Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

INFORMATION ANALYSIS DIRECTORATE

General Practice Quality and Outcomes Framework Achievement and Exceptions Reporting Statistics 2021/22

Based on administrative data for April 2021-March 2022 recorded on the Payment Calculation and Analysis System (PCAS) at 30th June 2022

Introduction

This bulletin summarises the eighteenth year of Quality and Outcomes Framework (QOF) achievement and exception reporting data from general practices, relating to the period from April 2021 to March 2022.

QOF is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the general medical services (GMS) contract, introduced on 1 April 2004.

The QOF contains groups of indicators, against which practices score points according to their level of achievement. QOF awards surgeries achievement points for (i) managing chronic diseases and addressing public health; (ii) providing services for cervical screening and contraception; (iii) surveying patient experience; and (iv) improving quality and productivity with regard to secondary care referrals. The overall structure of the Framework including number of indicators and maximum number of points available are provided on page 5.

All data used in this bulletin are 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 2022.

Disease prevalence data are used to calculate QOF points and payments, with adjustments made to each practices pound per point, dependent on their prevalence of a disease or condition relative to the estimated regional Northern Ireland prevalence. These adjustments are known as the Adjusted Practice Disease Factor (APDF); further details on this process can be found on page 2.

QOF includes the concept of exception reporting. This was introduced to allow practices to pursue the quality improvement agenda and not be penalized where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side effect. Further details can be found on page 19.

This bulletin presents achievement statistics by domain, and at LCG and GP Federation levels. A time series of 2017/18 to 2021/22 achievement data is also presented. Summaries of exception rates are presented by indicator group, and at LCG and GP Federation levels. Accompanying data files including general practice data and an interactive dashboard are available on the DoH website.

The Impact of the Covid-19 Pandemic

During 2021/22 due to the continuing Covid-19 pandemic, the DoH agreed with NIGPC and the HSCB to continue standing down elements of the GMS contract. The *majority of* Quality and Outcomes Framework (QOF) activity and reporting remained suspended in 2021/2022. Therefore, QOF data for 2021/2022, including the exceptions data, may have been impacted upon and it is recommended that the use of this data in publications or drawing conclusions from it includes appropriate caveats acknowledging the unprecedented impact of Covid-19.

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Prevalence data and Adjusted Practice Disease Factors

Prevalence data are used within the QOF to calculate points and payments within each of the clinical domain areas. The number of pounds per point (£178.25 in 2021-22) in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the estimated regional Northern Ireland prevalence for that disease or condition. The aim of the prevalence adjustments in each of the QOF clinical domain areas is to deliver a more equitable distribution of payments in the light of different workloads that practices face in achieving the same number of points. Practices with a high prevalence of a specific disease or condition will receive more pounds per point for that clinical domain area than practices with a low prevalence of the same disease or condition. The amount by which the pounds per point is adjusted up or down is known as the Adjusted Practice Disease Factor (APDF). For example, a practice with an APDF of 1.20 for Asthma has a 20% higher adjusted prevalence than the Northern Ireland figure, and the adjusted pounds per point for asthma would equal = £178.25 * 1.20 = £213.90 per point. The QOF User Guidance Notes detail how prevalence is calculated and how it is used in the final payment calculations. The guidance includes a worked example.

The additional services indicators within the Public Health Domain (cervical screening and sexual health) do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are: (i) for Cervical screening services - females who have attained the age of 25 years but not yet attained the age of 65 years and (ii) for Contraceptive services - females who have not attained the age of 55 years. The basic pounds per point, £178.25 in 2021/22, in each additional services area is adjusted up or down by a Target Population Factor. Details of this adjustment are given in the QOF User Guidance Notes.

Limitations on 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 care quality 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 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 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.

Key Points: Quality and Outcomes Framework Achievement and Exception Reporting

- The average total QOF achievement of practices was 349.5 points (63.9%), from a maximum available QOF total of 547 points.

- Achievement data was received from 319 practices and data is reported on 317 practices*. The 317 practices received a total of £31.41 million, with an average award of £99,089 per practice.

- Across the domains, the average points achieved were:
    - Clinical: 201.4 (53.0%)
    - Public Health (including Additional Services): 34.6 (70.5%)
    - Patient Experience: 16.6 (92.4%)
    - Records & Systems: 96.9 (96.9%)

- Of the clinical registers collected for QOF that measure actual disease prevalence, the highest prevalence was for Hypertension (138.8 per 1,000 GP patients) and the lowest was for Osteoporosis (3.5 per 1,000 GP patients).

- The overall Northern Ireland exception rate was 2.58%.

- Of the 55 indicators for which exception data are published, the lowest exception rate at Northern Ireland level is for COPD005 (Chronic Obstructive Pulmonary Disease) (0.22%) and the highest exception rate is for AF006 (Atrial Fibrillation) (42.47%).

- The overall exception rates for GP practices* range from 1.12% to 8.26%.

* An agreement regarding QOF achievement was in place between the HSCB and 2 GP practices in relation to issues which the HSCB recognised would impact on QOF achievement in 2021/22. These issues related to a merger and a change of Contract. These 2 practices are excluded from all analysis.

Do's and Don'ts for QOF data

Do's

Use the information provided carefully

Note the limitations of the data

Be aware of how QOF works in terms of accounting for practice list size and disease prevalence

Note that patient details such as age or gender are not held – the data published is raw, unadjusted data

Take care to understand register definitions – especially when comparing with other prevalence sources. QOF prevalence does not necessarily equate to prevalence as may be defined by epidemiologists

You can re-use or publish QOF data, however you should source it to the Department of Health (NI)

Users of the data should be aware of practices serving different communities, e.g. practice lists with student populations

Don'ts

Don't use QOF data to make comparisons between practices in terms of the quality of care offered

Don't use QOF data to rank practices into league tables - QOF is only one measure of the quality of clinical care provided to patients

Don't compare practices by isolating particular QOF Domain points achieved

Don't add prevalence figures for conditions together, as this may result in double-counting and overestimation of combined prevalence - the PCAS system does not hold information on co-morbidity

Don't compare prevalence across years (or between countries) without checking for changes to indicators or definitions

Don't sum practice data without checking if any have been supressed

Structure of the 2021/22 Framework

The Quality and Outcomes Framework consists of 4 domains (Clinical, Records & Systems, Public Health and Patient Experience) each containing a range of areas described by a total of 63 indicators. These indicators have points attached that are given to GP practices based on how they are performing against these measures. The maximum number of points achievable by a practice is 547. The domains and their constituent areas are illustrated in Figure 1 below. A full detailed list of the indicators is presented in Annex A. The Framework has remained unchanged in terms of indicators, definitions and points since 2016/17, a summary of the changes preceding this can be found in Annex B.

Figure 1: Quality and Outcomes Framework 2021/22: Domains, Areas

Domain	Area	No. of Indicators	Max. Points Available
Clinical	Diabetes Mellitus	10	73
	Coronary Heart Disease	4	48
	Asthma	3	41
	Chronic Obstructive Pulmonary Disease	5	32
	Heart Failure	3	25
	Atrial Fibrillation	2	22
	Mental Health	6	22
	Dementia	2	21
	Depression	1	21
	Hypertension	1	20
	Stroke and Transient Ischaemic Attack	6	20
	Rheumatoid Arthritis	3	17
	Cancer	1	6
	Osteoporosis	2	6
	Palliative Care	2	6
	Domain Total	51	380
Public Health	Blood Pressure	1	15
	Cervical Screening	1	11
	Cardiovascular Disease – Primary Prevention	2	10
	Smoking	1	10
	Sexual Health	1	3
	Domain Total	6	49
Records & Systems	Domain Total	5	100
Patient Experience	Domain Total	1	18
Framework Total		63	547

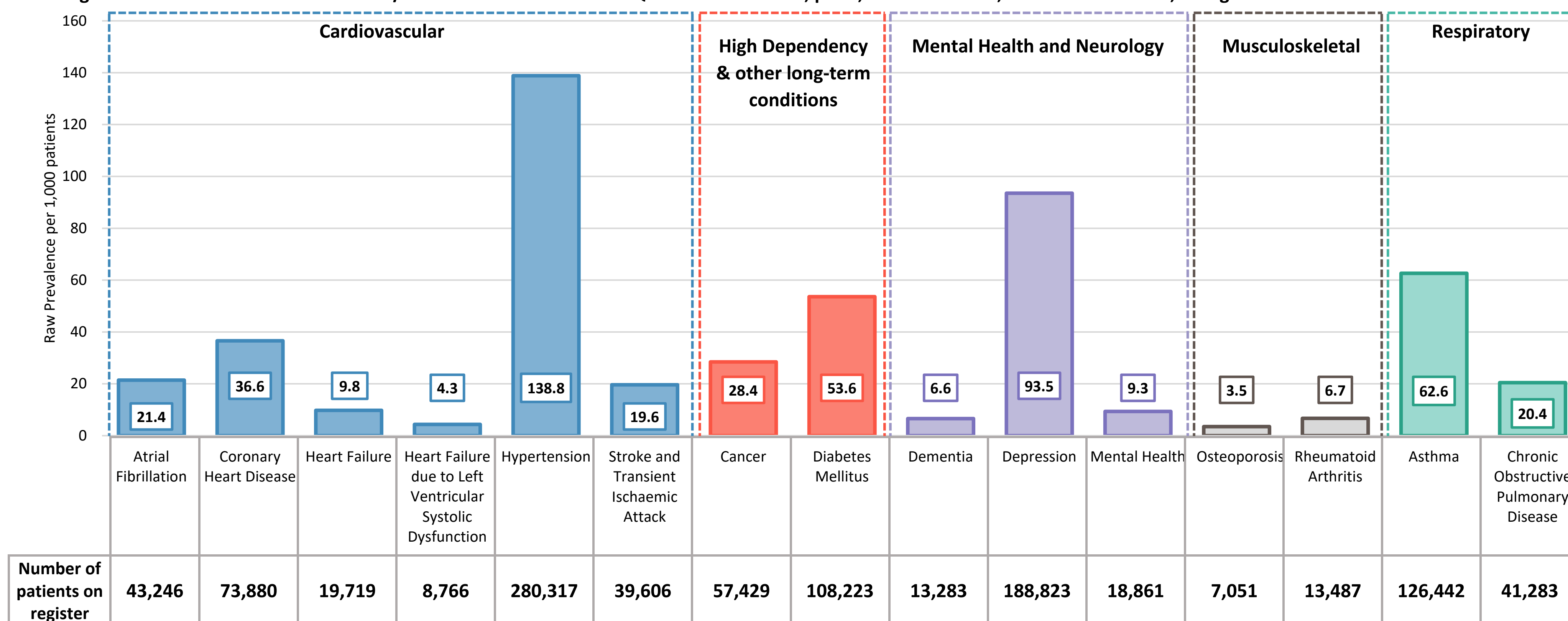
Disease Prevalence in the Framework

An important feature of QOF is the establishment of registers from which the prevalence of various conditions can be estimated. These conditions are all included in the Clinical Domain where registers can be used to estimate the raw prevalence of 15 diseases/conditions within the population. There are no registers suitable for estimating prevalence within the Public Health, Patient Experience or Records & Systems domains.

A statistical release on 'Raw Disease Prevalence in Northern Ireland' is available from the DoH website and this provides a more detailed explanation of how prevalence is calculated alongside a summary of the latest statistics. An interactive dashboard containing data by LCG and Federation Areas for the last 5 years is also available.

The chart below shows the raw prevalence rates for 15 of the registers that count patients with specific conditions or diseases in the 2021/22 Framework. The raw prevalence rate ranged from 138.8 per 1,000 patients for Hypertension to 3.5 per 1,000 patients for Osteoporosis.

Figure 2: Raw Prevalence of 15 disease/ conditions included in the QOF Clinical Domain, per 1,000 GP Patients, at 31st March 2022, All Ages



	Atrial Fibrillation	Coronary Heart Disease	Heart Failure	Heart Failure due to Left Ventricular Systolic Dysfunction	Hypertension	Stroke and Transient Ischaemic Attack	Cancer	Diabetes Mellitus	Dementia	Depression	Mental Health	Osteoporosis	Rheumatoid Arthritis	Asthma	Chronic Obstructive Pulmonary Disease
Number of patients on register	**43,246**	**73,880**	**19,719**	**8,766**	**280,317**	**39,606**	**57,429**	**108,223**	**13,283**	**188,823**	**18,861**	**7,051**	**13,487**	**126,442**	**41,283**

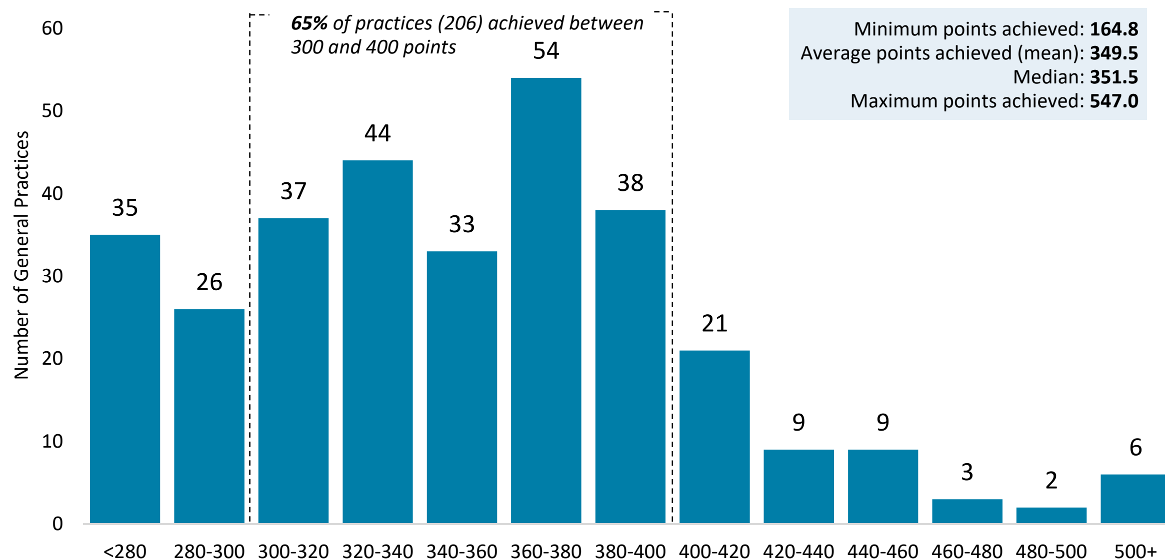
Quality and Outcomes Framework Achievement Statistics

2021/22

- Overall and by Domain
- By LCG and Federation Area
- Time Series (2017/18-2021/22)

Overall Achievement in the Quality & Outcomes Framework

Figure 3: Distribution of total points achieved by general practices

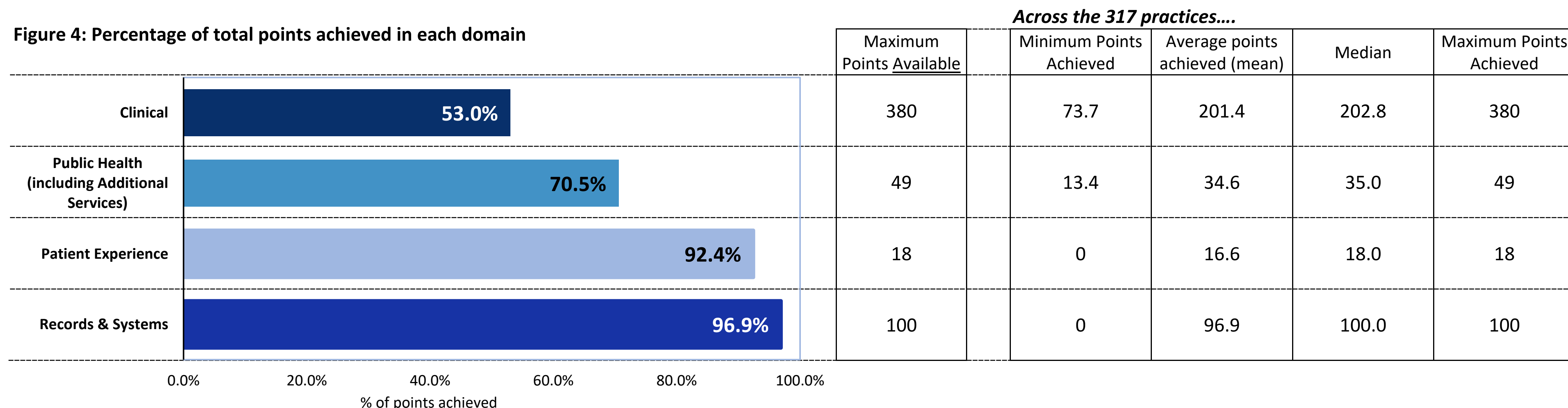


Overall Achievement

- QOF achievement data for 2020/21 was received from 319 practices in Northern Ireland. Data are reported throughout this report on 317 practices*.
- Figure 3 shows the distribution of total QOF points achieved across all 317 practices. One practice achieved the full 547 points.
- Average QOF achievement was 349.5 points, which equates to 63.9% of total points achievable. Median QOF achievement was 351.5 points (64.3%).
- 65% of practices (206) achieved in the range of 300 to 400 points.
- The percentage of total QOF points achieved was highest in the Records and Systems domain (96.9%), followed closely by the Patient Experience Domain (92.4%). Achievement was notably lower in the Public Health (70.5%) and Clinical Domains (53.0%).

Achievement by Domain

Figure 4: Percentage of total points achieved in each domain



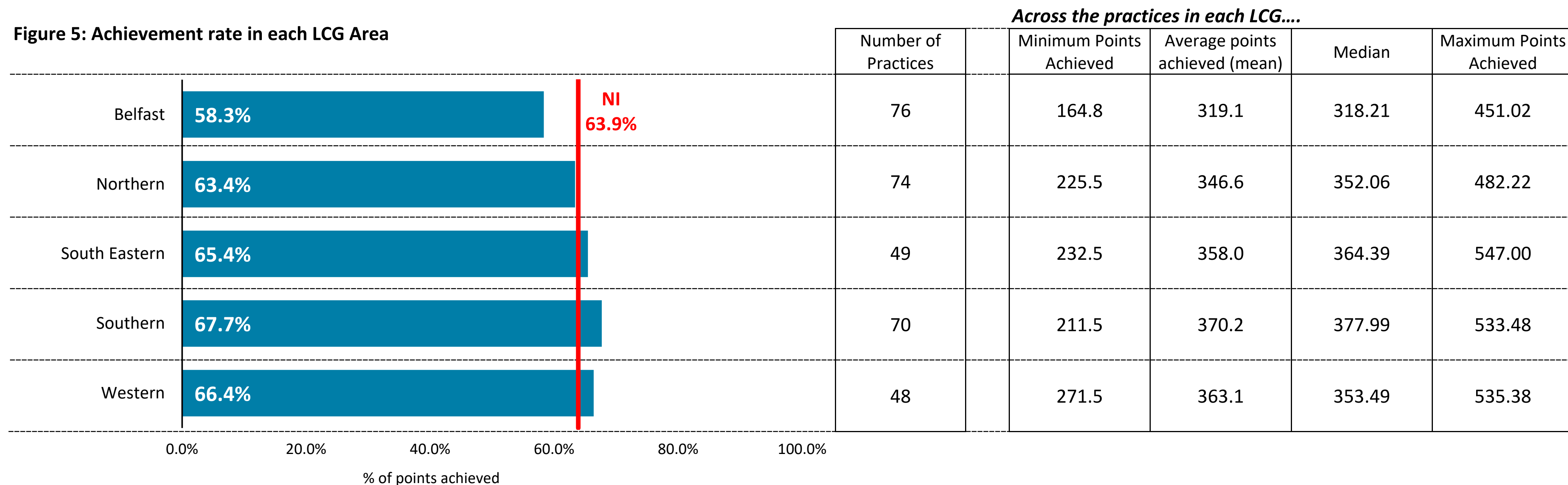
Across the 317 practices….

Domain	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved
Clinical	380	73.7	201.4	202.8	380
Public Health (including Additional Services)	49	13.4	34.6	35.0	49
Patient Experience	18	0	16.6	18.0	18
Records & Systems	100	0	96.9	100.0	100

* An agreement regarding QOF achievement was in place between the HSCB and 2 GP practices in relation to issues which the HSCB recognised would impact on QOF achievement in 2021/22. These issues related to a merger and a change of Contract. These 2 practices are excluded from all analysis.

Achievement by Local Commissioning Group (LCG) Area

Figure 5: Achievement rate in each LCG Area



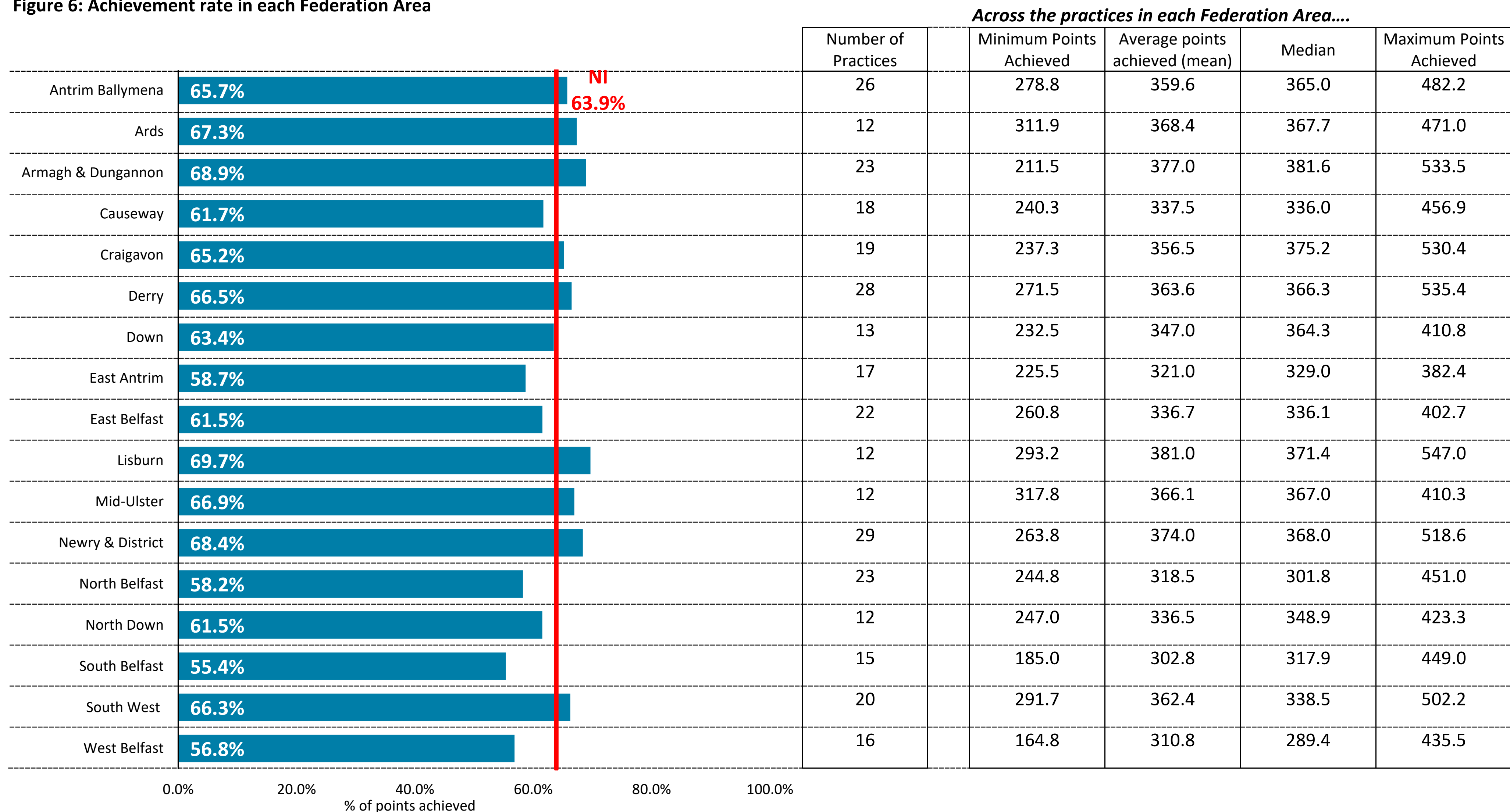
Across the practices in each LCG….

LCG	Number of Practices	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved
Belfast	76	164.8	319.1	318.21	451.02
Northern	74	225.5	346.6	352.06	482.22
South Eastern	49	232.5	358.0	364.39	547.00
Southern	70	211.5	370.2	377.99	533.48
Western	48	271.5	363.1	353.49	535.38

- Figure 5 shows the average QOF achievement rate of practices in each LCG area, as well as the number of practices, and the minimum, maximum, average and median points achieved for each LCG. The Northern Ireland average achievement rate is also shown.
- The average achievement rate at LCG area level ranges from 58.3% (319.1 points) in the Belfast LCG to 67.7% (370.2 points) in the Southern LCG, compared to the average Northern Ireland QOF achievement rate of 63.9% (349.5 points).
- Achievement across the last five years of QOF by LCG is presented on page 14.

Achievement by Federation Area

Figure 6: Achievement rate in each Federation Area



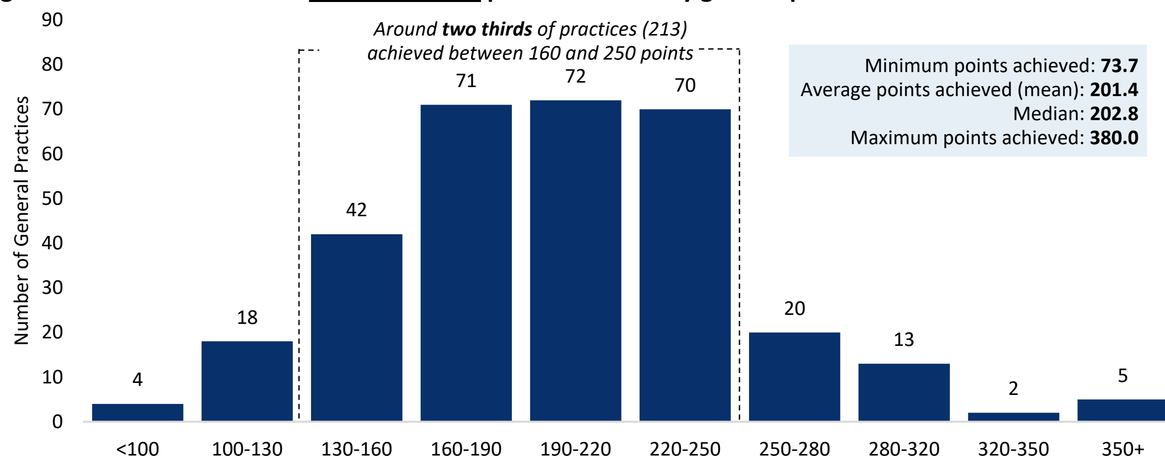
Across the practices in each Federation Area….

Federation Area	Number of Practices	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved
Antrim Ballymena	26	278.8	359.6	365.0	482.2
Ards	12	311.9	368.4	367.7	471.0
Armagh & Dungannon	23	211.5	377.0	381.6	533.5
Causeway	18	240.3	337.5	336.0	456.9
Craigavon	19	237.3	356.5	375.2	530.4
Derry	28	271.5	363.6	366.3	535.4
Down	13	232.5	347.0	364.3	410.8
East Antrim	17	225.5	321.0	329.0	382.4
East Belfast	22	260.8	336.7	336.1	402.7
Lisburn	12	293.2	381.0	371.4	547.0
Mid-Ulster	12	317.8	366.1	367.0	410.3
Newry & District	29	263.8	374.0	368.0	518.6
North Belfast	23	244.8	318.5	301.8	451.0
North Down	12	247.0	336.5	348.9	423.3
South Belfast	15	185.0	302.8	317.9	449.0
South West	20	291.7	362.4	338.5	502.2
West Belfast	16	164.8	310.8	289.4	435.5

- Figure 6 shows the average QOF achievement rate of practices in each GP Federation area, as well as the number of practices, and the minimum, maximum, average and median points achieved for each Federation. The average achievement rate at Federation level ranges from 55.4% (302.8 points) in the South Belfast Federation to 69.7% (381.0 points) in the Lisburn Federation, compared to the average Northern Ireland QOF achievement rate of 63.9% (349.5 points).

Achievement by Quality and Outcomes Framework Area – Clinical Domain

Figure 7: Distribution of total Clinical Domain points achieved by general practices



- Figure 7 shows the distribution of total Clinical points achieved across all 317 practices. One practice achieved the full 380 points available.
- Average achievement was 201.4 points, which equates to 53.0% of total points achievable. Median QOF achievement was 202.8 points (53.4%).
- Figure 8 shows the achievement rates and the minimum, maximum and average points values for each Clinical Domain area. Detailed achievement statistics and full descriptions of the indicators are presented in Appendix A.

Figure 8: Achievement rate in each Clinical Domain Area

Across the 317 practices ….

Clinical Domain Area	% of points achieved	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved
Diabetes Mellitus	63.8%	73	3.66	46.54	52.12	73.00
Coronary Heart Disease	73.7%	48	7.00	35.38	37.50	48.00
Asthma	43.4%	41	0.17	17.81	15.00	41.00
Chronic Obstructive Pulmonary Disease	43.1%	32	1.48	13.79	13.36	32.00
Heart Failure	86.2%	25	0.00	21.56	23.00	25.00
Atrial Fibrillation	69.8%	22	9.47	15.35	14.52	22.00
Mental Health	30.3%	22	0.00	6.66	5.95	22.00
Dementia	16.7%	21	0.00	3.50	1.81	21.00
Depression	26.5%	21	0.00	5.57	0.00	21.00
Hypertension	32.1%	20	0.00	6.42	2.68	20.00
Stroke and Transient Ischaemic Attack	71.0%	20	3.87	14.21	14.68	20.00
Rheumatoid Arthritis	24.8%	17	0.00	4.22	3.07	17.00
Cancer	22.2%	6	0.00	1.33	0.00	6.00
Osteoporosis	53.8%	6	0.00	3.23	3.00	6.00
Palliative Care	96.5%	6	3.00	5.79	6.00	6.00

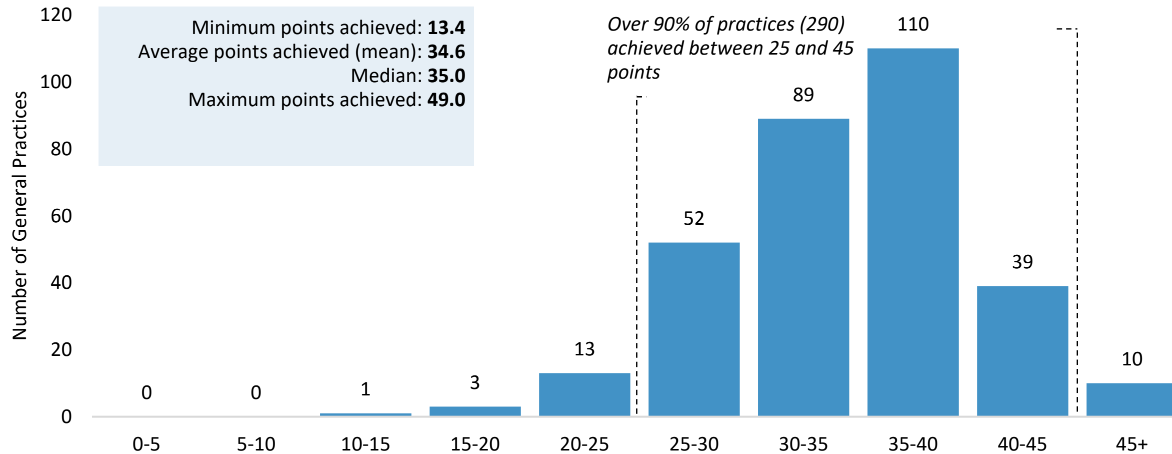
Clinical Domain - NI Rate 53.0%

0.0% 20.0% 40.0% 60.0% 80.0% 100.0%

% of points achieved

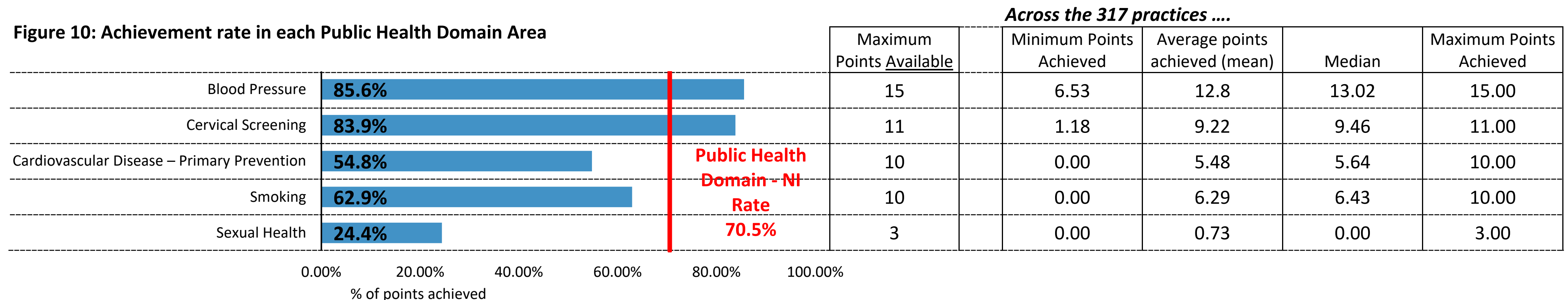
Achievement by Quality and Outcomes Framework Area – Public Health Domain (including Public Health – Additional Services)

Figure 9: Distribution of total Public Health Domain points achieved by general practices



- Figure 9 shows the distribution of total Public Health points achieved across all 317 practices. One practice achieved the full 49 points available.
- Average achievement was 34.6 points, which equates to 70.5% of total points achievable. Median QOF achievement was 35.0 points (71.5%).
- Figure 10 shows the achievement rates and the minimum, maximum and average points values for each Public Health Domain area. Detailed achievement statistics and full descriptions of the indicators are presented in Appendix A.

Figure 10: Achievement rate in each Public Health Domain Area



Across the 317 practices ....

	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved
Blood Pressure	15	6.53	12.8	13.02	15.00
Cervical Screening	11	1.18	9.22	9.46	11.00
Cardiovascular Disease – Primary Prevention	10	0.00	5.48	5.64	10.00
Smoking	10	0.00	6.29	6.43	10.00
Sexual Health	3	0.00	0.73	0.00	3.00

Achievement by Quality and Outcomes Framework Area – 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; 293 practices (92.4%) received the full 18 points.

Achievement by Quality and Outcomes Framework Area – Records & Systems Domain

There are 5 indicators in this domain, with a total of 100 points available; 299 practices (94.3%) achieved the full 100 points.

Achievement by QOF Grouping

The QOF indicators are presented here using 'QOF Groups'.

Table 1 shows achievement according to these QOF groups and Table 2 lists the conditions within each of the QOF groups. Further information about the QOF indicators may be found in Annexes A and B.

Table 1. 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	50,720	35,263	69.5%
Fertility, Obstetrics & Gynaecology	2	4,438	3,156	71.1%
High Dependency & other long-term conditions	13	26,945	17,012	63.1%
Lifestyle	1	3,170	1,994	62.9%
Mental Health and Neurology	9	20,288	4,985	24.6%
Musculoskeletal	5	7,291	2,361	32.4%
Respiratory	8	23,141	10,017	43.3%
Undefined group	6	37,406	35,994	96.2%

Source: PCAS, July 2022

Table 2. 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

QOF Group	Condition/Measure
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

Time Series: 2017/18 - 2021/22

Overall Achievement

Figure 11: Overall achievement rate, 2017/18-2021/22

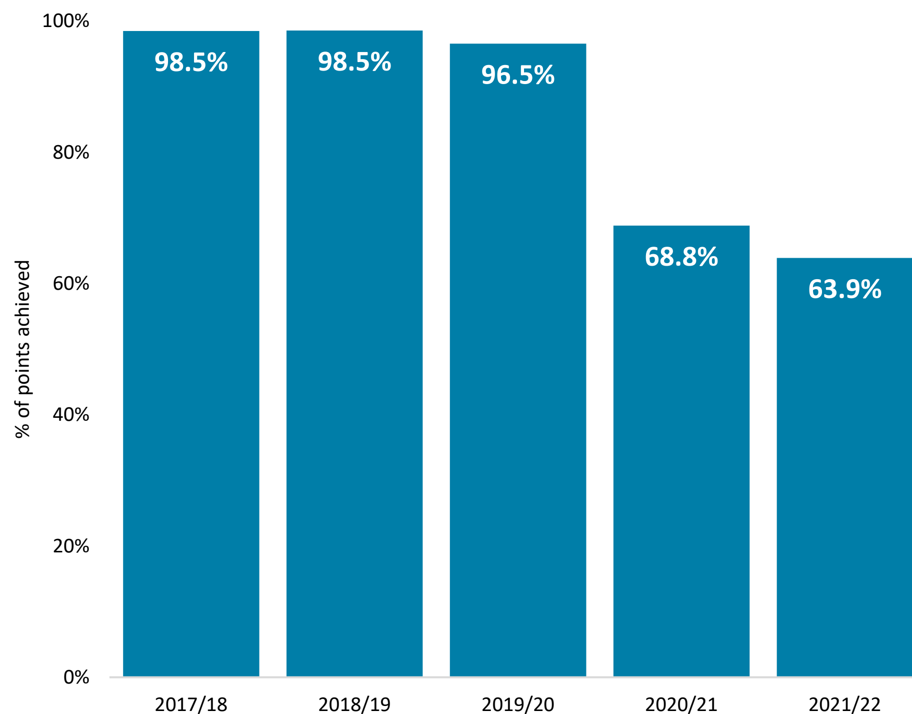
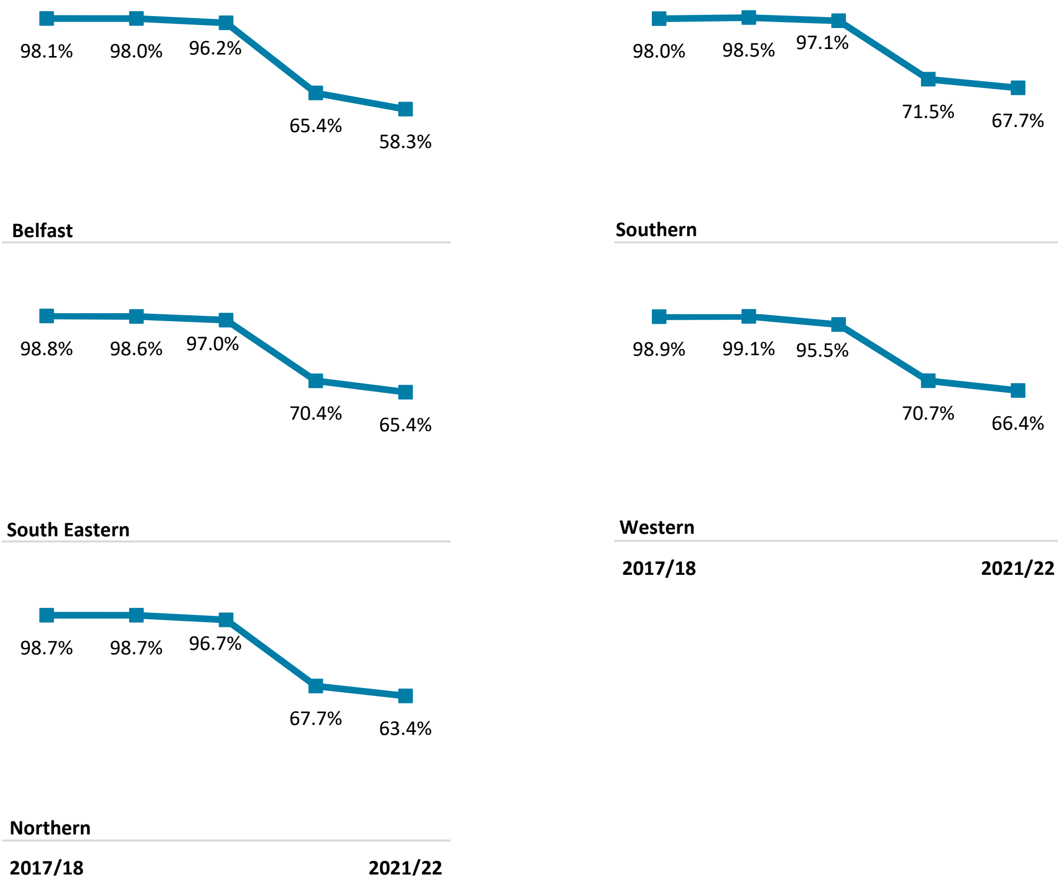


Figure 12: Achievement rate by LCG Area, 2017/18-2021/22



- Achievement levels across all five LCGs in 2021/22 were again notably lower than the high levels of achievement seen prior to 2020/21. The lowest achievement was in the Belfast LCG (58.3%) compared to the highest achievement in the Southern LCG (67.7%), but all LCGs had reductions in achievement levels.
- The outbreak of Covid-19 in the final quarter of 2019/2020 had a significant impact on how GP practices managed the treatment of their patients. During 2021/22, due to the continuing Covid-19 pandemic, the DoH agreed with NIGPC and the HSCB to continue standing down elements of the GMS contract. The majority of Quality and Outcomes Framework (QOF) activity and reporting remained suspended in 2021/2022. QOF data therefore, for 2021/2022, including the exceptions data, may have been impacted upon and it is recommended that the use of this data in publications or drawing conclusions from it includes appropriate caveats acknowledging the unprecedented impact of Covid-19.

Time Series: 2017/18 - 2021/22

Achievement by Domain - Clinical Domain

Figure 13: Clinical Domain achievement rate, 2017/18-2021/22

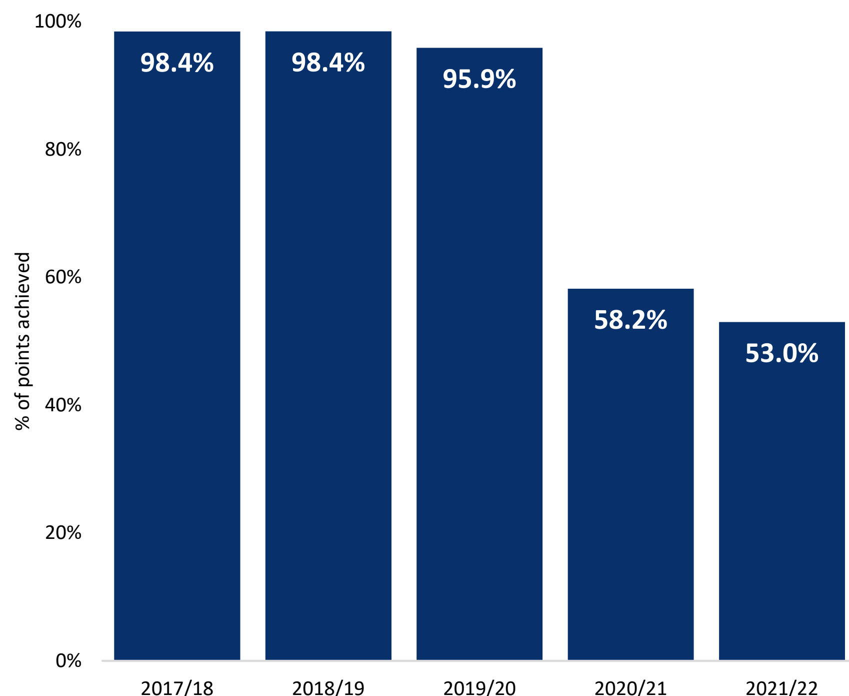
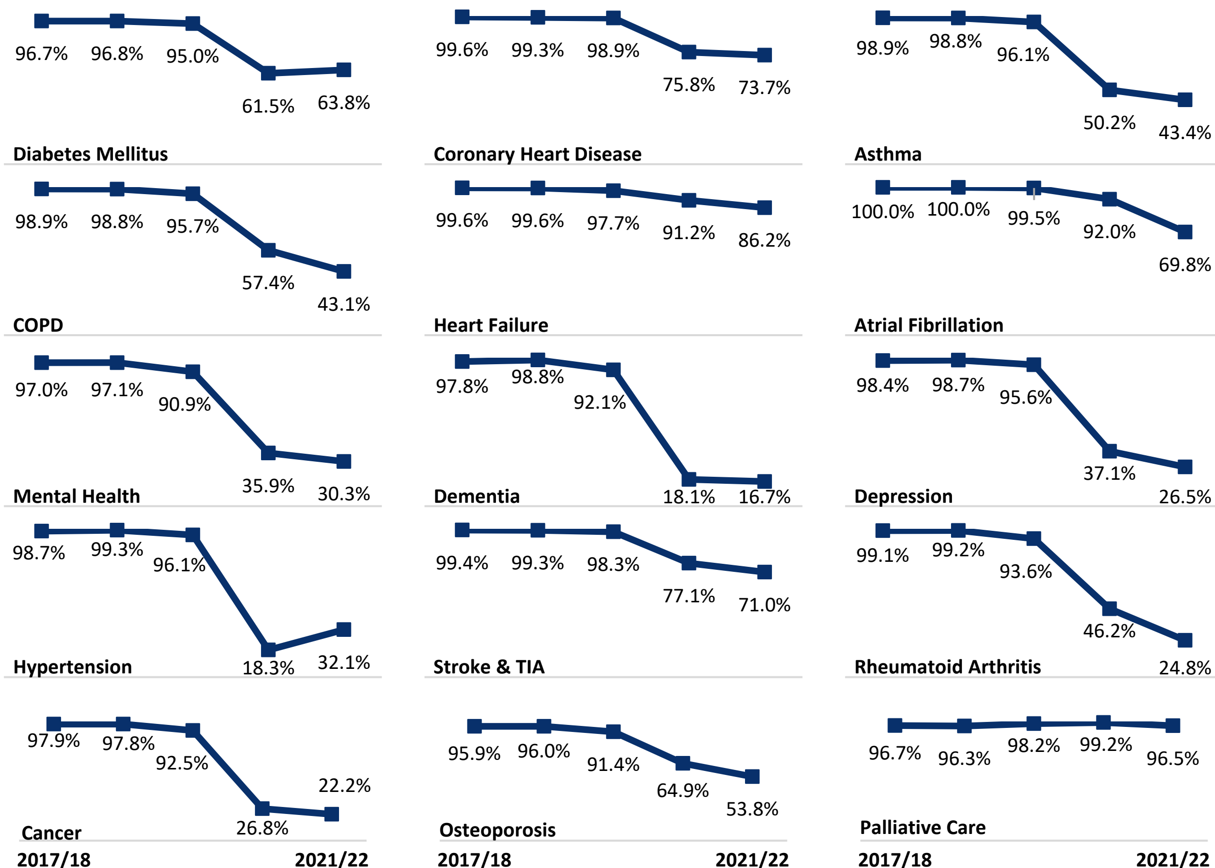


Figure 14: Achievement rate by Clinical Domain Area, 2017/18-2021/22



- Overall achievement in the Clinical domain has shown further decline on that of last year, with an achievement rate of 53.0% for 2021/22 (Figure 13).
- Figure 14 shows that the majority of clinical domain areas show this decline in achievement, with many already having a notably lower achievement level last year. Of particular note are the clinical domain areas of Cancer, Dementia and Rheumatoid Arthritis, which like most clinical domain areas have historically shown high levels of achievement.

Time Series: 2017/18 - 2021/22

Achievement by Domain – Public Health Domain (including Additional Services)

Figure 15: Public Health Domain achievement rate, 2017/18-2021/22

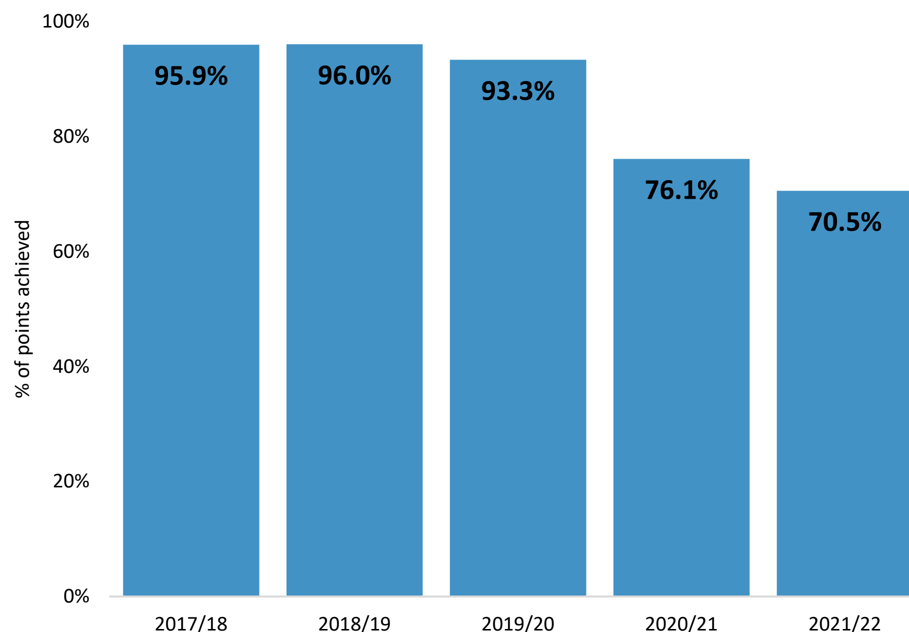
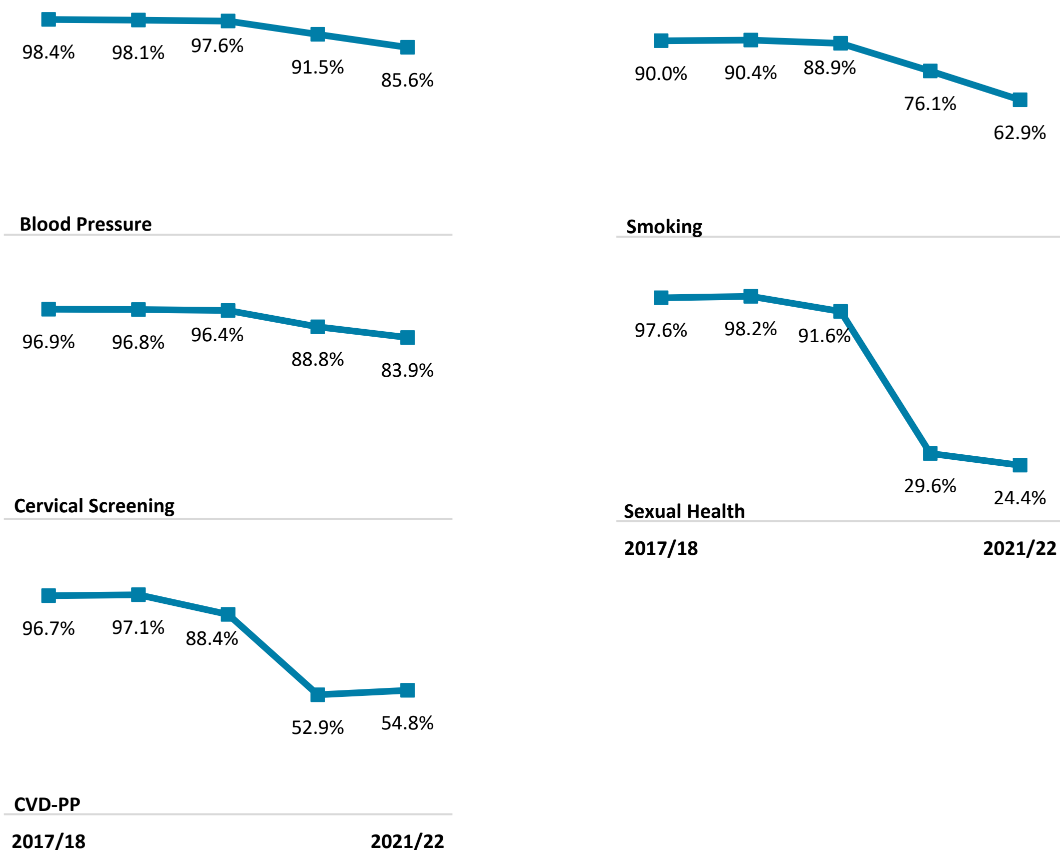


Figure 16: Achievement rate by Public Health Domain Area, 2017/18-2021/22

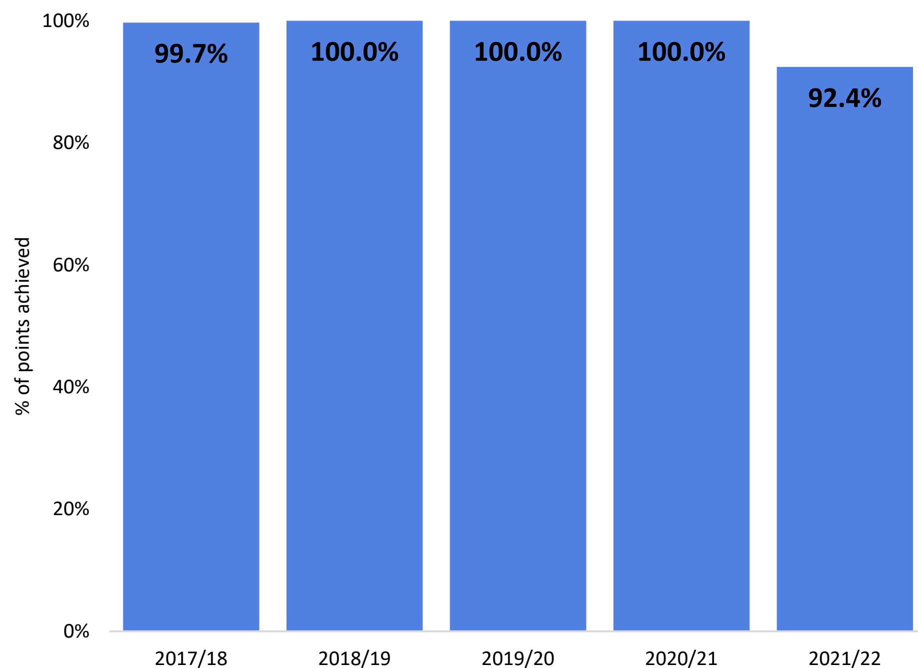


- Overall achievement in the Public Health domain for 2021/22 was 70.5%, a small decrease on the achievement level seen last year (Figure 15).
- Figure 16 shows that most of the Public Health domain areas had lower achievement rates than those of the previous year, with the Sexual Health domain area being notable with an achievement rate of 24.4%. Again, all of the domain areas have shown historically high achievement rates.
- The CVD-PP Domain area shows a small increase in achievement, from 52.9% last year to 54.8% for 2021/22, although this remains much lower than achievement levels seen in previous years.

Time Series: 2017/18 - 2021/22

Achievement by Domain – Patient Experience Domain

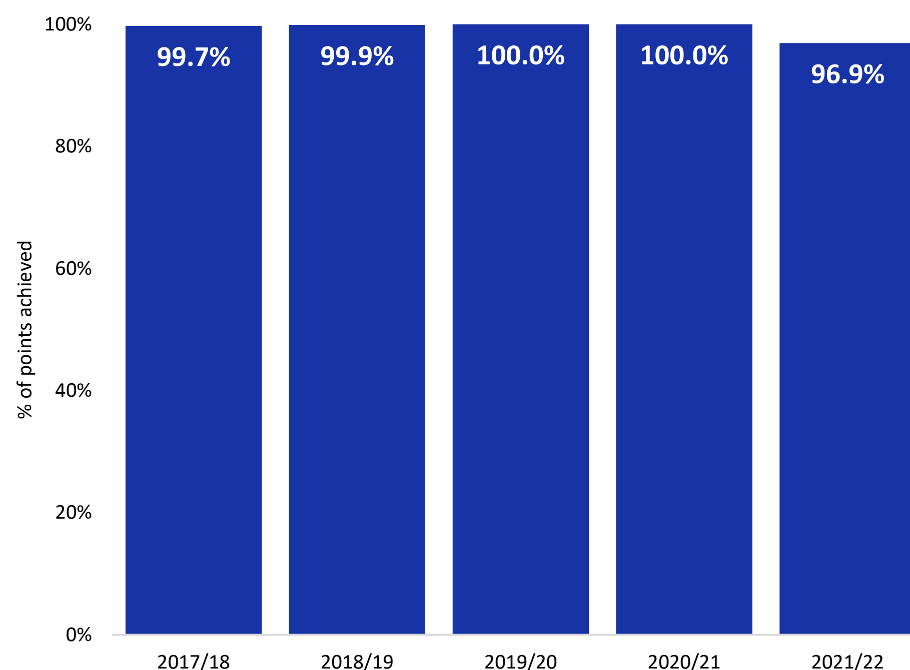
Figure 17: Patient Experience achievement rate, 2017/18-2021/22



Time Series: 2017/18 - 2021/22

Achievement by Domain – Records & Systems Domain

Figure 18: Records & Systems Domain achievement rate, 2017/18-2021/22



- Achievement in both the Patient Experience and Records & Systems domains remain high, although both have shown a small decrease on the full achievement of the previous few years.
- 293 GP practices (92.4%) achieved the full 18 points in the Patient Experience domain, which consists of one indicator for which practices can received either full (18) or no points.
- 299 GP practices (96.6%) achieved the full 100 points available in the Records and Systems, which is made up of five indicators, some of which relate to the process of patient referrals.

Quality and Outcomes Framework Exception Reporting Statistics 2021/22

- Criteria for Exception
- Calculation of Exception rates
- Exception reporting summaries
- By LCG, Federation Area and GP Practice

Criteria for Exception

The criteria for a patient being excepted are detailed in Annex D12 of the Statement of Financial Entitlement as follows,

a) patients who have been recorded as refusing to attend review who have been invited on at least 3 occasions during the financial year to which the achievement payments relate (except in the case of indicator CS002, where the patient should have been invited on at least 3 occasions during the period specified in the indicator during which the achievement is to be measured i.e. the preceding 5 years ending on 31st March in the financial year to which achievement payments relate);
b) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail;
c) patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels;
d) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal;
e) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contraindication or have experienced an adverse reaction;
f) where a patient has not tolerated medication;
g) where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their medical records following a discussion with the patient;
h) where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease; or
i) where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B, these patients are removed from the denominator for all indicators in that disease area where the care has not been delivered. For example, in the case of a contractor with 100 patients on the Coronary Heart Disease (CHD) register, of which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95, with the 5 patients being excepted. However, all 100 patients with CHD would be included in the calculation of the Adjusted Practice Disease Factor (APDF) (see page 2). This would apply to all relevant indicators in the CHD set.

In addition, contractors may exception report patients from single indicators if they meet criteria in Annex D12(c)-(i), for example a patient who has heart failure due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin receptor converting enzyme inhibitors (ACE inhibitors) and angiotensin receptor blocker (ARB) could be exception reported from Heart Failure (HF) indicator HF003NI. This would result in the patient being removed from the denominator for that indicator only.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have excepted patients from an indicator and this should be identifiable in the patient record.

It is **not possible to publish exception rates by specific reason** of exception due to practices using different IT systems. The sequence by which the clinical system of each practice (such as EMIS, InPractice, iSoft and Merlok) searches for exception reasons varies, and if a patient has been excepted for more than one reason, the hierarchy of exception reasons may differ between these systems and it is therefore unclear which exception reason was chosen.

Calculation of Exception Rate

Summaries of exception rates for 2021/22 are presented in this report. The denominator is the number of patients that can appropriately be included in an indicator.

The exception rate calculation is: $\left[\frac{Number\ of\ Exceptions}{(Exceptions+Denominator)}\right] \times 100$

Exception Reporting Summaries

Table 3. Northern Ireland Exception Rates by Indicator Group

Condition	Denominator	Exceptions	Exception rate
Asthma	187,455	1,762	0.93%
Atrial Fibrillation	53,139	32,947	38.27%
Blood Pressure	856,704	3,422	0.40%
Cancer	6,414	1,296	16.81%
CHD	286,883	7,021	2.39%
COPD	148,851	11,334	7.08%
Cervical Screening	475,828	30,728	6.07%
CVD-PP	9,131	1,196	11.58%
Dementia	14,968	707	4.51%
Depression	7,326	1,474	16.75%
Diabetes	901,092	28,054	3.02%
Heart Failure	32,556	711	2.14%
Hypertension	274,798	4,018	1.44%
Mental Health	60,756	1,545	2.48%
Osteoporosis	6,866	176	2.50%
Rheumatoid Arthritis	31,511	612	1.91%
Sexual Health	4,410	40	0.90%
Smoking	1,643,353	5,441	0.33%
STIA	174,970	4,604	2.56%

- Table 3 summarises exception rates for 55 individual indicators by indicator group. Tables 4 and 5 show the ten highest and ten lowest exception rates by indicator.
- The highest exception rate at Northern Ireland level, at 42.47%, is attributed to AF006 (Atrial Fibrillation 6, defined as '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').
- At 0.22%, the lowest exception rate at Northern Ireland level is for COPD (COPD005), defined as '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'.

Table 4: Ten highest exception rates, at Northern Ireland level, by indicator

Indicator Code*	Name	Denominator	Exceptions	Exception rate
AF006	Atrial Fibrillation	24,764	18,279	42.47%
AF007	Atrial Fibrillation	28,375	14,668	34.08%
COPD004	COPD	33,473	7,527	18.36%
CAN003	Cancer	6,414	1,296	16.81%
DEP001	Depression	7,326	1,474	16.75%
MH008	Mental Health	4,196	777	15.62%
CVD-PP011	CVD-PP	6,745	1,023	13.17%
CVD-PP012	CVD-PP	2,386	173	6.76%
CS002	Cervical Screening	475,828	30,728	6.07%
COPD002	COPD	25,648	1,623	5.95%

Table 5: Ten lowest exception rates, at Northern Ireland level, by indicator

Indicator Code*	Name	Denominator	Exceptions	Exception rate
CON003	Sexual Health	4,410	40	0.90%
MH003	Mental Health	17,046	154	0.90%
AST003	Asthma	124,850	987	0.78%
DEM003	Dementia	2,441	19	0.77%
BP002	Blood Pressure	856,704	3,422	0.40%
CHD005	CHD	73,213	263	0.36%
AST004	Asthma	9,203	33	0.36%
STIA007	STIA	27,404	93	0.34%
SMOK001	Smoking	1,643,353	5,441	0.33%
COPD005	COPD	9,892	22	0.22%

* Indicator code definitions can be found in Annex A.

Exception Rates by Local Commissioning Group (LCG) and Federation Areas

Figure 19: Overall Exception rates by LCG

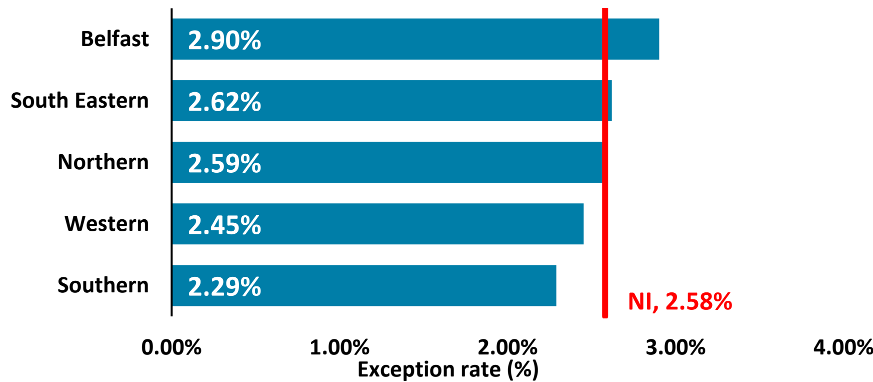
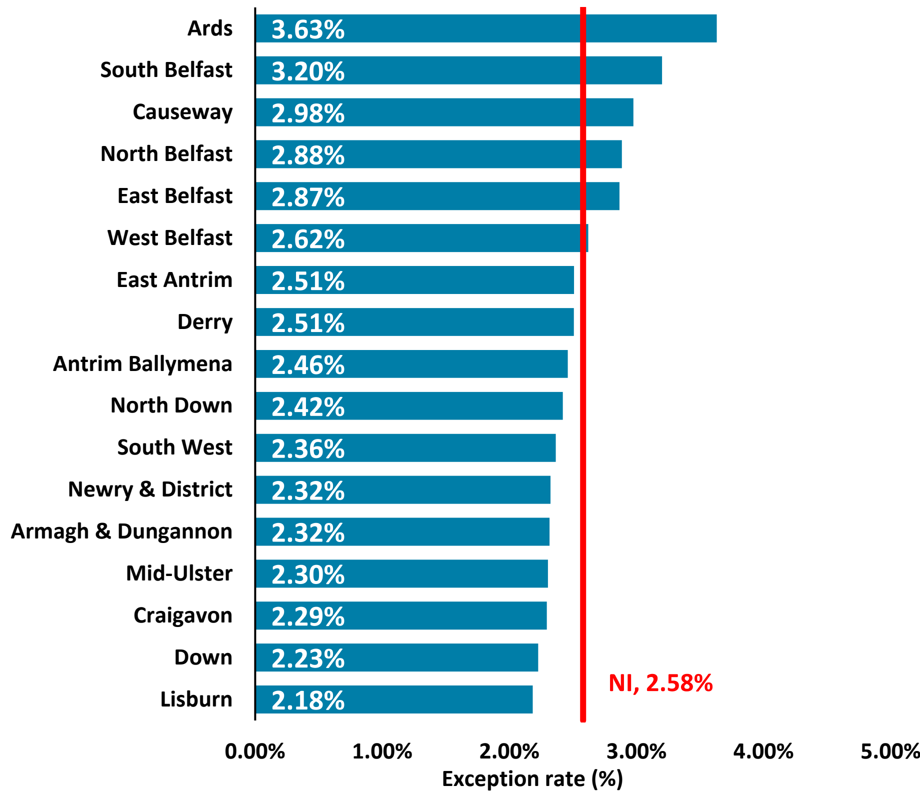
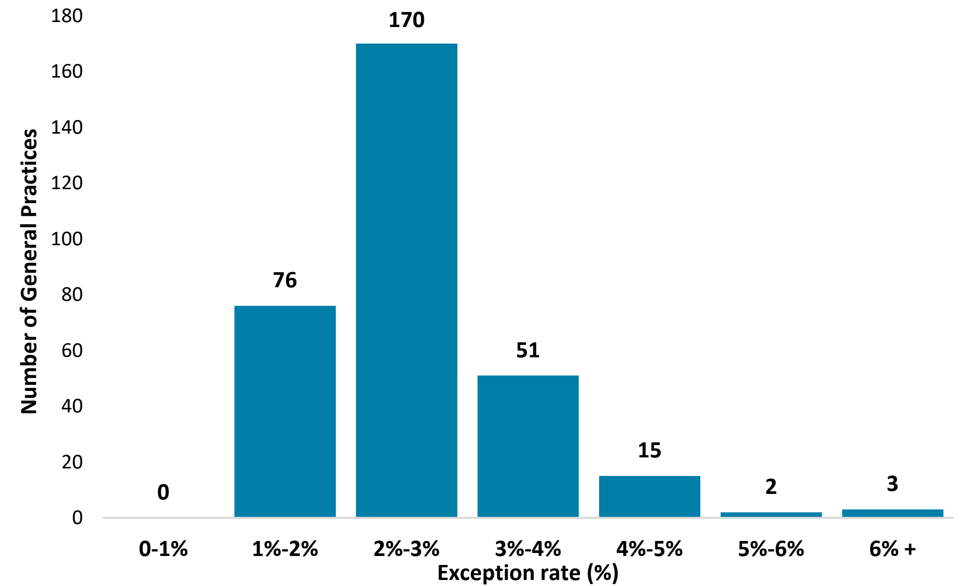


Figure 20: Overall Exception rates by Federation Area



Exception Rates by Practice

Figure 21: Distribution of exception rates recorded by general practices



- Figures 19 and 20 show the overall exception rates in each Local Commissioning Group and Federation Area, with the NI Exception rate included on each.
- The Southern LCG has the lowest overall exception rate at 2.29% and the Belfast LCG has the highest overall exception rate at 2.90%.
- The Lisburn Federation has the lowest overall exception rate at 2.18% and the Ards Federation has the highest overall exception rate at 3.63%
- Figure 21 shows the Distribution of exception rates recorded by general practices. The majority of general practices (170, 53.6% of practices) had exception rates in the range of 2% to 3%. Only three practices had exception rates greater than 6%

Annex A:

QOF Indicators and Points Achieved

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	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	4,755	4,268	89.75%
Clinical	Asthma (AST)	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	6,340	977	15.41%
Clinical	Asthma (AST)	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	1,902	401	21.08%
Clinical	Atrial fibrillation	AF006NI	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more)	12	3,804	1,696	44.57%
Clinical	Atrial fibrillation	AF007	In those patients with atrial fibrillation whose latest record of a CHA_2DS2-VASc score is 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	10	3,170	3,169	99.98%
Clinical	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	1,902	422	22.17%
Clinical	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	5,389	3,128	58.05%
Clinical	Secondary prevention of coronary heart disease (CHD)	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	5,389	4,898	90.89%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	Secondary prevention of coronary heart disease (CHD)	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	2,219	2,182	98.35%
Clinical	Secondary prevention of coronary heart disease (CHD)	CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	2,219	1,006	45.32%
Clinical	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	1,585	1,370	86.44%
Clinical	Chronic obstructive pulmonary disease (COPD)	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	2,853	297	10.42%
Clinical	Chronic obstructive pulmonary disease (COPD)	COPD004NI	The percentage of patients with COPD with a record of FEV_1 in the preceding 3 years	7	2,219	1,315	59.25%
Clinical	Chronic obstructive pulmonary disease (COPD)	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	1,585	463	29.22%
Clinical	Chronic obstructive pulmonary disease (COPD)	COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	1,902	926	48.71%
Clinical	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	4,755	366	7.69%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	Dementia (DEM)	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	1,902	744	39.13%
Clinical	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	6,657	1,765	26.51%
Clinical	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	2,536	1,729	68.18%
Clinical	Diabetes mellitus (DM)	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	3,170	1,698	53.56%
Clinical	Diabetes mellitus (DM)	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	1,902	1,035	54.42%
Clinical	Diabetes mellitus (DM)	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	951	618	64.99%
Clinical	Diabetes mellitus (DM)	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	5,389	4,636	86.03%
Clinical	Diabetes mellitus (DM)	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	2,536	1,384	54.56%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	Diabetes mellitus (DM)	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	3,170	1,944	61.34%
Clinical	Diabetes mellitus (DM)	DM010	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	951	412	43.34%
Clinical	Diabetes mellitus (DM)	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	1,268	173	13.63%
Clinical	Diabetes mellitus (DM)	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	1,268	1,125	88.73%
Clinical	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	1,902	1,424	74.86%
Clinical	Heart failure	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	3,170	2,594	81.83%
Clinical	Heart failure	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 betablocker licensed for heart failure	9	2,853	2,817	98.75%
Clinical	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	6,340	2,037	32.12%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	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	1,902	142	7.45%
Clinical	Mental health (MH)	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	1,268	273	21.55%
Clinical	Mental health (MH)	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	1,268	76	5.98%
Clinical	Mental health (MH)	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	1,585	1,172	73.95%
Clinical	Mental health (MH)	MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1	317	187	58.95%
Clinical	Mental health (MH)	MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2	634	260	41.03%
Clinical	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	951	594	62.46%
Clinical	Osteoporosis: secondary prevention of fragility fractures	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	951	429	45.07%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	Palliative Care (PC)	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	951	939	98.74%
Clinical	Palliative Care (PC)	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	951	897	94.32%
Clinical	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	1,585	100	6.33%
Clinical	Rheumatoid arthritis (RA)	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	2,219	859	38.70%
Clinical	Rheumatoid arthritis (RA)	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	1,585	379	23.94%
Clinical	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	1,585	730	46.03%
Clinical	Stroke and transient ischaemic attack (STIA)	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	634	553	87.22%
Clinical	Stroke and transient ischaemic attack (STIA)	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	1,585	1,399	88.26%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Clinical	Stroke and transient ischaemic attack (STIA)	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	1,268	1,216	95.93%
Clinical	Stroke and transient ischaemic attack (STIA)	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	634	346	54.58%
Clinical	Stroke and transient ischaemic attack (STIA)	STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	634	260	41.01%
Public Health	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	1,585	817	51.57%
Public Health	Cardiovascular disease – primary prevention (CVD-PP)	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	1,585	920	58.03%
Public Health	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	4,755	4,070	85.60%
Public Health	Smoking (SMOK)	SMOK001NI	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10	3,170	1,994	62.91%
Public Health (Additional Services)	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	3487	2924	83.85%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Public Health (Additional Services)	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	951	232	24.42%
Patient Experience	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 2022	18	5706	5274	92.43%
Records & Systems	Records & Systems	RS001	General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialties.	20	6340	6060	95.58%
Records & Systems	Records & Systems	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	6340	6160	97.16%
Records & Systems	Records & Systems	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	6340	6100	96.21%
Records & Systems	Records & Systems	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	6340	6200	97.79%

Annex A: QOF Indicators and Points Achieved

Domain	Indicator area	Indicator ID	Indicator definition	Points Available (per practice)	Points Available (NI)	Points Achieved (NI)	% of Points Achieved
Records & Systems	Records & Systems	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.	20	6340	6200	97.79%

An agreement regarding QOF achievement was in place between the HSCB and 2 practices in relation to issues which the HSCB recognised would impact on QOF achievement in 2020/21. These issues related to practice closures, dispersals and mergers and the subsequent impact on practices. These 2 practices are excluded from all tables and analysis.

Annex B:

Timeline of changes to the QOF Framework

Annex B: Timeline of changes to the QOF Framework

Timeline of changes to the QOF Framework

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.

Contact

For further information regarding this statistical bulletin, or to make any comments or feedback, please contact:

Information & Analysis Directorate,
Department of Health,
Room 2, Annex 2, Castle Buildings,
Stormont Estate,
Belfast, BT4 3SQ
Telephone: 028 9052 2160
E-mail: qofdataenquiries@health-ni.gov.uk

This bulletin presents the QOF Statistics in a new format and we would particularly appreciate any comments or feedback, which can be sent to the lead statistician, Penny Murray, at the e-mail address above.