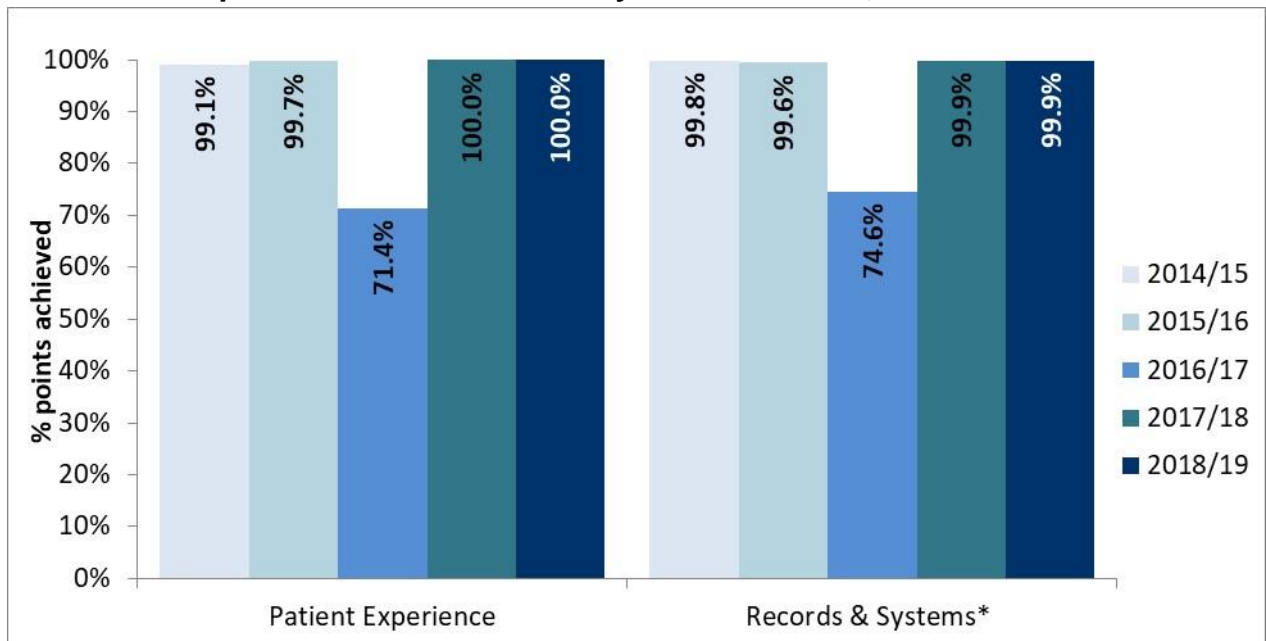
Source: PCAS, July 2019

* Records & Systems was previously Quality & Productivity

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Asthma (AST)	AST002	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis	15	4,845	4,838	99.85%
	AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20	6,460	6,316	97.77%
	AST004	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6	1,938	1,928	99.46%
Atrial fibrillation	AF006NI	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12	3,876	3,874	99.96%
	AF007	In those patients with atrial fibrillation whose latest record of a CHA2DS2-VASc score is 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	10	3,230	3,230	100.00%
Cancer (CAN)	CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis	6	1,938	1,896	97.85%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Secondary prevention of coronary heart disease (CHD)	CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	17	5,491	5,488	99.94%
	CHD003NI	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	17	5,491	5,477	99.75%
	CHD005	The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or anti-coagulant is being taken	7	2,261	2,259	99.91%
	CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	2,261	2,167	95.83%
Chronic obstructive pulmonary disease (COPD)	COPD002NI	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register	5	1,615	1,610	99.71%
	COPD003	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9	2,907	2,852	98.10%
	COPD004NI	The percentage of patients with COPD with a record of FEV1 in the preceding 3 years	7	2,261	2,251	99.55%
	COPD005NI	The percentage of patients with COPD and Medical Research Council dyspnoea grade >3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 15 months	5	1,615	1,609	99.60%
	COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	1,938	1,886	97.33%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Dementia (DEM)	DEM002	The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	15	4,845	4,837	99.84%
	DEM003	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before and 6 months after entering on to the register	6	1,938	1,866	96.27%
Depression (DEP)	DEP001NI	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded	21	6,783	6,696	98.72%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Diabetes mellitus (DM)	DM002NI	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8	2,584	2,584	100.00%
	DM003NI	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less	10	3,230	3,185	98.60%
	DM004NI	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less	6	1,938	1,910	98.53%
	DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	969	945	97.57%
	DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17	5,491	5,455	99.34%
	DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	2,584	2,415	93.48%
	DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10	3,230	2,991	92.59%
	DM010	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	969	927	95.62%
	DM012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4	1,292	1,134	87.76%
	DM015NI	The percentage of male patients with diabetes, on the register, with whom erectile dysfunction has been discussed. Where appropriate patients should have been offered advice/investigation/treatment.	4	1,292	1,269	98.25%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Heart failure	HF002NI	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 15 months after entering on to the register	6	1,938	1,929	99.55%
	HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10	3,230	3,213	99.47%
	HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9	2,907	2,898	99.69%
Hypertension	HYP002NI	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	20	6,460	6,418	99.34%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Mental health (MH)	MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6	1,938	1,916	98.86%
	MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months	4	1,292	1,243	96.23%
	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	4	1,292	1,237	95.77%
	MH008NI	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years	5	1,615	1,575	97.50%
	MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1	323	315	97.62%
	MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2	646	611	94.62%
Osteoporosis: secondary prevention of fragility fractures	OST002	The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent	3	969	920	94.98%
	OST005	The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent	3	969	940	97.05%
Palliative Care (PC)	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	969	954	98.45%
	PC002	The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	3	969	912	94.12%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Rheumatoid arthritis (RA)	RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months	5	1,615	1,589	98.36%
	RA003NI	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years	7	2,261	2,252	99.61%
	RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years	5	1,615	1,605	99.37%
Stroke and transient ischaemic attack (STIA)	STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15months) is 150/90 mmHg or less	5	1,615	1,615	100.00%
	STIA004NI	The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years	2	646	645	99.80%
	STIA005NI	The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	5	1,615	1,610	99.69%
	STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken	4	1,292	1,291	99.91%
	STIA008NI	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA	2	646	641	99.17%
	STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	646	613	94.87%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Cardiovascular disease – primary prevention (CVD-PP)	CVD-PP011NI	The percentage of patients with a new diagnosis of hypertension recorded in the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who are aged 30 or over and who have not attained the age of 75, who have a CVD risk assessment score recorded in the preceding 15 months.	5	1,615	1,582	97.97%
	CVD-PP012NI	In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score in the preceding 15 months of ≥20%: the percentage who are currently treated with statins.	5	1,615	1,553	96.19%
Blood Pressure (BP)	BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	4,845	4,751	98.06%
Smoking (SMOK)	SMOK001NI	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10	3,230	2,920	90.39%
Cervical Screening	CS002NI	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	3,553	3,438	96.77%
Sexual Health	CON003NI	The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception in the preceding 3 years.	3	969	952	98.25%

Annex A: Clinical and Public Health indicator types

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
Patient Experience (PE)	PE001NI	The practice undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question "Would you recommend your GP practice to someone who has just moved into the local area?" and one follow-up question (see guidance). The practice should survey at least 2% of the practice list size and need to get a minimum of 50 responses. A summary report is required to be submitted to the Regional Board by 31 March 2017	18	5,814	5,814	100.00%
Records & Systems	RS001	General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialties.	10	3,230	3,230	100.00%
	RS002	The Practice reviews its own CCG Referral Data. Firstly to ensure that ALL GPs, including locums, are using CCG for referrals to all (available) Consultant led specialties. Secondly to look at referral patterns compared to previous years and neighbouring practices.	20	6,460	6,460	100.00%
	RS003	The practice engages with between three and six neighbouring practices to discuss outpatient referrals. This should include identifying any issues with CCG use and looking at referral patterns and pathways.	20	6,460	6,420	99.38%
	RS004	The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter. Information should include Date of Admission, Specialty and Diagnosis	20	6,460	6,460	100.00%
	RS005	The Practice runs the Data Quality in Practice (DQIP) minimum dataset queries (to include queries to calculate the electronic frailty index) in conjunction with the R&S tool, supported by the clinical informatics team on a six monthly basis. The extracts are shared with the HSCB in pseudonymised form. The practice will create and maintain a patient frailty register by coding patients identified by the electronic frailty index, presented in a dashboard in the R&S tool, using the appropriate Read code for mild, moderate or severe frailty.	30	9,690	9,690	100.00%

Annex B: QOF group and Condition/ Measure reference table

QOF Group		Condition/ Measure	Domain	Number of Indicators	Points available
Cardiovascular	AF	Atrial Fibrillation	Clinical	2	22
	BP	Blood Pressure	Public Health	1	15
	CHD	Secondary prevention of coronary heart disease	Clinical	4	48
	CVD-PP	Cardiovascular disease - primary prevention	Public Health	2	10
	HF	Heart Failure	Clinical	3	25
	HYP	Hypertension	Clinical	1	20
	STIA	Stroke and transient ischaemic attack	Clinical	6	20
			Total	**19**	**160**
High dependency & other long-term conditions	CAN	Cancer	Clinical	1	6
	DM	Diabetes mellitus	Clinical	10	73
	PC	Palliative care	Clinical	2	6
			Total	**13**	**85**
Fertility, obstetrics & gynaecology	CS	Cervical screening	Public Health - additional services	1	11
	CON	Sexual health	Public Health - additional services	1	3
			Total	**2**	**14**
Lifestyle	SMOK	Smoking	Public Health	1	10
			Total	**1**	**10**
Mental health and neurology	DEM	Dementia	Clinical	2	21
	DEP	Depression	Clinical	1	21
	MH	Mental health	Clinical	6	22
			Total	**9**	**64**
Musculoskeletal	OST	Osteoporosis: secondary prevention of fragility fractures	Clinical	2	6
	RA	Rheumatoid arthritis	Clinical	3	17
			Total	**5**	**23**
Respiratory	AST	Asthma	Clinical	3	41
	COPD	Chronic obstructive pulmonary disease	Clinical	5	32
			Total	**8**	**73**
Undefined group	PE	Patient Experience	Patient Experience	1	18
	R&S	Records & Systems	Records & Systems	5	100
			Total	**6**	**118**
			Grand Total	**63**	**547**