EXCEPTION REPORTING BULLETIN FOR NORTHERN IRELAND 2007/08

This bulletin summarises the third year of available Exception Reporting data from the Quality & Outcomes Framework (QOF) relating to April 2007 to March 2008. The source of this data is the Payment Calculation and Analysis System (PCAS), a Northern Ireland IT system used by general practices that supports the QOF payment process.

Summary

- The overall Northern Ireland exception rate was 5.1%.
- Of the 63 indicators for which exception data are published, the lowest exception rate at Northern Ireland level is for Smoking 01 (0.3%) and the highest exception rate is for Epilepsy 08 (24.3%).
- At general practice level, 75% of practices have overall exception rates of between 3% and 8%.

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For further information contact:

Information & Analysis Directorate
Department of Health, Social Services & Public Safety
Room 2, Annexe 2
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Telephone: 028-90-522700

Email: qofdataenquiries@dhsspsni.gov.uk

1. Introduction to Exception Reporting

The Quality and Outcomes Framework (QOF) includes the concept of exception reporting. This has been introduced to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side effect.

Practices can exclude specific patients from data collected to calculate QOF achievement scores. Patients with specific diseases can be excluded from the denominators of individual QOF indicators if the practice is unable to deliver recommended treatments to those patients.

Extract from Annex D of the Statement of Financial Entitlement -

The following criteria have been agreed for exception reporting:

A) patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months;

B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty;

C) patients newly diagnosed within the practice or who have recently registered with the practice, 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, another 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;

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;

I) where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B this would apply to the disease register and these patients would be subtracted from the denominator for all other indicators. For example, in a practice with 100 patients on the CHD disease register, in 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. This would apply to all relevant indicators in the CHD set.

In addition, practices may exception-report patients relating to single indicators, for example a patient who has left ventricular dysfunction (LVD) but who is intolerant of ACE inhibitors could be exception-reported. This would again be done by removing the patient from the denominator.

In some instances, a patient may have been referred to a specialist with the expectation that a test or investigation would be carried out. Where this has not been done (e.g. a specialist has ordered an alternative test to an echocardiogram for a patient with heart failure), that patient would be exception-reported (as in I above). In other cases, e.g. a diabetic with a hospital summary of an annual review which had no record of fundoscopy, it would be the GP's overall responsibility to ensure that appropriate care had been given.

Practices should report the number of exceptions for each indicator set and individual indicator. Practices may be called on to justify why they have excepted patients from the quality framework and this should be identifiable in the clinical record.

2. Exception Reporting in the Payment Calculation and Analysis System (PCAS)

Presented here are summaries of exception rates for 2007/08. There are 64 specific reasons that are used to except patients from the denominators of indicators. Patients are not excepted from disease register counts (i.e. Indicator 1 in each clinical area), but they can be excepted from the denominator of subsequent indicators in each clinical area.

Within PCAS these reasons are all classed as exceptions, however for the purposes of this publication we have agreed with UK colleagues a distinction between those that are true exceptions and those that are actually exclusions (see Exception/Exclusion Lookup). Exclusions refer to reasons that make the patient ineligible for inclusion in an indicator's denominator, for example because they do not meet the age requirement of the indicator.

Note that we cannot publish exception rates by specific reason of exception. This is because the sequence by which each GP clinical system (EMIS, InPractice Vision, iSoft Torex and Merlok) searches for exception reasons varies and so where a patient has been excepted for more than one reason; it is not clear which sequence has been used by each clinical system and therefore which exception reason was chosen.

3. Calculation of Exception and Exclusion Rates

The list of exceptions and exclusions can be found with the data tables under Exception/Exclusion Lookup.

The denominator is the number of patients that can appropriately be included in an indicator.

The exception rate calculation is:

$$\frac{\text{Number of Exceptions}}{(\text{Exceptions} + \text{Denominator})} \times 100$$

The exclusion rate calculation is:

$$\frac{\text{Number of Exclusions}}{(\text{Exclusions} + \text{Exceptions} + \text{Denominator})} \times 100$$

4. Exception Reporting Summaries for 2007/08

Table 1 shows exception rates for 17 QOF areas at Northern Ireland level. The exception rate percentage is calculated as follows: exceptions divided by (denominator plus exceptions) multiplied by 100.

Table 1: Exception Rates at Northern Ireland level by Indicator Group

Indicator Group	Sum of Denominators	Sum of Exceptions	Exception Rate
Asthma	112,216	7,545	6.3%
Atrial Fibrillation	27,286	1,029	3.6%
Cancer	4,085	70	1.7%
Cervical Screening	395,528	37,045	8.6%
CHD	514,460	32,958	6.0%
CKD	131,656	8,690	6.2%
COPD	98,271	10,352	9.5%
Dementia	9,096	541	5.6%
Depression	133,711	4,892	3.5%
Diabetes	814,471	46,100	5.4%
Epilepsy	36,831	4,356	10.6%
Heart Failure	8,763	1,100	11.2%
Hypertension	427,075	9,929	2.3%
Hypothyroidism	55,119	197	0.4%
Mental Health	29,494	3,596	10.9%
Smoking (status recorded)	409,043	1,561	0.4%
Stroke	164,860	11,185	6.4%
All Indicators	3,371,965	181,146	5.1%

We are presenting exception rates for 63 individual indicators. Tables 2 and 3 show the ten highest and ten lowest exception rates at Northern Ireland level by indicator.

Table 2: Ten highest exception rates at Northern Ireland level by indicator

Indicator *	Sum of Denominators	Sum of Exceptions	Exception Rate
EPILEPSY 08	10,394	3,334	24.3%
STROKE 10	25,359	4,707	15.7%
DIABETES 18	51,635	9,489	15.5%
COPD 08	23,947	4,247	15.1%
CHD 10	64,304	11,374	15.0%
MENTAL HEALTH 07	1,096	192	14.9%
CHD 12	65,054	10,624	14.0%
CKD 04	31,493	4,471	12.4%
MENTAL HEALTH 06	11,479	1,576	12.1%
HEART FAILURE 03	6,005	805	11.8%

* See QOF indicator Lookup for definitions

At Northern Ireland level, the highest exception rate is for Epilepsy 08, which records 'the percentage of patients aged 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months. The same indicator had the highest exception rate in 2006/07. Four of the 10 highest exception rates are within indicators relating to recording of influenza immunisation.

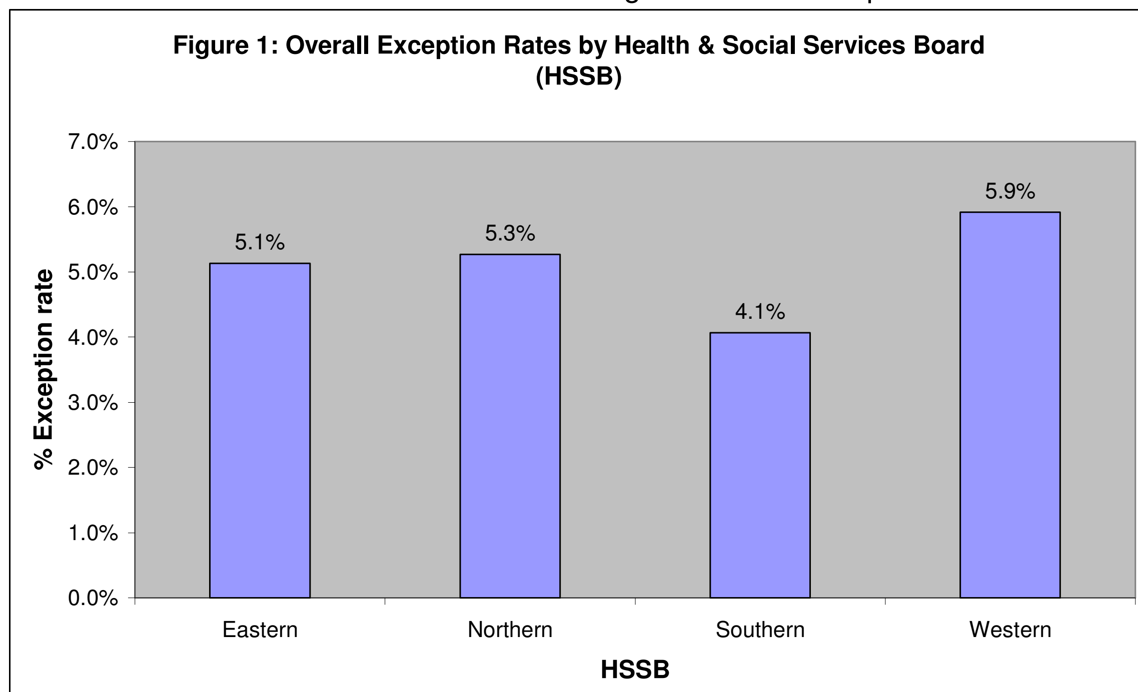
Table 3: Ten lowest exception rates at Northern Ireland level by indicator

Indicator *	Sum of Denominators	Sum of Exceptions	Exception Rate
SMOKING 01	343,434	1,163	0.3%
HYPOTHYROID 02	55,119	197	0.4%
CKD 02	51,971	220	0.4%
SMOKING 02	65,609	398	0.6%
CHD 05	74,884	794	1.0%
DIABETES 11	60,350	774	1.3%
HYPERTENSION 04	215,717	2,785	1.3%
DIABETES 22	60,161	953	1.6%
STROKE 05	29,587	502	1.7%
CANCER 03	4,085	70	1.7%

* See QOF indicator Lookup for definitions

The lowest exception rate at Northern Ireland level is for Smoking 1, which is 'the percentage of patients with any or any combination of CHD, stroke, hypertension, diabetes, COPD or asthma, whose notes record smoking status in the previous 15 months". The same indicator had the lowest exception rate in 2006/07. Five of the 10 lowest exception rates are within indicators relating to recording of blood pressure.

Figure 1 shows the overall exception rates at Health & Social Services Board. Comparatively, the Southern Health Board has the lowest overall exception rate at 4.1% and the Western Health Board has the highest overall exception rate at 5.9%.



5. Summary statistics for Exception Rates at Practice Level

- The overall exception rates at general practice level ranged from 1.6% to 17.4%.
- The average exception rate was 5.0%.
- There were 150 (42%) general practices with an overall exception rates higher than the average of 5.0%.
- 75% of practices have overall exception rates of between 3% and 8%.

Figure 2 shows a frequency distribution of general practice exception rates. Note that the detailed practice level tables should be consulted when comparing rates at practice level as high exception rates may actually refer to small numbers of patients.