Quality and Outcomes Framework

2015-16

Quality and Outcomes Framework statistics for Northern Ireland 2015/16

This bulletin summarises the twelfth year of Quality and Outcomes Framework (QOF) achievement data from general practices, reporting on the period from April 2015 to March 2016. The major changes to QOF in this period were the subsuming of some indicators relating to registers of conditions into core funding, the retirement of other indicators and conditions and the replacement of conditions with alternatives.

All data used in this bulletin is from the Payment Calculation and Analysis System (PCAS), a Northern Ireland (NI) IT system used to support the QOF payment process and is dated 1st April 2016.

Summary

- The average total QOF achievement of practices was 539.05 (98.55%), from a maximum available QOF total of 547.

- From the QOF indicators that measure the prevalence of a disease, the highest recorded prevalence was for Hypertension (13.32%) and the lowest was for Osteoporosis (0.21%).

- Across the clinical domains, the average points achieved were:
    - Clinical: 374.33 (98.51%)
    - Public Health: 33.56 (95.89%)
    - Public Health (Additional Services): 13.66 (97.55%)
    - Patient Experience: 17.95 (99.71%)
    - Records & Systems: 99.56 (99.56%).

- The 347 practices received a total of £30.52million, with an average award of £87,950 per practice[1].

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[1] Practices experienced delays in implementing changes to QOF systems in 2015/16, making it more difficult for GPs to manage their performance against QOF targets. Given these difficulties, DoH reached agreement with the Northern Ireland General Practitioners' Committee (NIGPC) that QOF payments for 2015/16 would be based on either a practice's actual performance or their average performance for the previous two years against the relevant targets, whichever is better.

The Health and Social Care Board (HSCB) calculated the percentage of clinical points achieved by each practice in 2015/16 and compared this to the average percentage of clinical points achieved in the previous two years to identify variances. For practices who achieved a lower percentage in 2015/16, the percentage variance has been applied to 2015/16 clinical achievement and the additional payment calculated was paid to practices in June 2016.

Contents

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1. Introduction

The figures in this bulletin are derived from PCAS, a system that uses data from general practices to calculate the QOF achievement of, and payments due to, individual practices. 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)[2].

The 2015/16 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 2016; 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 2016 formed the basis for figures for the complete financial year April 2015 to March 2016. Any adjustments made by the Health and Social Care Board in the period April to June 2016 are included. This publication uses the most recent figures for each practice as at 30 June 2016 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 2015/16 QOF exception reporting in a separate bulletin[3].

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[2] Department of Health. (2016) *QOF NI Achievement Data 2015-16* [.zip] Available from: https://www.health-ni.gov.uk/publications/quality-and-outcomes-framework-qof-achievement-data-201516 [Accessed: 21st October 2016].
[3] Department of Health. (2016) *QOF Exception reporting bulletin 2015/16* [.pdf] Available from: https://www.health-ni.gov.uk/publications/exception-reporting-data-201516 [Accessed: 21st October 2016].

2. Disease Prevalence in the Quality & Outcomes Framework

An important feature of QOF is the establishment of registers to use when calculating the prevalence of various conditions. There are 22 registers within QOF and 17 of these may be used to calculate the prevalence of their respective conditions within the population. The prevalence figures for these 17 conditions are presented in table 5 under section 4.5 below.

The Department has published raw (unadjusted) disease prevalence as prevalence information on its website, which is the number on the disease register of a practice on 31st March 2016 as a proportion of its registered patients at 1st January 2016. 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.

The recording of patients who have been diagnosed with some conditions is limited to those diagnosed with the condition and who are over a certain age. The conditions, and age limits, are: Diabetes (patients aged 17 and over), Depression (patients aged 18 and over), Osteoporosis (patients aged 50 and over) and Rheumatoid Arthritis (patients aged 16 and over). The publication includes these age-specific registers and counts of total patients in this age bracket and calculates the prevalence of each condition based on both the whole population and the age-specific population.

A report entitled 'Raw Disease Prevalence in Northern Ireland'[4] shows the calculation for disease prevalence for a practice and how it is used in the calculations for QOF payment to that practice. This report and the data used in its calculation[5] file are available from the Department's website via the Statistics section.

More detailed information on prevalence itself, how to interpret it and the definitions of registers used in its calculation may be found in a factsheet published by the Department[6].

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[4] Department of Health. (2016) *2015/16 Raw Disease Prevalence Data for Northern Ireland* [Online] Available from: https://www.health-ni.gov.uk/sites/default/files/publications/health/rdp-ni-2016.pdf [Accessed: 29th September 2016].

[5] Department of Health. (2016) *Raw Disease Prevalence Data for Northern Ireland* [.xls] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/rdpt-tables.xlsx [Accessed 29th September 2016].

[6] Department of Health. (2016) *QoF Prevalence Factsheet* [Online] Available from https://www.health-ni.gov.uk/publications/quality-and-outcomes-framework-qof-factsheets [Accessed 25th October 2016].

3. Content of the Quality & Outcomes Framework

Changes to the Quality & Outcomes Framework in 2015/16

Effect of subsuming registers into core funding

This year, 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. However, registers for some clinical areas still exist if other indicators still assessed for QOF remain on the system (Asthma or CHD, for example), but the subsuming of registers for other conditions resulted in their complete removal from the QOF assessment (Epilepsy, Learning Disabilities and Obesity).

Indicators retired

Seven indicators were retired this year, they were: AF005NI, CHD006, DM005NI, DM014, PAD002, PAD003NI and PAD004. The retirement of these indicators removed a total of 37 points from the maximum QOF achievement.

Replacement of indicators

Eleven indicators were replaced this year; indicators AF006NI and AF007 replaced AF005 and AF004, while indicators RS001, RS002, RS003, RS004 RS005 and RS006 replaced indicators QP001NI, QP002NI, QP003NI, QP004NI, QP005NI, QP006NI, QP007NI, QP008NI and QP009NI. This had a final effect of adding 6 points to the maximum QOF point achievement.

The total effect of these changes to the number of indicators was to remove 102 points from the QOF. The monetary value of these points was added to the core funding for practices.

Table 1. A summary of changes to the QOF in 2015/16

Action	Indicator	New indicator	Effect on QOF total
Subsumed into core funding	AF001	None	- 5
	AST001NI		- 4
	CAN001		- 5
	CHD001		- 4
	CON001		- 4
	COPD001		- 3
	DEM001		- 5
	DM001		- 6
	EP001		- 1
	HF001		- 4
	HYP001		- 6
	LD001		- 4
	MH001		- 4
	OB001NI		- 8
	OST001		- 3
	PAD001		- 2
	RA001		- 1
	STIA001		- 2
Subsumed into core funding sub-total			**- 71**
Retired	AF005NI	None	- 6
	CHD006		- 10
	PAD002		- 2
	PAD003NI		- 3
	PAD004		- 2
	DM005NI		- 3
	DM014		- 11
Retired indicators sub-total			**- 37**
Replaced	AF002	AF006NI	2
	AF004	AF007	4
	QP001NI QP002NI QP003NI QP004NI QP005NI QP006NI QP007NI QP008NI QP009NI	RS001 RS002 RS003 RS004 RS005 RS006	0
Replaced indicators subtotal			**6**
Total change to maximum QOF achievement			**- 102**
New maximum QOF achievement			**547**

Table 1 shows that there was an overall reduction of 102 points in the maximum QOF points available, resulting in a maximum available QOF points total of 547 in 2015/16.

Summary of domains

The QOF has 4 domains, each containing a range of areas described by key indicators that describe different areas of achievement. These 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; 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% 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.** 6 indicators in 1 area: Records and Systems (RS). This domain has a maximum QOF achievement of 100 points (18.3% of the total).

To ease comparisons with previous years, Additional Services have been presented separately to the Public Health indicators.

4. Overall Achievement in the Quality & Outcomes Framework

4.1   Summary at individual GP level

347 practices, all of the practices in Northern Ireland, participated in the QOF in 2015/16. 64 practices achieved the full 547 points, with an average QOF achievement of 539.05 points (98.55%) and a median QOF achievement of 543.41 points (99.34%).

Figure 1. The distribution of QOF points achievement of practices
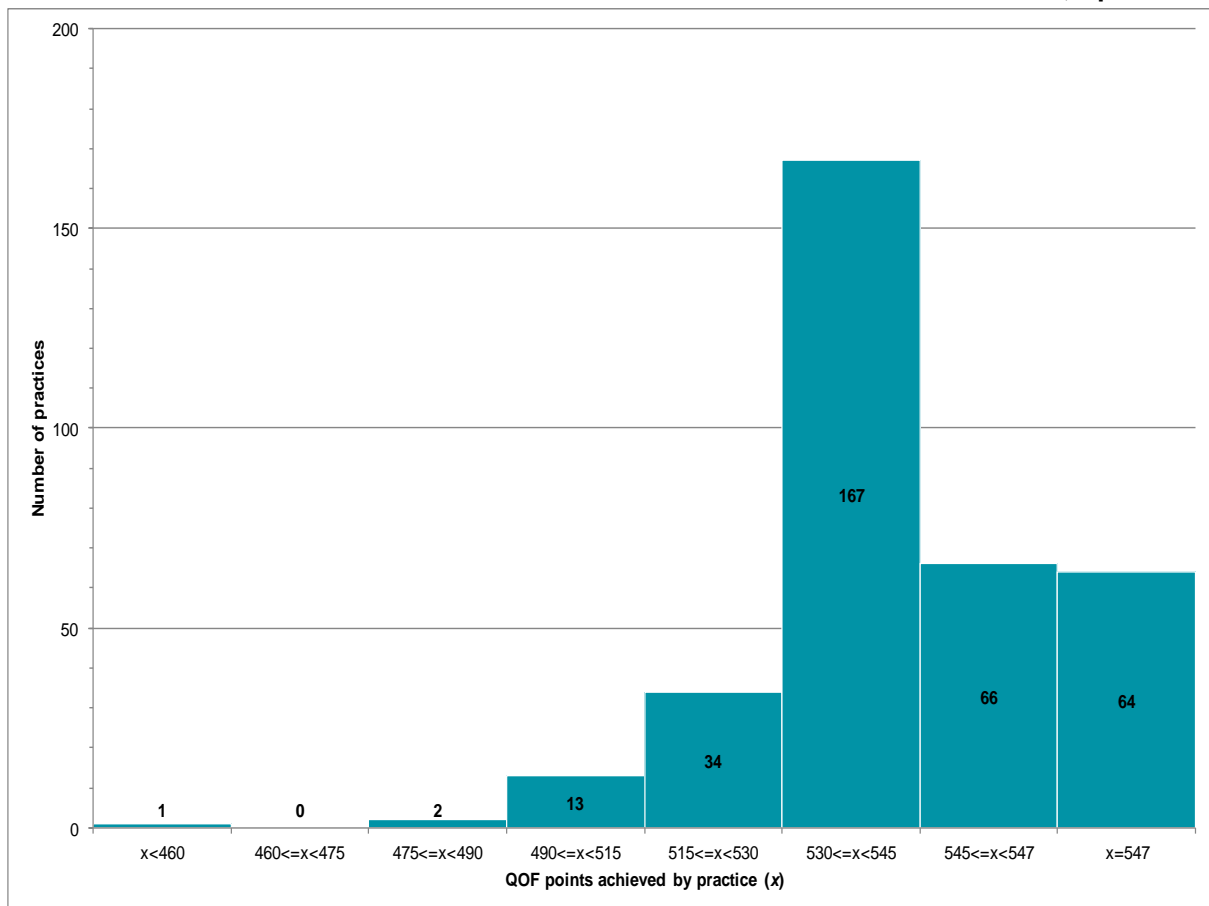**Source: PCAS achievement data, April 2016**

Figure 1 shows the distribution of QOF points achievement across individual practices. The *x*-axis shows the group boundaries of QOF points achieved and the *y*-axis shows the frequency of practices in that group.

4.2   Summary at Local Commissioning Group level

Figure 2. Average QOF points achievement rate of practices in each LCG
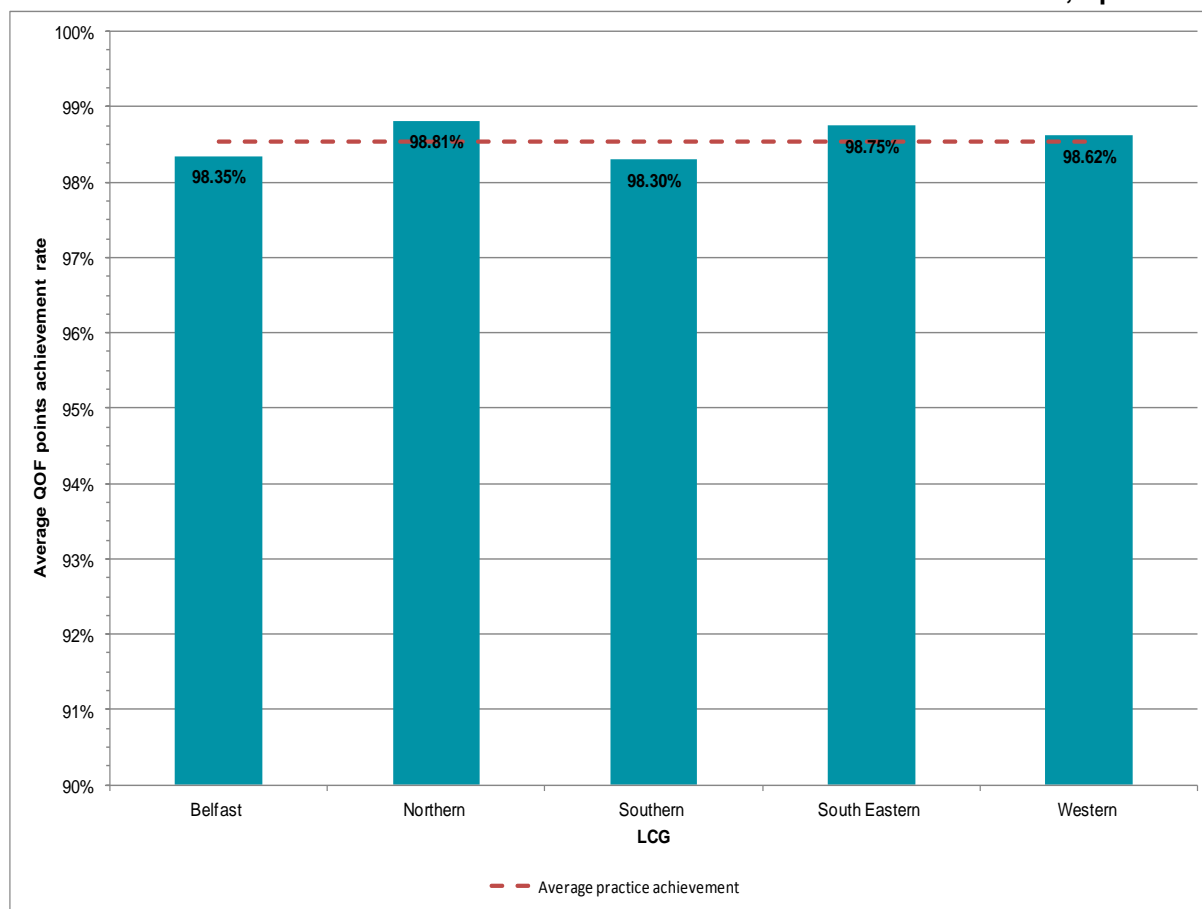**Source: PCAS achievement data, April 2016**

Figure 2 shows the average QOF achievement rate of practices in each Local Commissioning Group (LCG) and allows a comparison with the average achievement rate. The average achievement rate at LCG level ranges from 98.30% (Southern LCG) to 98.81% (Northern LCG), compared to the average QOF achievement rate of 98.55%.

4.3   Domain Level Achievement

Table 2 shows the average points achieved by practices in each domain.

Table 2. Average practice achievement in each QOF domain
**Source: PCAS achievement data, April 2016**

Domain		Points		
Name	Indicators	Maximum	Average	% of domain total
Clinical	51	380	374.33	98.51%
Public Health	4	35	33.56	95.89%
Public Health – Additional Services	2	14	13.66	97.55%
Patient Experience	1	18	17.95	99.71%
Records & Systems	6	100	99.56	99.56%

4.3.1 Clinical domain and Public Health domain

Figure 3 shows the distribution of QOF points achieved by practices in the Clinical and Public Health domains. It shows that 299 practices each achieved over 400 QOF points for these domains (86% of practices achieved a minimum of 96% of the available points) and that 67 practices achieved the maximum of 415 QOF points available for these domains.

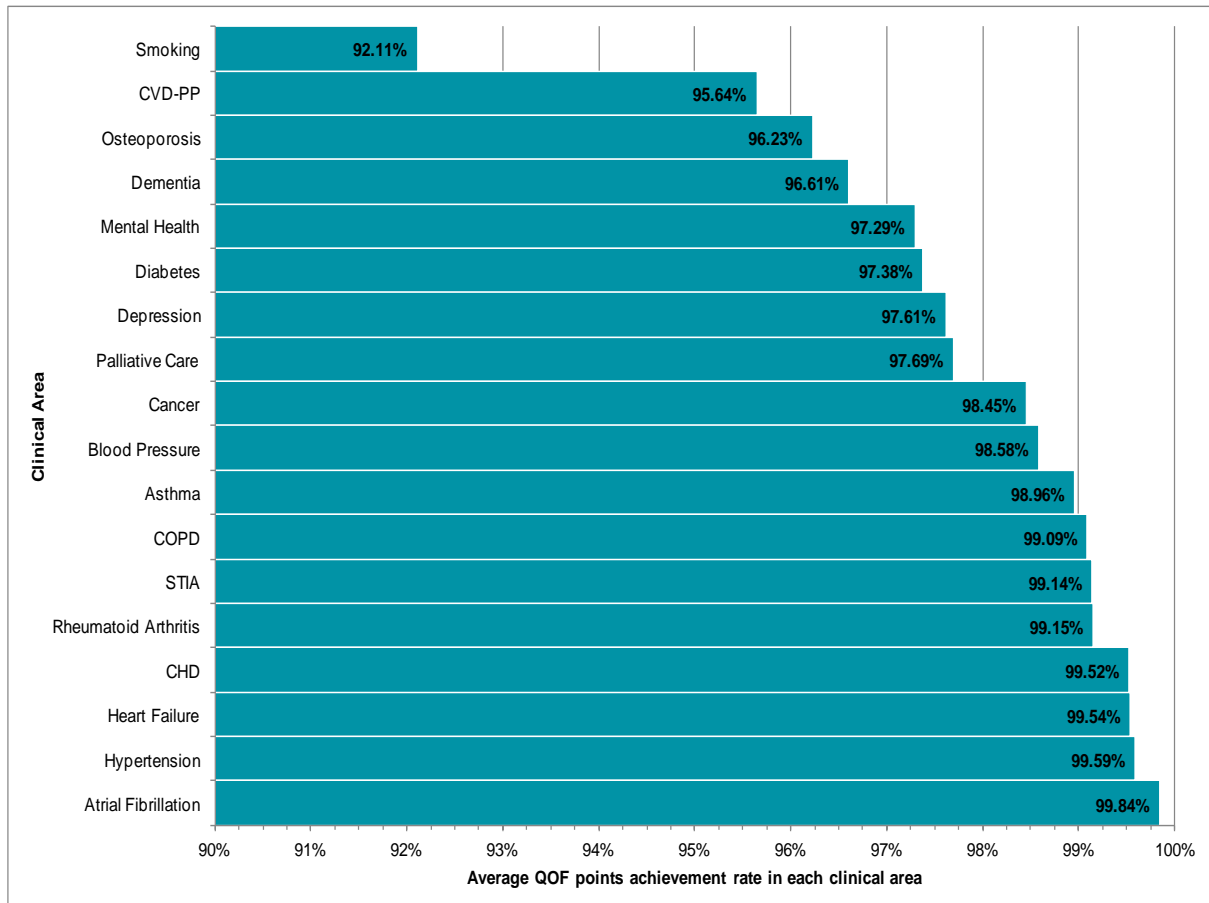The average QOF points achievement of practices in these domains was 407.89, or 98.29%.

Figure 3. The distribution of QOF points achievement in the Clinical and Public Health domains
Source: PCAS achievement data, April 2016
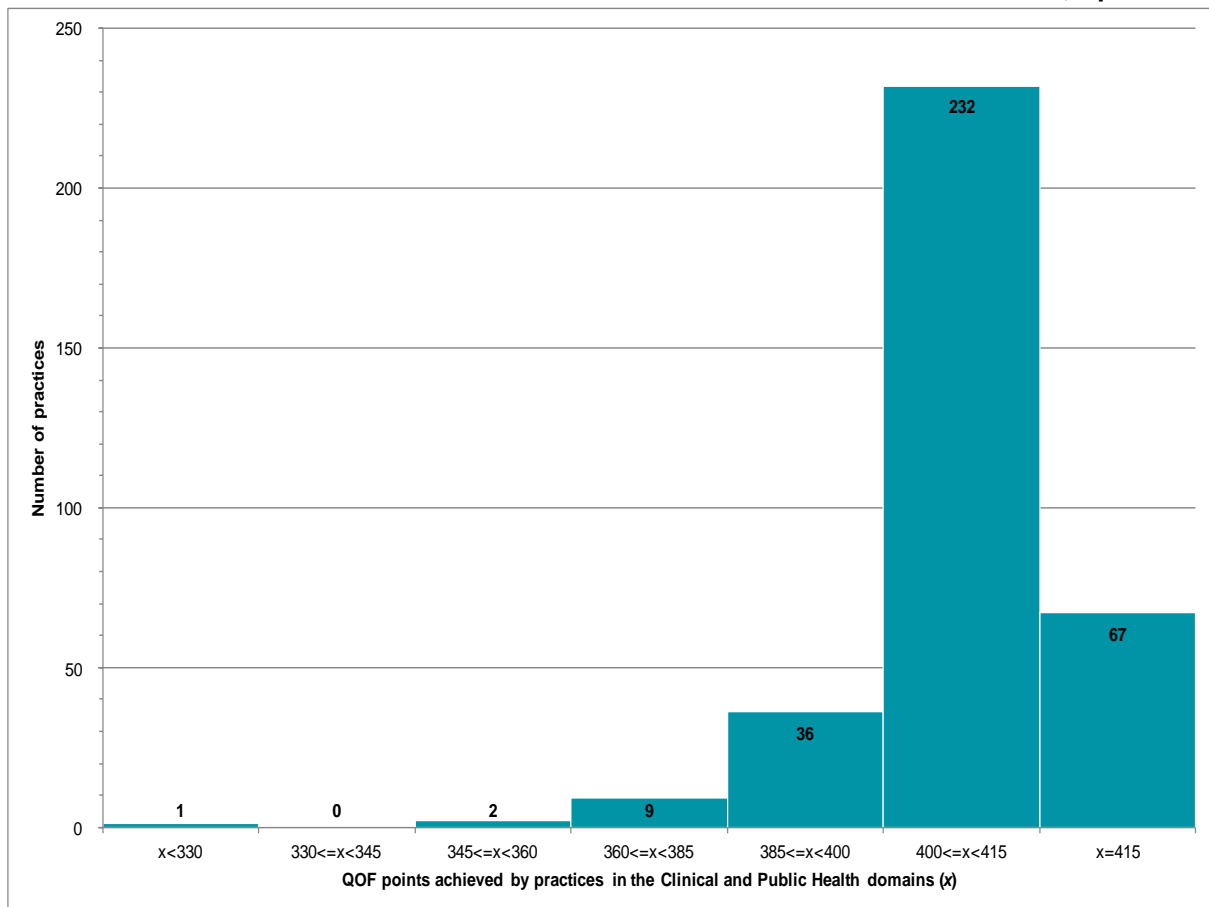
Clinical domain and Public Health domain areas

There are 15 areas in the Clinical domain and 3 areas in the Public Health domain (excluding the Public Health – Additional Services domain), with areas not necessarily having the same number of indicators and points practices within each clinical area.

Figure 4. The average QOF points achievement rate in clinical areas in the Clinical and Public Health domains
Source: PCAS achievement data, April 2016

No practice achieved maximum points for these clinical areas combined and the lowest average QOF achievement rate was 92.11% in the clinical area of Smoking (SMOK).

4.3.2 Public Health – Additional Services

Figure 5 shows the distribution of QOF points achieved by practices in the Public Health – Additional Services domain. It shows that 307 practices each achieved over 13 QOF points for this domain (88% of practices achieved a minimum of 93% of the available points) and that 264 practices achieved the maximum of 14 QOF points available for this domain.

Figure 5. The distribution of QOF points achievement in the Public Health – Additional Services domain
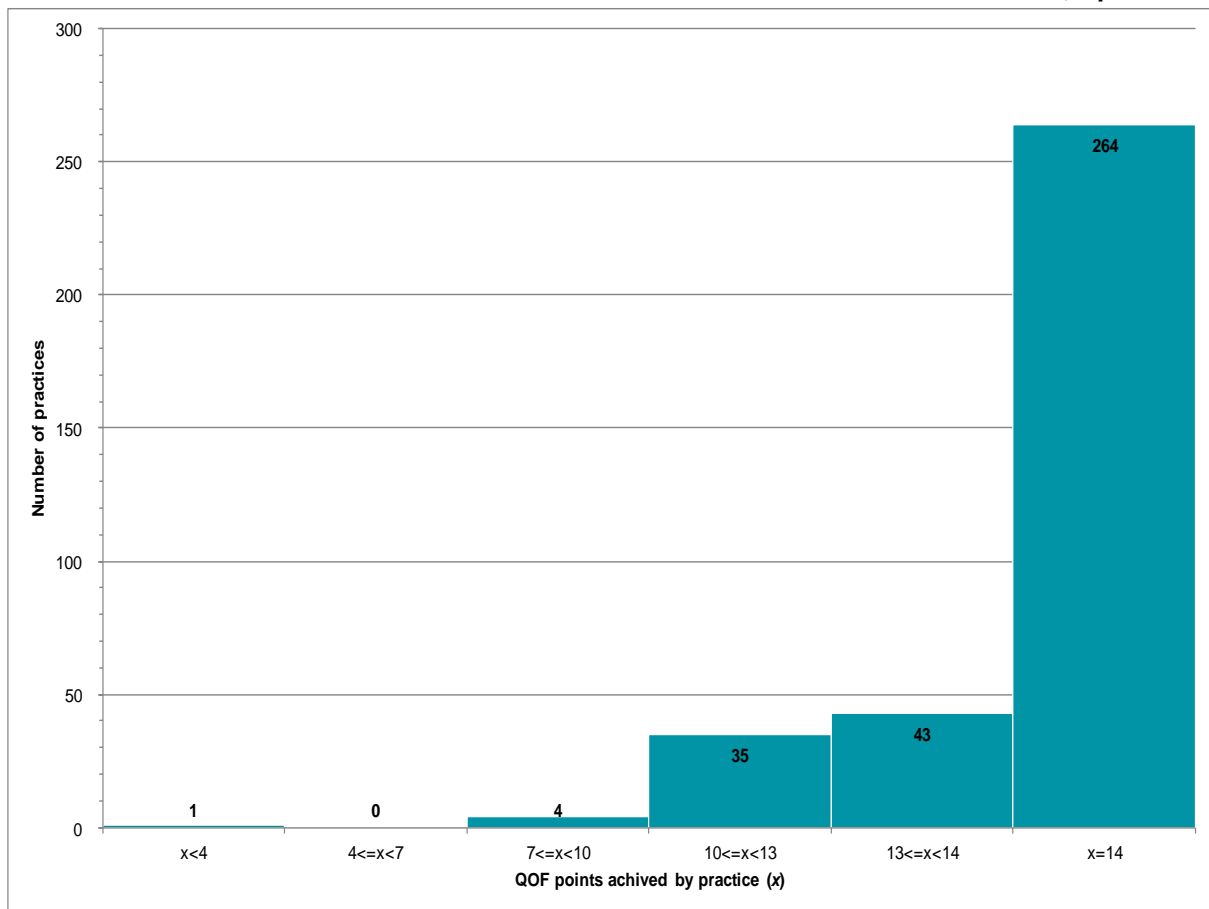**Source: PCAS achievement data, April 2016**

Figure 6 shows that practices achieved an average of 97.37% of the available QOF points for Cervical Screening and an average of 98.21% of the available QOF points for Sexual Health; these clinical areas had the same number of indicators but a different number of QOF points available.

Figure 6. The average QOF points achievement rate in clinical areas in the Public Health - Additional Services domain
Source: PCAS achievement data, April 2016
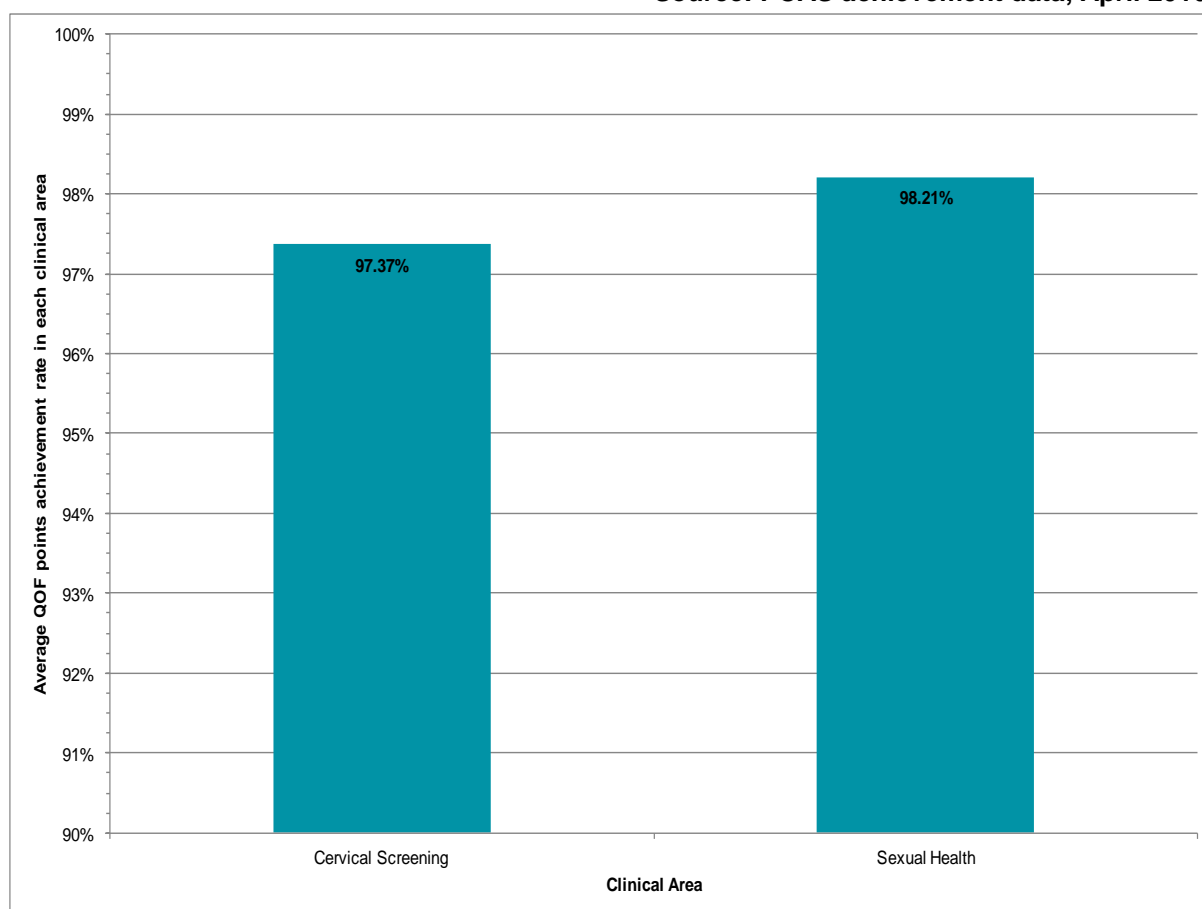
4.3.3 Patient Experience domain

There is one clinical area in this domain, the eponymous 'Patient Experience', which focuses on a survey of patients of a practice who have had contact with the practice within the last year. Practices may achieve either all 18 points or 0 points in this domain; only one practice did not achieve any points in this domain.

4.4 QOF groups

Historically, the National Institute for Health and Care Excellence (NICE) provided labels for clinical areas, giving groups of clinical areas 'Indicator Labels'. These are no longer provided and the QOF indicators used by practices in England since 2013/14 are used as substitute grouping labels. Table 3 shows QOF points achievement according to these QOF indicators and table 4 lists the constituent clinical areas of the QOF groups, while more information about the QOF indicators and their groups may be found in Annex B.

Table 3. Total QOF points achievement according to QOF indicator group
Source: PCAS achievement data, April 2016

QOF indicator group	Indicator count	NI total points	NI maximum points	%
Cardiovascular	19	55,076.26	55,520	99.20%
Fertility, Obstetrics & Gynaecology	2	4,738.82	4,858	97.55%
High Dependency & other long-term conditions	13	28,750.10	29,495	97.47%
Lifestyle	1	3,196.21	3,470	92.11%
Mental Health and Neurology	9	21,580.23	22,208	97.17%
Musculoskeletal	5	7,852.55	7,981	98.39%
Respiratory	8	25,082.22	25,331	99.02%
Undefined group	7	40,774.00	40,946	99.58%

Table 4. QOF group categorisations

QOF indicator group	Clinical area
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 Quality & Productivity

4.5   Prevalence summary

Table 5 shows the percentage prevalence for appropriate clinical registers within QOF.

Table 5. QOF prevalence for Northern Ireland at 31st March 2016
Source: Disease prevalence data for Northern Ireland, April 2016[7]

Clinical disease area		Prevalence for QOF payment purposes	*prevalence where the register is limited to age-specific groups
Asthma		6.03%	
Atrial Fibrillation		1.68%	
Cancer		2.18%	
COPD		1.97%	
Coronary Heart Disease		3.82%	
CVD - Primary Prevention		1.01%	
Dementia		0.70%	
Depression* (population aged 18+)		6.75%	8.71%
Diabetes* (population aged 17+)		4.53%	5.74%
Heart Failure	standard	0.80%	
	due to LVSD	0.22%	
Hypertension		13.33%	
Mental Health		0.88%	
Osteoporosis* (population aged 50+)		0.21%	0.63%
Rheumatoid Arthritis* (population aged 16+)		0.61%	0.76%
Stroke & TIA		1.85%	

Prevalence Day moved from the 14th of February to the 31st of March in 2008/09 to align it with National QOF Achievement Day. Prevalence was calculated using register counts at 31st March 2016 and total list sizes at 1st January 2016.

QOF registers for 5 clinical areas have maintained a consistent definition since April 2004: Asthma, Cancer, CHD, Hypertension and STIA. A small change was made to the diagnosis codes for Diabetes Mellitus in 2006 regarding eligibility for the register. The definition of Epilepsy changed in 2006 from patients aged 16+ to patients aged 18+.

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[7] Department of Health. (2016) *Raw Disease Prevalence Data for Northern Ireland* [.xls] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/rdpt-tables.xlsx [Accessed 29th September 2016].

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, Heart Failure, Heart Failure due to LVD, Learning Disabilities, Obesity, Palliative Care and 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 clinical 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.

Of the 18 Clinical domain and Public Health (not including Additional Services) registers collected for QOF, 3 have been excluded from table 5 because they do not measure disease prevalence. The excluded registers are: the Smoking register, 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 not disease prevalence registers. The Depression register, while it does not measure prevalence of this condition, but rather new diagnoses of it, has been retained in table 5.

Of the registers collected for QOF from which prevalence can be derived, Heart Failure due to Left Ventricular Dysfunction is the least prevalent (0.22%) and Hypertension is the most prevalent (13.33%) amongst patients. A prevalence summary report and trend data is available on the Department's website via the Statistics section[8].

The raw prevalence is derived by dividing the count of patients on the register for that clinical area by the total number of registered patients for that practice (all ages). The register is age-specific for 4 of these 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 is not simply the sum of those patients who have been diagnosed with each, divided by the total registered patients list, as this sum would ignore those who have been diagnosed with both.

Additional criteria to the simple 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[9].

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[8] Department of Health. (2016) *2015/16 Raw Disease Prevalence Data for Northern Ireland* [Online] Available from: https://www.health-ni.gov.uk/sites/default/files/publications/health/rdp-ni-2016.pdf [Accessed: 29th September 2016].

[9] General Medical Services, (2015) *General Medical Services (Statement of Financial Entitlements) Directions (Northern Ireland) 2015* [Online]. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/GMS%20Statement%20of%20Financial%20Entitlements%20NI%20-%202015-2016.pdf [Accessed 3rd October 2016].

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 compare the quality of care of different practices. For instance, the clinical disease areas chosen for the QOF represent the minority of patients in Northern Ireland and therefore achievement in these areas does not reflect the full workload of practices.

- The QOF system takes practice list size and disease prevalence into account before calculating payment, therefore 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, or 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 a consequent 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 the indicators will affect achievement in that clinical area 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 (I or II) 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

Changes for the 2015/16 year

The QOF changed significantly this year; these changes have been discussed in section 3 and summarised in table 1. The full domains and their constituent areas, points available and changes for the 2015/16 year are summarised in table 6.

Table 6. All QOF domains and their constituent areas, points available within each area and changes made for the 2015/16 year

Domain	Clinical Area	Indicators	Change	Points 2014/15	Points 2015/16
Clinical	Asthma	AST001NI	Subsumed into core funding	4	0
		AST002	No Change	15	15
		AST003	No Change	20	20
		AST004	No Change	6	6
	Atrial Fibrillation	AF001	Subsumed into core funding	5	0
		AF002	Replaced by AF006NI	10	0
		AF004	Replaced by AF007	6	0
		AF005NI	Retired	6	0
		AF006NI	Replacement for AF002	0	12
		AF007	Replacement for AF004	0	10
	Cancer	CAN001	Subsumed into core funding	5	0
		CAN002	No change	6	6
	Coronary Heart Disease	CHD001	Subsumed into core funding	4	0
		CHD002	No change	17	17
		CHD003NI	No change	17	17
		CHD005	No change	7	7
		CHD006	Retired	10	0
		CHD007	No change	7	7

Clinical	Chronic Obstructive Pulmonary Disease	COPD001	Subsumed into core funding	3	0
		COPD002NI	No change	5	5
		COPD003	No change	9	9
		COPD004NI	No change	7	7
		COPD005NI	No change	5	5
		COPD007	No change	6	6
	Dementia	DEM001	Subsumed into core funding	5	0
		DEM002	No change	15	15
		DEM003	No change	6	6
	Depression	DEP001NI	No change	21	21
	Diabetes Mellitus	DM001	Subsumed into core funding	6	0
		DM002NI	No change	8	8
		DM003NI	No change	10	10
		DM004NI	No change	6	6
		DM005NI	Retired	3	0
		DM006	No change	3	3
		DM007	No change	17	17
		DM008	No change	8	8
		DM009	No change	10	10
		DM010	No change	3	3
		DM012	No change	4	4
		DM014	Retired	11	0
		DM015NI	No change	4	4
	Epilepsy	EP001	Subsumed into core funding	1	0
	Heart Failure	HF001	Subsumed into core funding	4	0
		HF002NI	No change	6	6
		HF003	No change	10	10
		HF004	No change	9	9
	Hypertension	HYP001	Subsumed into core funding	6	0
		HYP002NI	No change	20	20

	Learning Disabilities	LD001	Subsumed into core funding	4	0
	Mental Health	MH001	Subsumed into core funding	4	0
		MH002	No change	6	6
		MH003	No change	4	4
		MH007	No change	4	4
		MH008NI	No change	5	5
		MH009	No change	1	1
		MH010	No change	2	2
	Osteoporosis	OST001	Subsumed into core funding	3	0
		OST002	No change	3	3
		OST005	No change	3	3
	Peripheral Arterial Disease	PAD001	Subsumed into core funding	2	0
		PAD002	Retired	2	0
		PAD003NI	Retired	3	0
Clinical		PAD004	Retired	2	0
	Palliative Care	PC001	No change	3	3
		PC002	No change	3	3
	Rheumatoid Arthritis	RA001	Subsumed into core funding	1	0
		RA002	No change	5	5
		RA003NI	No change	7	7
		RA004	No change	5	5
	Stroke and Transient Ischaemic Attack	STIA001	Subsumed into core funding	2	0
		STIA003	No change	2	2
		STIA004NI	No change	5	5
		STIA005NI	No change	2	2
		STIA007	No change	5	5
		STIA008	No change	2	2
		STIA009	No change	4	4
Patient Experience	**Patient Experience**	PE001NI	No change	18	18

|					
	Blood Pressure	BP002	No Change	15	15
	Cardiovascular Disease – Primary Prevention	CVD-PP011NI	No Change	5	5
		CVD-PP012NI	No Change	5	5
Public Health	**Obesity**	OB001NI	Subsumed into core funding	8	0
	Smoking	SMOK001NI	No Change	10	10
Public Health – Additional Services	**Cervical Screening**	CS002NI	No Change	11	11
	Sexual Health	CON001	Subsumed into core funding	4	0
		CON002NI	No Change	3	3
Quality & Productivity	**Quality & Productivity**	QP001NI	Replaced by 'Records & Systems' domain	5	0
		QP002NI		5	0
		QP003NI		11	0
		QP004NI		5	0
		QP005NI		15	0
		QP006NI		28	0
		QP007NI		7	0
		QP008NI		9	0
		QP009NI		15	0
Records & Systems	**Records & Systems**	RS001NI	Replacement for 'Quality & Productivity' domain	0	20
		RS002NI		0	8
		RS003NI		0	8
		RS004NI		0	30
		RS005NI		0	20
		RS006NI		0	14

Summary						
Domain	**2014/15**			**2015/16**		
	Clinical Areas	**Indicators**	**Points**	**Clinical Areas**	**Indicators**	**Points**
Clinical	18	74	470	15	51	380
Patient Experience	1	1	18	1	1	18
Public Health	4	5	43	3	4	35
Public Health – Additional Services	2	3	18	2	2	14
Quality & Productivity/ Records & Systems	1	9	100	1	6	100
Total	26	100	649	22	64	547

Table 6 shows that a combination of indicators being subsumed into core funding, the retirement of other indicators and the replacement of both indicators and whole clinical areas has reduced the total number of clinical areas from 26 to 22, the total number of indicators from 100 to 64 and the maximum QOF achievement from 649 points to 547 points for the 2015/16 QOF year.

Total points achieved by Local Commissioning Group

The average QOF points achievement rate of practices in each LCG is shown in figure 7, as well the same figure for previous years. It shows that practices in each LCG have maintained a consistently high achievement rate and that there is little difference in the average achievement rate across LCGs.
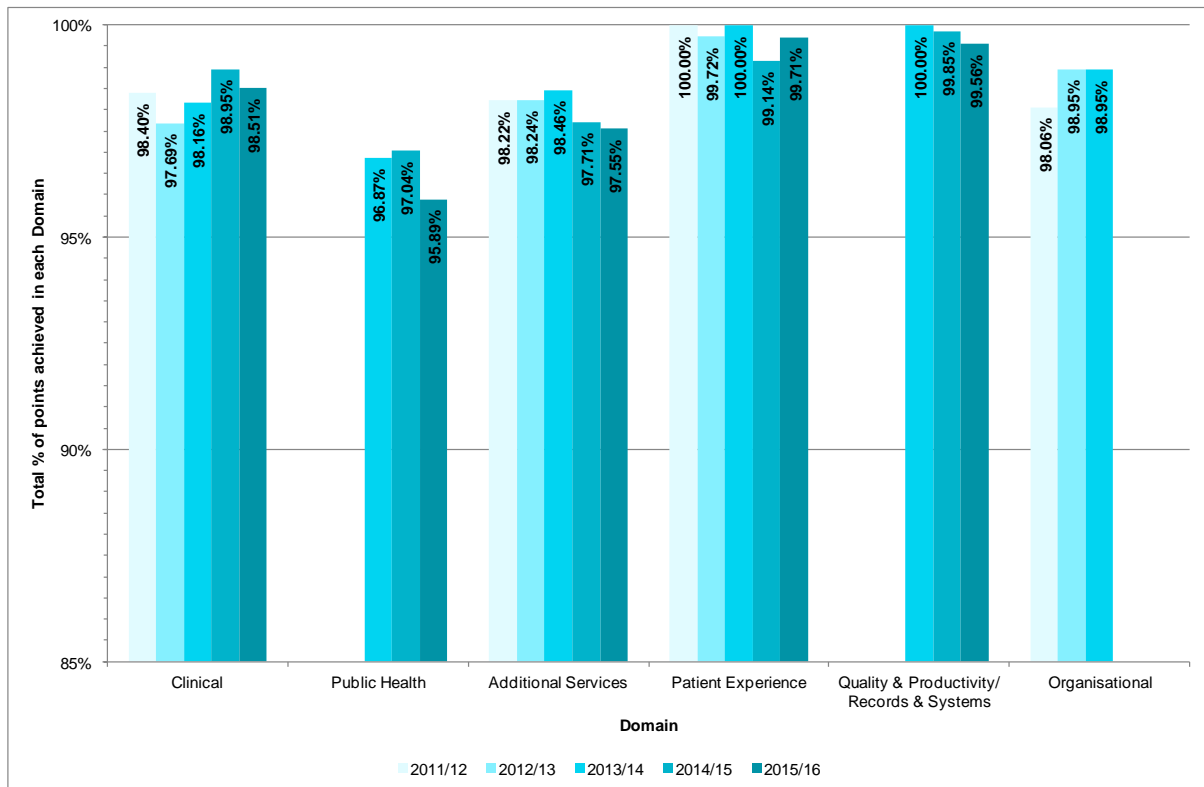
Figure 7. Average QOF achievement rate of practices in each LCG
Source: PCAS achievement data
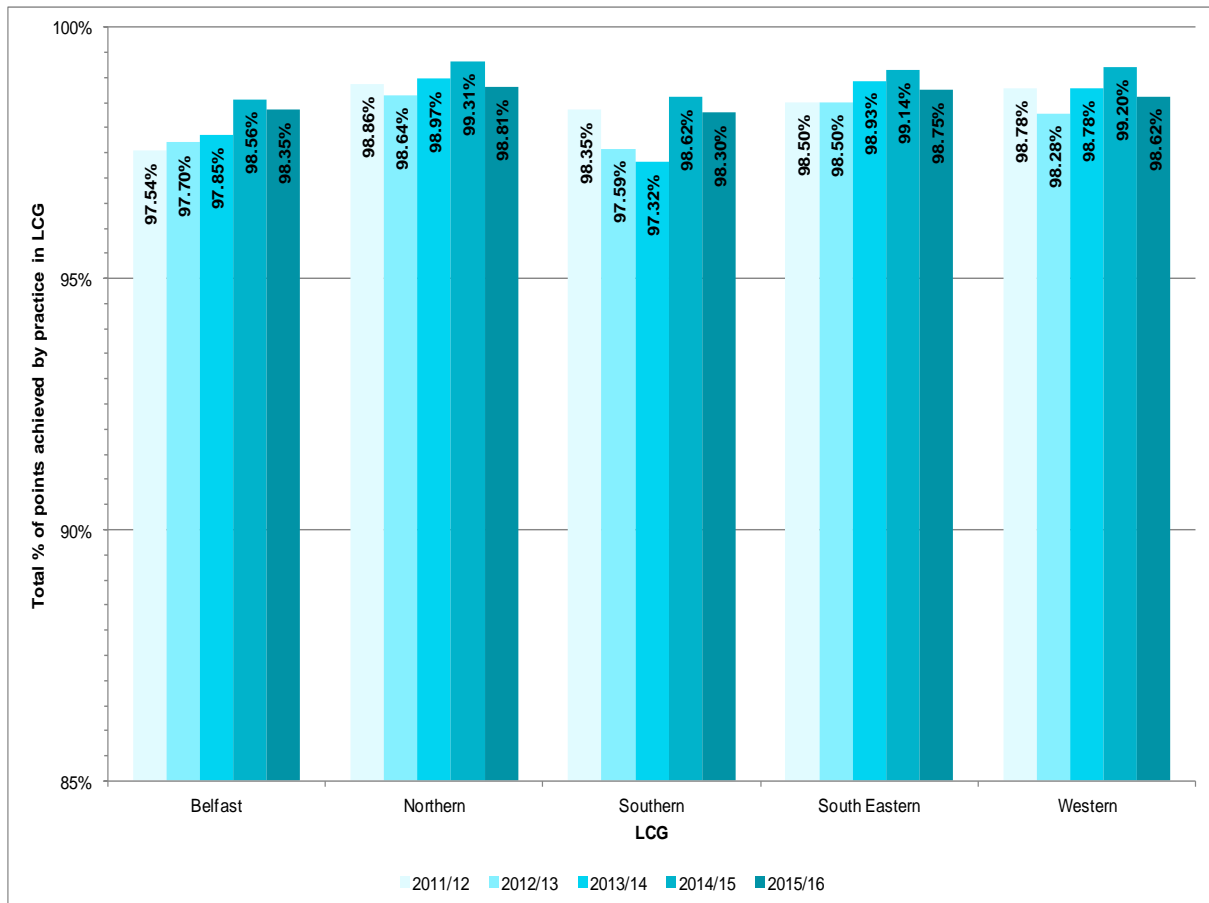
Domain achievement summary

The average QOF achievement rate of practices in each of the domains has also been consistently high for the past number of years. Figure 8 shows the QOF achievement rate within these domain groups and that it does not vary much with time or across groups.

Figure 8. Average QOF achievement rate of practices in each Clinical Domain
Source: PCAS achievement data

Clinical and Public Health domains

Figures 9a, 9b and 9c show the average QOF achievement rate of practices in the Clinical domain, which has declined slightly in the year 2015/16. The achievement rate is still very high, but the achievement rate for all clinical areas apart from Blood Pressure, Osteoporosis and Palliative Care has declined slightly when compared to the achievement rate of 2014/15.

Figure 9a. The average QOF achievement rate of practices in each clinical area of the Clinical domain and the Public Health domain (A-C)
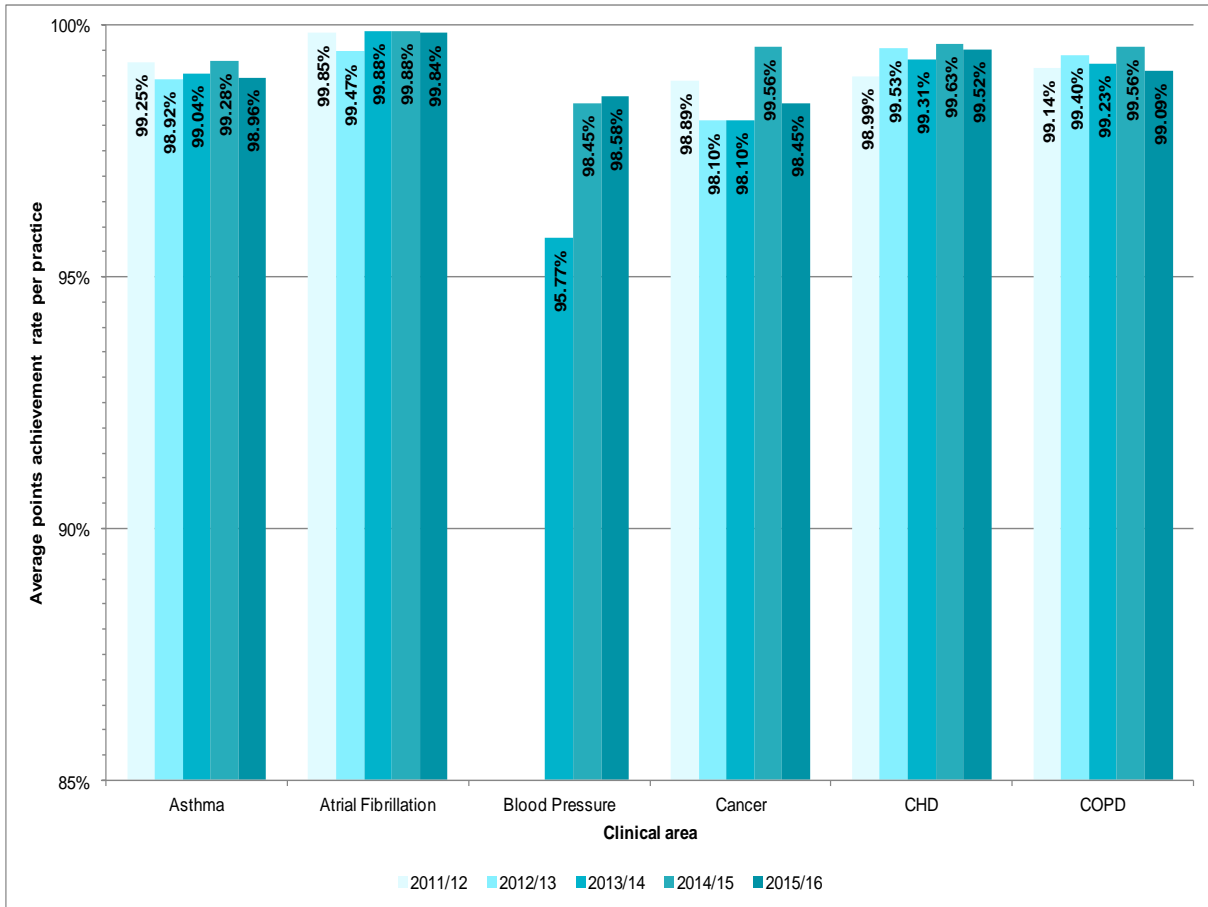**Source: PCAS achievement data**

Figure 9b. The average QOF achievement rate of GPs in each clinical area of the Clinical domain and the Public Health domain (C-H)
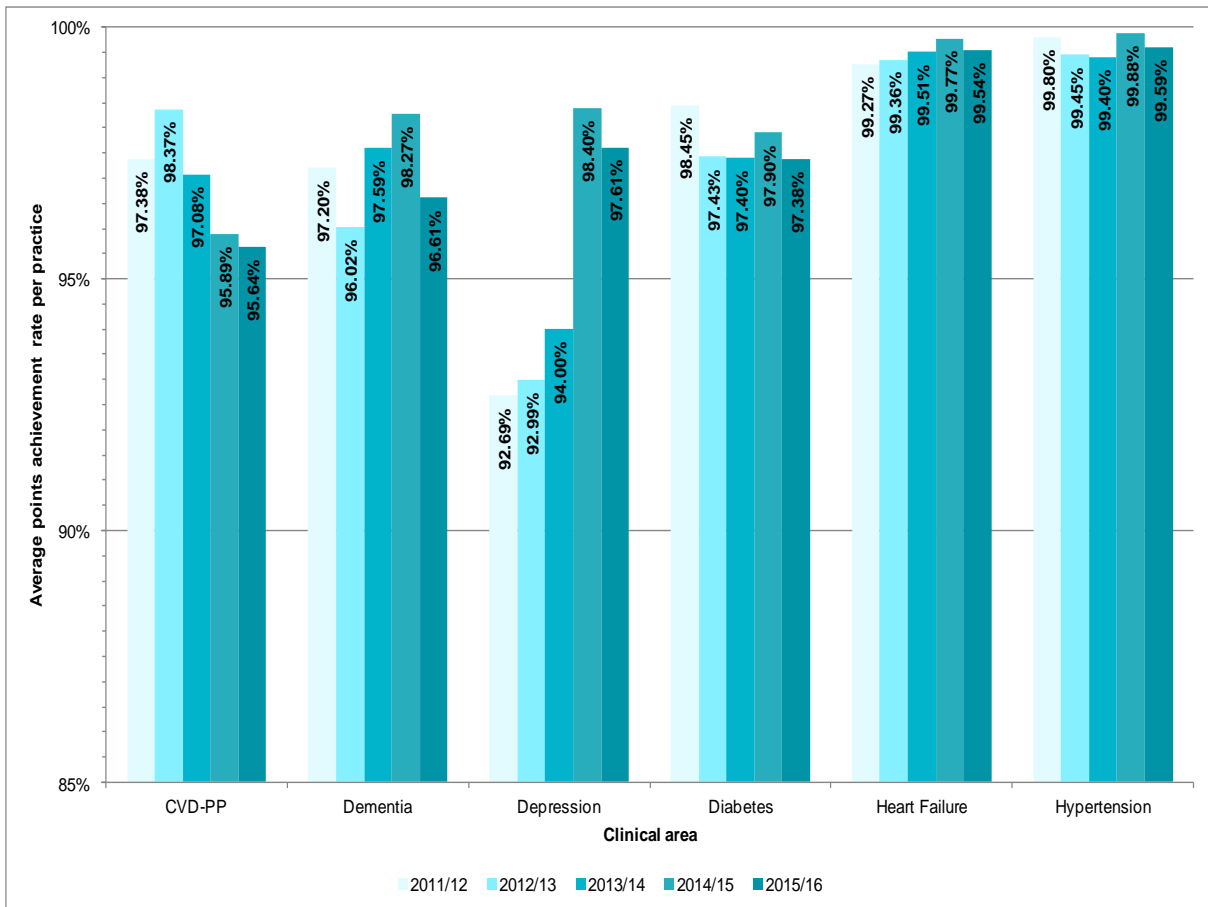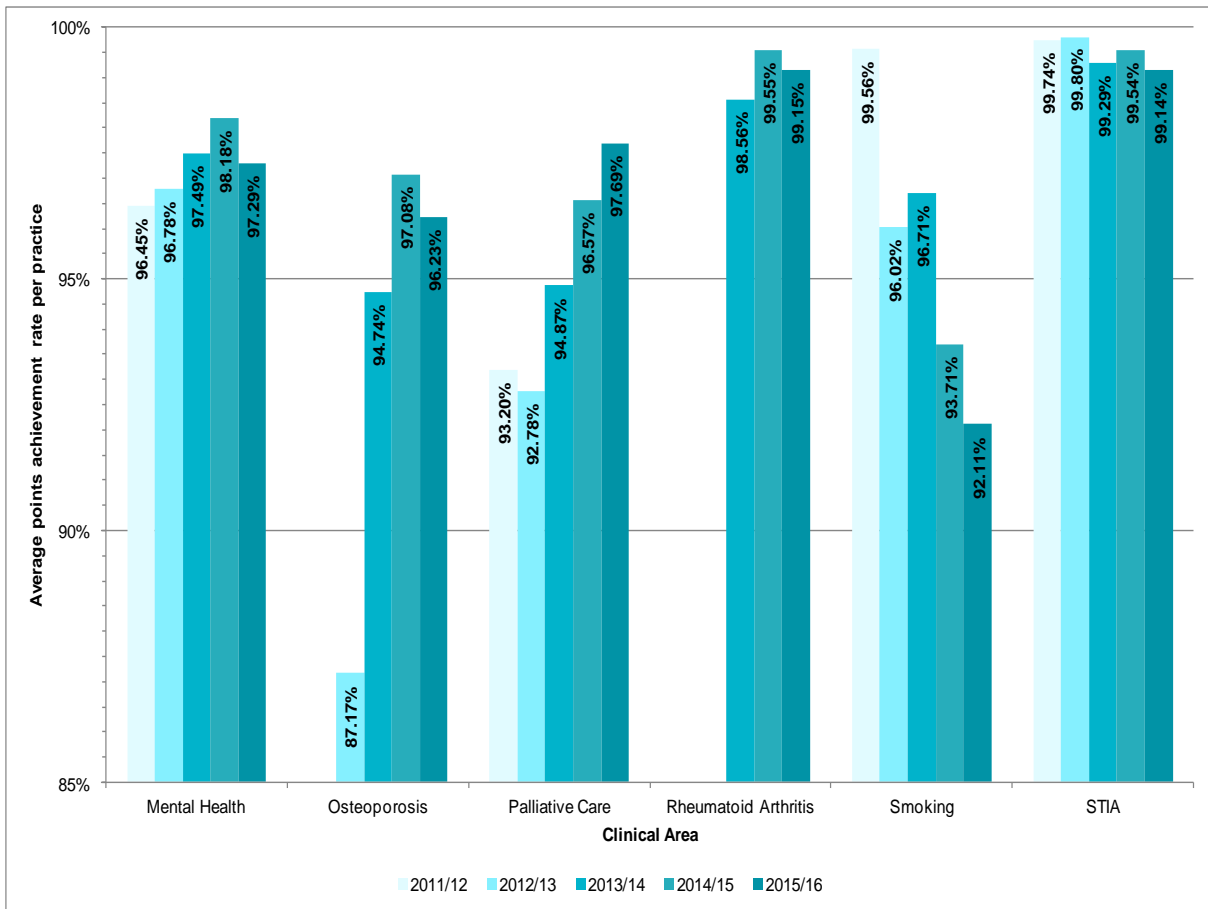**Source: PCAS achievement data**

Figure 9c. The average QOF achievement rate of GPs in each clinical area of the Clinical domain and the Public Health domain (M-S)
Source: PCAS achievement data

Public Health – Additional Services domain

GPs have maintained their high level of QOF achievement in this domain for both clinical areas, with achievement of over 97% in each area. However, average QOF achievement in the Sexual Health area declined slightly from 99% to 98%, while average QOF achievement in Cervical Screening has increased from slightly less than 97% to slightly more than 97%; these are illustrated by figure 10.
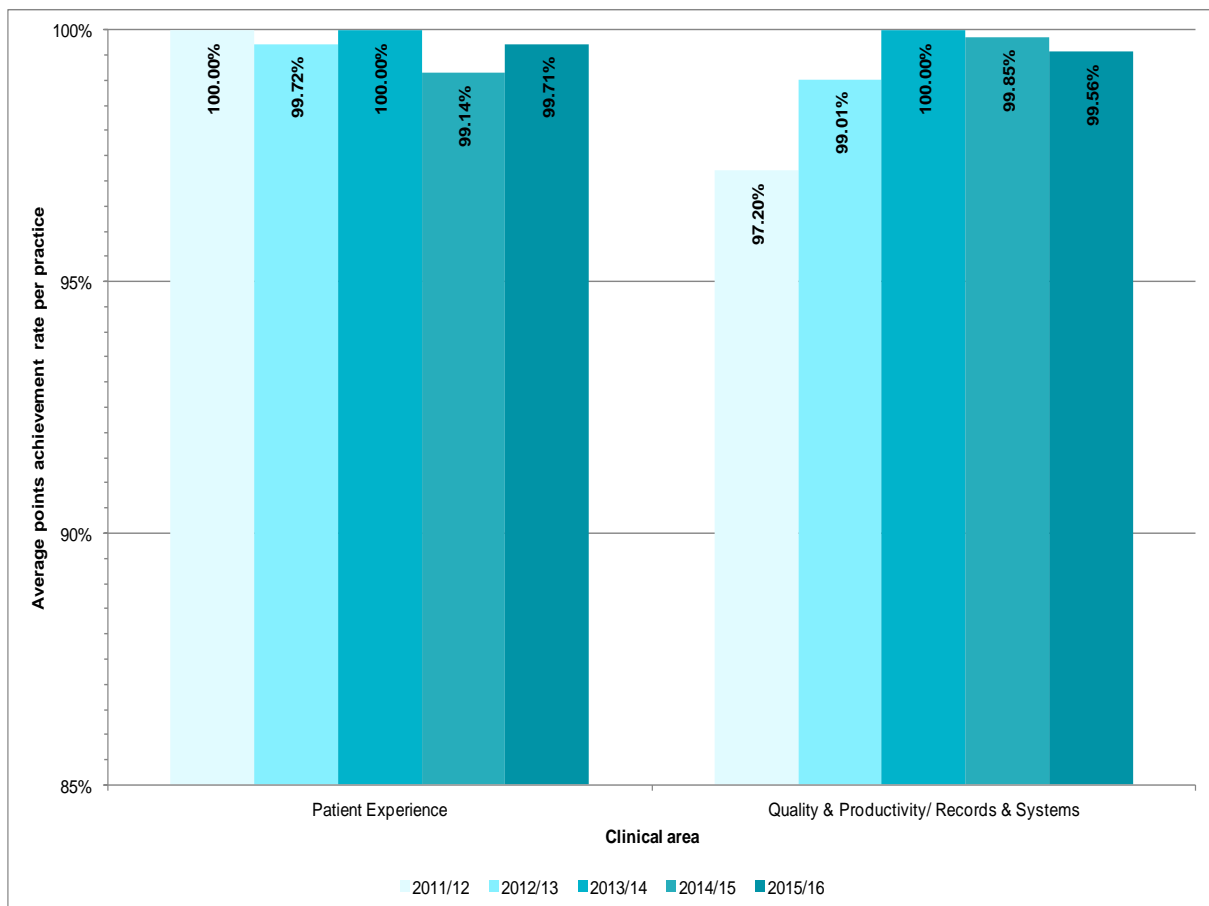
Figure 10. The average QOF achievement rate of GPs in each clinical area of the Public Health – Additional Services domain
Source: PCAS achievement data
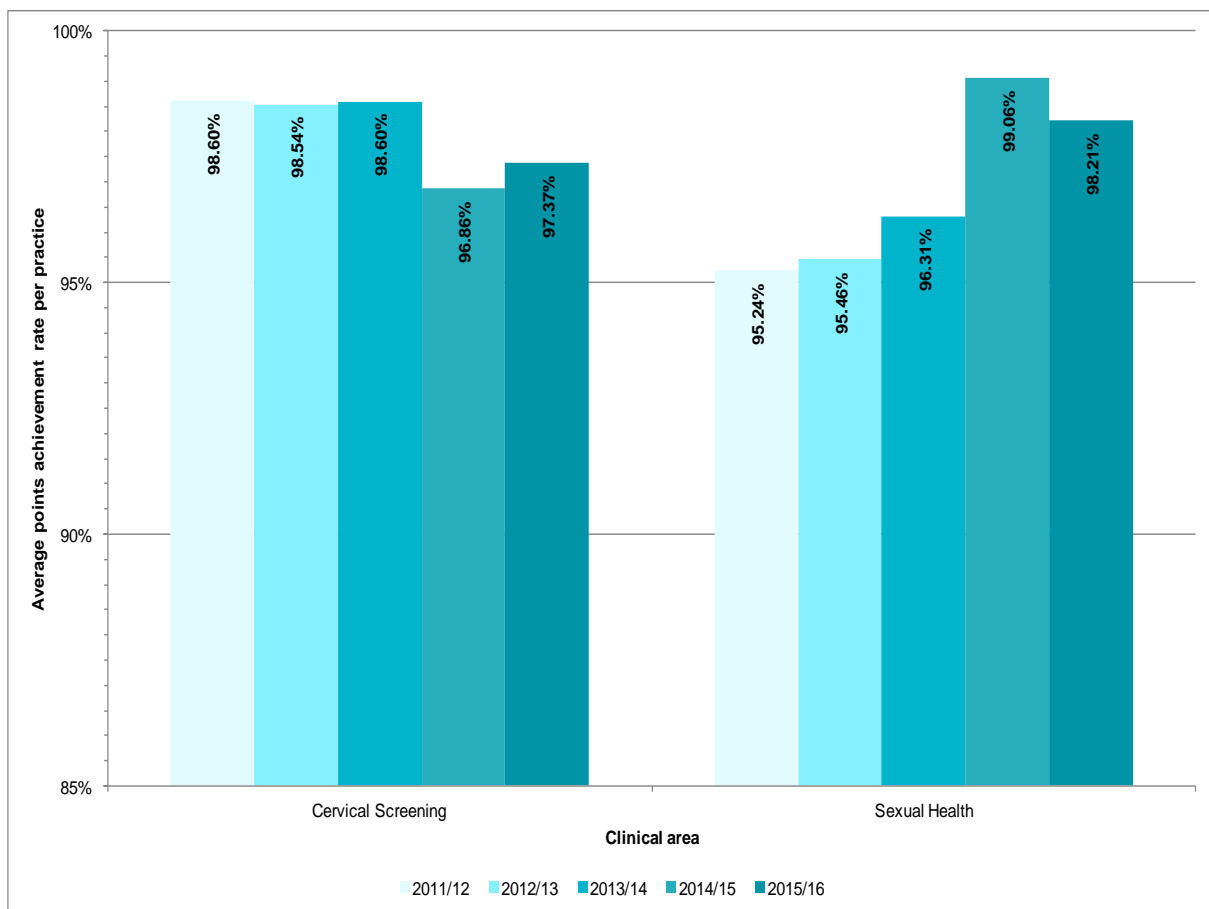
Patient Experience domain and Quality & Productivity domain

Average QOF achievement rate in the 'Patient Experience' clinical area improved slightly in the past year, from just over 99% to just under 100%, a very high average achievement rate. However, average QOF achievement rates in the Quality & Productivity domain declined very slightly. This domain completely changed in the past year, as all nine indicators from 2014/15 were replaced by six indicators in 2015/16. This total change may have contributed to the slight decline in average QOF achievement. Figure 11 shows the average QOF achievement rates for these domains.

Figure 11. The average QOF achievement rate of GPs in each clinical area of the Patient Experience domain and the Quality & Productivity domain
Source: PCAS achievement data

Clinical domain indicators						
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 anytime after diagnosis	15	5,205	5,160.21	99.14%
	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	6,940	6,854.55	98.77%
	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	2,082	2,064.24	99.15%
Atrial Fibrillation (AF)	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	4,164	4,152.00	99.71%
	AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	10	3,470	3,470.00	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	2,082	2,049.81	98.45%

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	5,899	5,896.84	99.96%
	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	5,899	5,899.00	100.00%
	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	2,429	2,426.48	99.90%
	CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	2,429	2,354.49	96.93%
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	1,735	1,728.37	99.62%
	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	3,123	3,071.63	98.35%
	COPD004NI	The percentage of patients with COPD with a record of FEV_1 in the preceding 3 years	7	2,429	2,428.71	99.99%
	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	1,735	1,724.62	99.40%
	COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	2,082	2,049.90	98.46%

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	5,205	5,155.37	99.05%
	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	2,082	1,884.45	90.51%
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	7,287	7,113.13	97.61%

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	2,776	2,776.00	100.00%
	DM003NI	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15months) is 140/80 mmHg or less	10	3,470	3,453.69	99.53%
	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	2,082	2,062.70	99.07%
	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	1,041	1,016.50	97.65%
	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	5,899	5,886.10	99.78%
	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	2,776	2,649.64	95.45%
	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	3,470	3,204.05	92.34%
	DM010	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	1,041	1,015.97	97.60%
	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	1,388	1,244.43	89.66%
	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	1,388	1,357.21	97.78%

Heart failure (HF)	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	2,082	2,071.99	99.52%
	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	3,470	3,449.30	99.40%
	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	3,123	3,114.00	99.71%
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	6,940	6,911.51	99.59%
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	2,082	2,073.25	99.58%
	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	1,388	1,347.29	97.07%
	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	1,388	1,343.23	96.77%
	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	1,735	1,693.32	97.60%
	MH009	The percentage of patients on lithium therapy with a record of serum creatinine & TSH in the preceding 9 months	1	347	333.58	96.13%
	MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2	694	636.61	91.73%

Osteoporosis: secondary prevention of fragility fractures (OST)	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	1,041	989.33	95.04%
	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	1,041	1,014.08	97.41%
Palliative Care (PC)	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	1,041	1,032.00	99.14%
	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	1,041	1,002.00	96.25%
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	1,735	1,703.50	98.18%
	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	2,429	2,420.54	99.65%
	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	1,735	1,725.10	99.43%

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 15 months) is 150/90 mmHg or less	5	1,735	1,732.25	99.84%
	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	694	693.51	99.93%
	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	1,735	1,733.33	99.90%
	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	1,388	1,385.96	99.85%
	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	694	675.40	97.32%
	STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	694	660.01	95.10%

Public Health domain indicators

Indicator area	Indicator ID	Indicator definition	Points available (per practice)	Points Available (NI)	Points Achieved (NI)	% of points achieved
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	5,205	5,131.31	98.58%
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.	99	34,353	7,962.00	23.18%
	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.	21	7,287	1,642.00	22.53%
Smoking (SMOK)	SMOK001NI	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10	3,470	3,196.21	92.11%
Public Health - Additional Services domain indicators						
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	3,817	3,716.44	97.37%
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	1,041	1,022.38	98.21%

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
	CVDPP	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	6	100
			Total	**7**	**118**
			Total	**64**	**547**