QUALITY & OUTCOMES FRAMEWORK STATISTICS FOR NORTHERN IRELAND 2004/05

This bulletin summarises the first year of Quality & Outcomes Framework (QOF) achievement data from general practices relating to April 2004 to March 2005. 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 average total QOF points achieved in Northern Ireland was 989 (94.2%) of the 1,050 points available.
- Of the 10 clinical disease areas collected by QOF, prevalence was highest for hypertension (10.29%) and lowest for cancer diagnosed after 1 April 2003 (0.44%).
- The average points achieved in the four main domains was 524.8 points (95.4%) for clinical, 165.0 points (89.7%) for organisational, 97.4 points (97.4%) for patient experience and 34.6 points (96.0%) for additional services.

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1. Introduction

1.1. Overview

The Quality and Outcomes Framework (QOF) is a new system of payment designed to remunerate and reward 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 new General Medical Services (nGMS) Contract, introduced on 1st April 2004. Information on the GMS Contract can be found at http://www.dhsspsni.gov.uk/hss/gp_contracts/index.asp . Participation in the QOF is voluntary; although in 2004/05, all practices in Northern Ireland did participate. The QOF measures achievement against 146 indicators in 4 domains and 3 measures of breadth of quality across those domains.

A significant proportion of the new money tied to the nGMS contract is available to reward practices for providing higher quality services. Payments associated with the QOF provided a new funding stream for 2004/05, and in total have accounted for £27.7 million of a total of £183.7 million invested in general practices in Northern Ireland for 2004/05.

It is important that the data are not taken out of context. A lower points achievement does not necessarily mean that patients are receiving poorer quality care. Taking part in the QOF is voluntary and there will be a whole variety of reasons why some practices may not achieve as high quality scores as others, many of them outside the direct control of the practice. It should be stressed that participation in the QOF is only one measure of the quality of clinical care provided to patients. This context should be taken into consideration when looking at the figures.

1.2 Source of Data

The figures in this bulletin are derived from the Payment Calculation and Analysis System (PCAS), a Northern Ireland system that uses data from general practices to calculate individual practices' QOF achievement. A full set of QOF data tables can be found at http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-introduction.asp . The data are being published so that Health & Social Services Boards (HSSBs), Local Health & Social Care Groups (LHSCGs) and practices can see their own achievement in a broader context and to make the data widely available in order to meet Freedom of Information requirements. The figures presented are as submitted to PCAS. There is no adjustment for known factors that might influence disease prevalence such as the age structure of practice populations.

PCAS is a new IT system for general practices in Northern Ireland developed by MSDi to support the QOF. PCAS ensures consistency in the calculation of quality achievement and disease prevalence and is linked to the payment system. This means that payment rules underpinning the new GMS Contract are implemented consistently across all systems and all practices in Northern Ireland.

Figures are based on submissions made with reference to March 2005 for the complete financial year April 2004 to March 2005. All late submissions made by the end of June 2005 are included and also any adjustments made by the Health Boards in the period April to June 2005. This publication uses the most up-to-date figures for each practice as at 30 June 2005.

Users of data derived from PCAS should recognise that PCAS was established as a mechanism to support the calculation of practice QOF payments only. It does provide a potentially rich and valuable source of information but it is important to remember that it has been created with one purpose in mind, therefore applications of the data outside the remit of QOF may be limited (see "Recommendations around the use of QOF data" later in this bulletin).

1.3 Practice List Sizes

The 2004/05 QOF tables published by the DHSSPS use practice list sizes supplied to PCAS from the National Health Applications and Infrastructure Services (NHAIS), the national general practice payments system, as at 1st January 2005. 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.

1.4 Level of Detail Available

The DHSSPS can only provide information that it holds in its QOF database, derived from the PCAS system. As PCAS was designed to provide information for the QOF, that is, to give a count of disease register sizes only, no patient-specific or age-specific data is available. This means that, for example, PCAS will capture practice-aggregated information on patients with coronary heart disease and practice-aggregated information on patients with diabetes, but it is not possible to identify or analyse patients with both of these diseases.

Any additional information about general practices, or activity of general practices that is not held in the PCAS system, is not available. For example, there is no information available about individual patients. In addition, PCAS also does not hold further information around QOF, such as information on practice annual review visits by the Health Boards.

1.5 Exception Reporting

Practices may on occasion exclude specific patients from data collected to calculate QOF achievement scores. This has been introduced to allow practices to be rewarded for good quality care 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 (see the Statement of Financial Entitlement 2004/05 for full details). Exception reporting is a feature of practice contracts in respect of QOF but PCAS will not implement functionality on exception reporting until later in 2005. Exception reporting will not be possible in retrospect for 2004/05 PCAS data.

1.6 Benefits of QOF Tables

This release of summary tables of QOF data for 2004/05 will:

- Meet most requests for QOF data, providing users with immediate access to the information they require without having to request ad hoc analyses.

- Reduce the burden on local organisations to release this information. Practices, Local Health and Social Care Groups and Health Boards will be able to refer requests to the DHSSPS summary tables.

- Provide a single source for QOF information.

2. Disease Prevalence Data in the Quality & Outcomes Framework

Overview

An important feature of the QOF is the establishment of disease registers from which disease prevalence can be calculated. Prevalence is a measure of the burden of a disease in each general practice at a particular point in time (and is different to incidence, which is a measure of the number of newly diagnosed cases within a particular time period). Prevalence data are used within QOF to calculate and adjust points and payments within each of the 10 clinical domain areas. Specifically:

- Points can only be awarded to a practice for a given clinical domain area if the practice can produce a register of patients with that disease or condition, and

- The number of pounds per point in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the regional Northern Ireland prevalence for that disease or condition.

QOF prevalence data ("disease registers") are of clear interest from a public health perspective. At the time of publication, these prevalence data are very new and further work needs to be done to explore the reasons behind apparent local and regional variations in the prevalence of a specific condition. These prevalence data, although undoubtedly very useful, are also crude and there are likely to be good reasons for variations. Some types of reasons are known (for example, differences between practices in the age profiles of their patients) but are yet to be quantified. Other reasons for variations may be less obvious and are still to be determined.

For Northern Ireland reporting of PCAS information on these web pages, DHSSPS is reporting raw (unadjusted) disease prevalence – that is, the number on a disease register on 14 February 2005 (including late returns up to 11th April 2005 but referring to National Prevalence Day) as a proportion of patients on a practice list as at 1 January 2005. A report on "Raw Disease Prevalence in Northern Ireland" is available. http://www.dhsspsni.gov.uk/hss/gp_contracts/documents/raw_disease.pdf

A more detailed explanation of how prevalence is used within the calculation for QOF payments is available at http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-context.asp#disease.

3. Contents the Quality & Outcomes Framework

Summary of Domains

The QOF contains four domains. Each domain contains a range of areas described by key indicators. The indicators describe different areas of achievement. These are:

- Clinical Domain: 76 indicators in 10 areas (Coronary Heart Disease and Left Ventricular Dysfunction; Stroke and Transient Ischaemic Attack; Hypertension; Diabetes Mellitus; Chronic Obstructive Pulmonary Disease; Epilepsy; Hypothyroidism; Cancer; Mental Health; and Asthma) worth up to a maximum of 550 points (52.4% of the total).

- Organisational Domain: 56 indicators in 5 areas (Records and Information about Patients; Information for Patients; Education and Training; Clinical and Practice Management and Medicines Management) worth up to a maximum of 184 points (17.5% of the total).

- Patient Experience Domain: 4 indicators in 2 areas (Patient Survey and Consultation Length) worth up to a maximum of 100 points (9.5% of the total).

- Additional Services Domain: 10 indicators in 4 areas (Cervical Screening; Child Health Surveillance; Maternity Services and Contraceptive Services) worth up to a maximum of 36 points (3.4% of the total).

Other Payment Points

- Holistic care payment: measures achievement across the clinical domain – worth up to 100 points (9.5% of the total).

- Quality practice payment: measures overall achievement in the organisational, patient experience and additional services domains – worth up to 30 points (2.9% of the total).

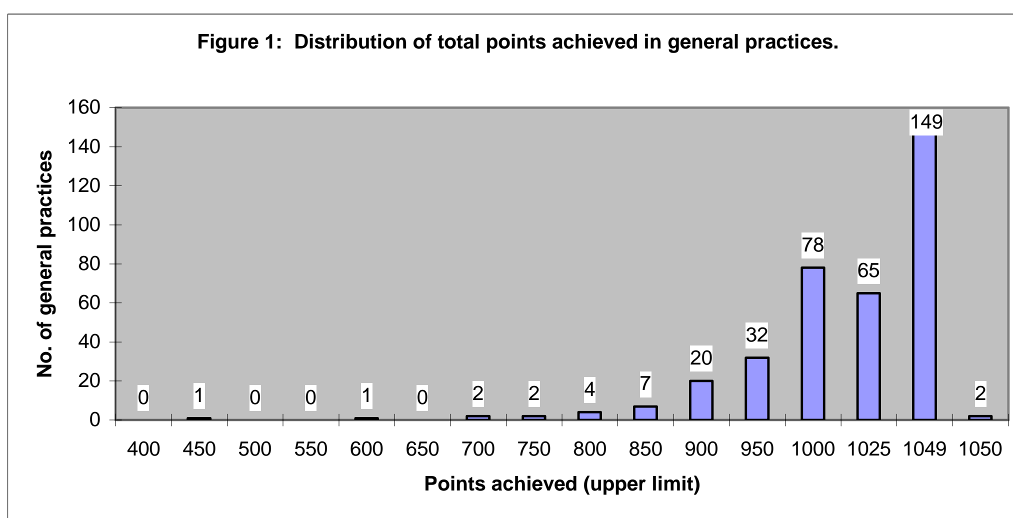
- An access bonus: rewards target level of achievement on patient access to a GP, nurse or health professional within 48 hours – worth 50 points (4.8% of the total).

4. <u>Overall Achievement in the Quality & Outcomes Framework</u>

4.1 Summary at Northern Ireland Level

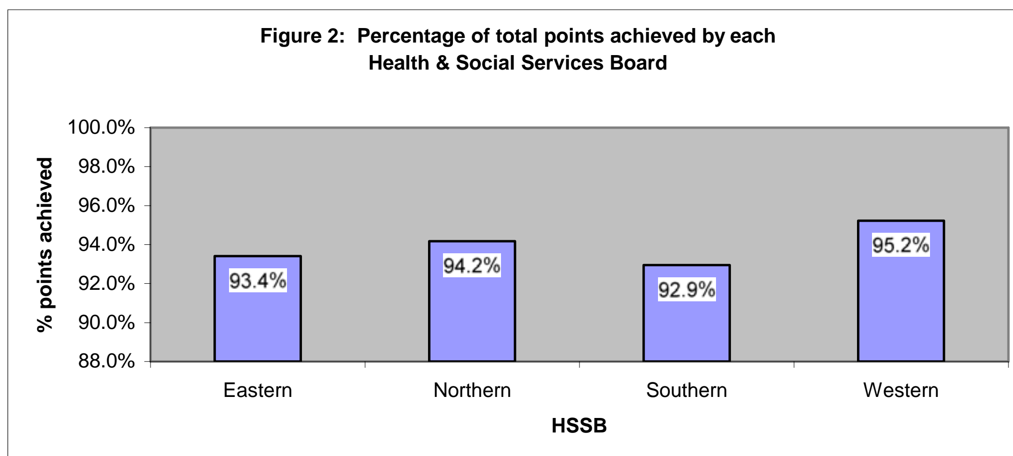
In Northern Ireland, QOF achievement data was received from 365 general practices. One submission covered 3 general practices, due to having a shared server. Overall, the average achievement of points in Northern Ireland was 989 of the 1,050 points available (94.2%). Only one practice achieved the maximum points of 1,050 with one further practice achieving 1.049.9 points. The median score achieved was 1,015.5 points.

Figure 1 below shows the distribution of points achieved across all practices. The points achieved axis is the upper limit of the range, so for example, the last range (labelled 1,050) counts those practices who had achieved more than 1,049 points or equal to 1,050 points of which there are 2 in Northern Ireland.



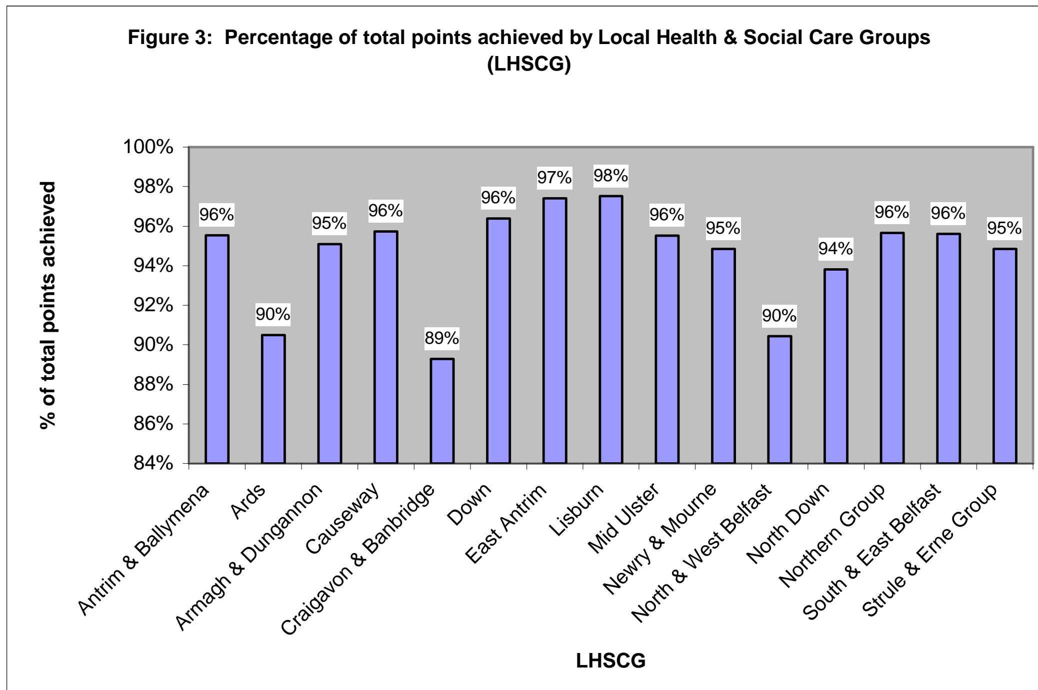
4.2 Summary at Health & Social Services Board (HSSB) Level

Figure 2 shows the average number of points achieved in each Health & Social Services Board. These range from 975.9 points (92.9%) in the Southern HSSB to 999.8 points (95.2%) in the Western HSSB.



4.3 Summary at Local Health & Social Care Groups (LHSCG) Level

Figure 3 shows the average number of points achieved in each Local Health & Social Care Group. These range from 937.5 points (89.3%) in the Craigavon & Banbridge LHSCG to 1,024 points (97.5%) in the Lisburn LHSCG.



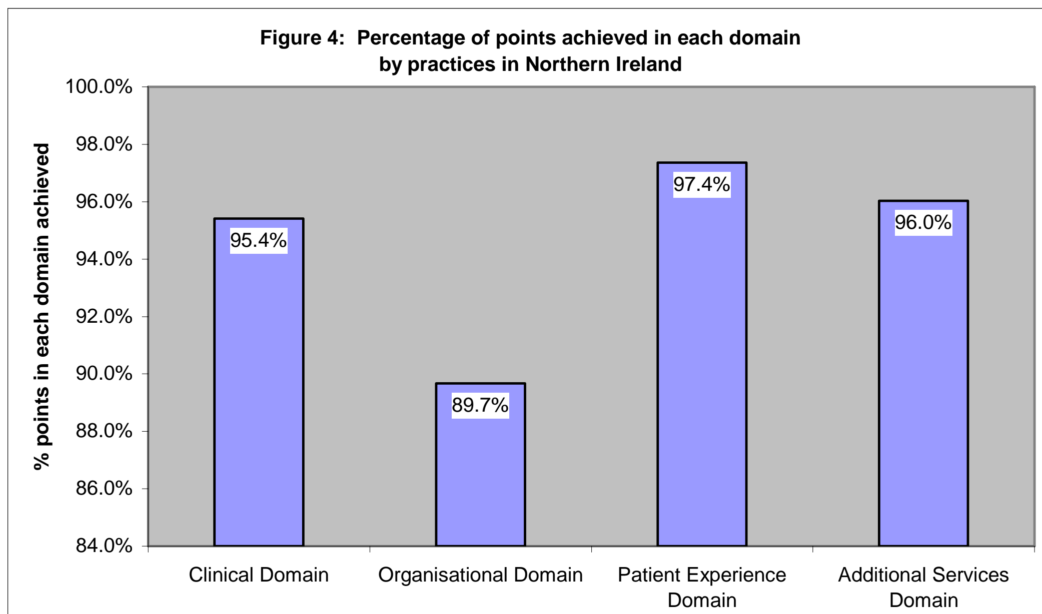
4.4 Domain Level Achievement

The average points achieved by general practices in Northern Ireland in each domain is as follows:

Domain	Average points achieved
Clinical	524.8
Organisational	165.0
Patient Experience	97.4
Additional Services	34.6

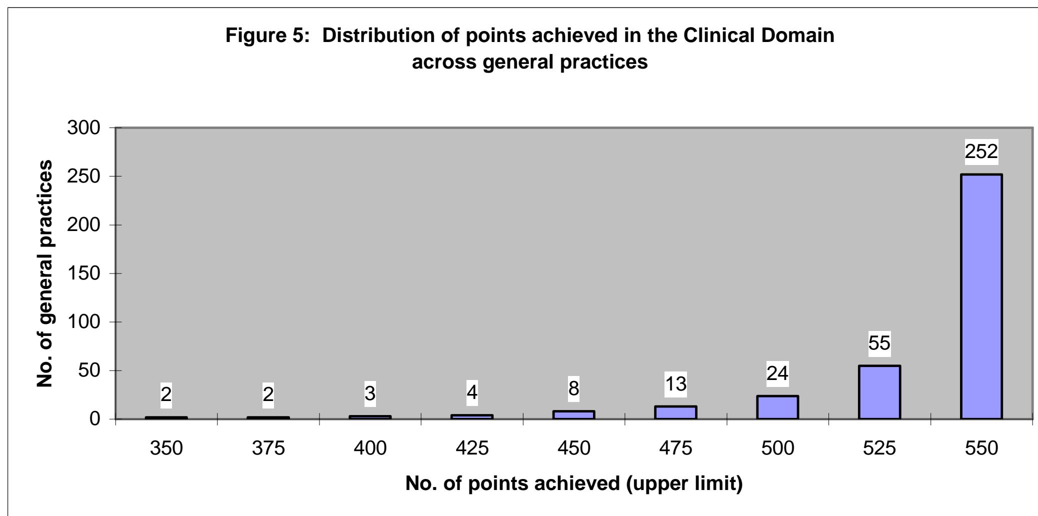
Note that each domain has a different number of indicators as well as a different number of points available.

Figure 4 below shows the percentage of points achieved that were available in each domain.



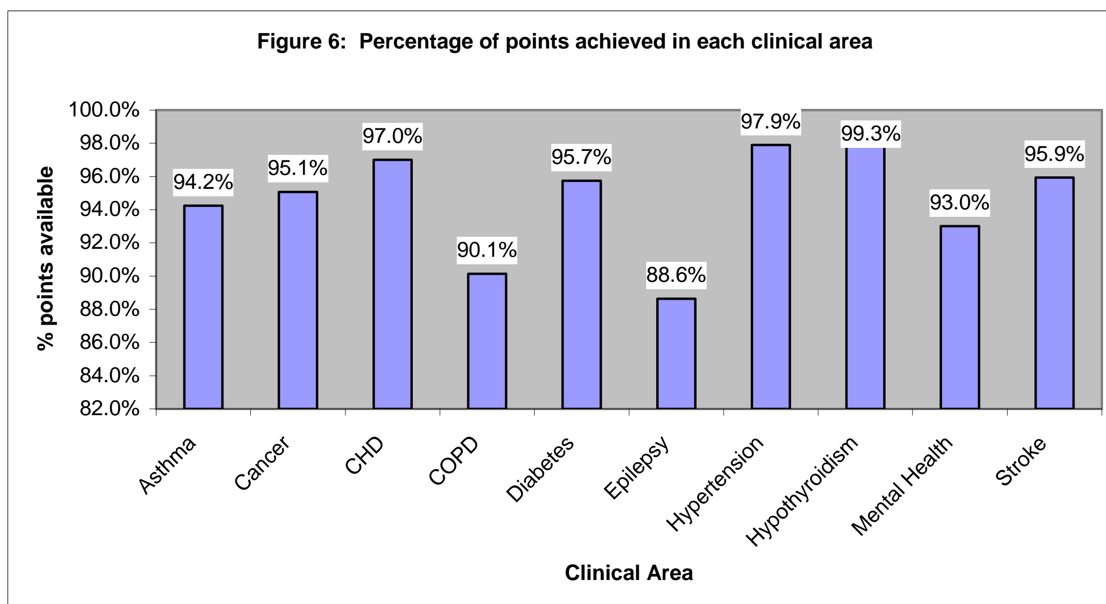
4.4.1 Clinical Domain

Figure 5 below shows the distribution of points achieved across general practices in the clinical domain. As shown, more than two-thirds of general practices (69.5%) achieved between 525 and 550 points, with 25 of those practices achieving the full 550 points. The average points achieved in this domain were 524.8 (95.4% of the total available).



Clinical Domain – disease areas

There are 10 disease areas within the clinical domain. Figure 6 shows the percentage of points achieved within each disease area.



The highest percentage points achieved were in the hypothyroidism and hypertension disease areas and the lowest in the epilepsy and chronic obstructive pulmonary disease (COPD) areas. Again it is important to note that there are a different number of indicators and points available for each disease area.

4.4.2 Organisational Domain

Figure 7 below shows the distribution of points achieved within the organisational domain. The average number of points achieved was 165 (89.7%). Only three general practices achieved the maximum 184 points available, however 158 (44%) achieved between 174 and 184 points.

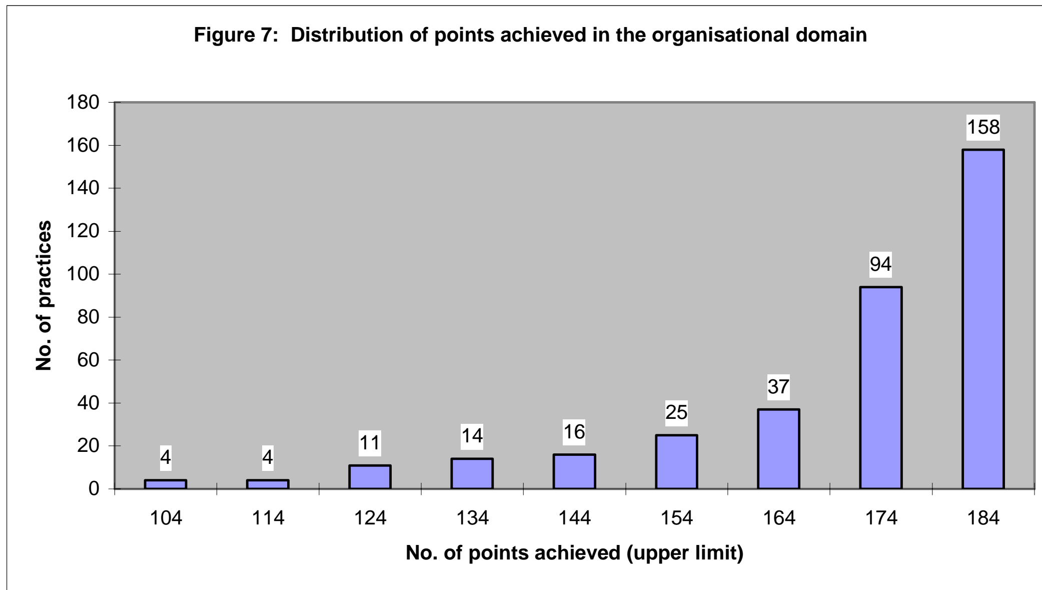
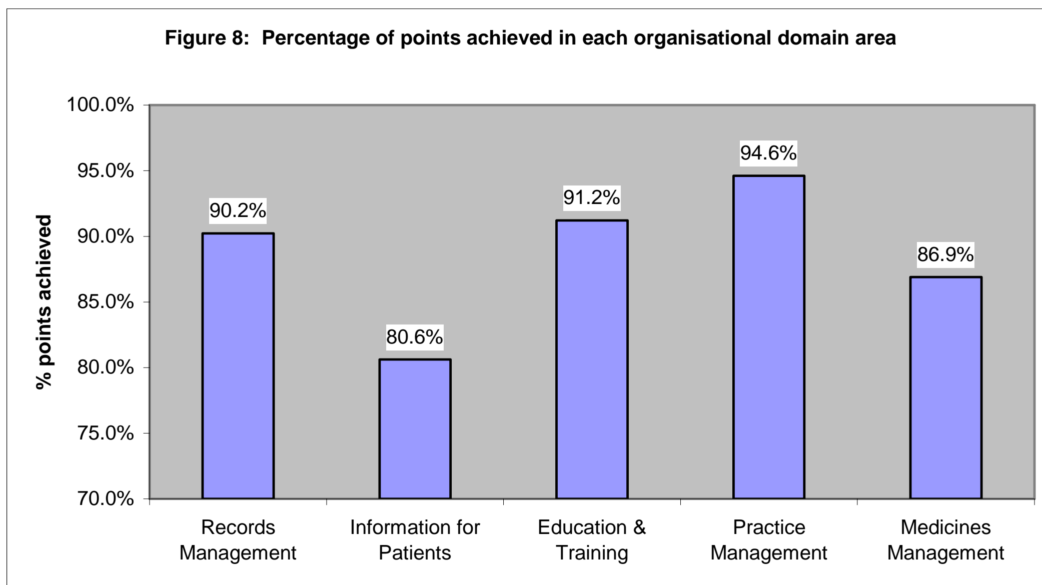
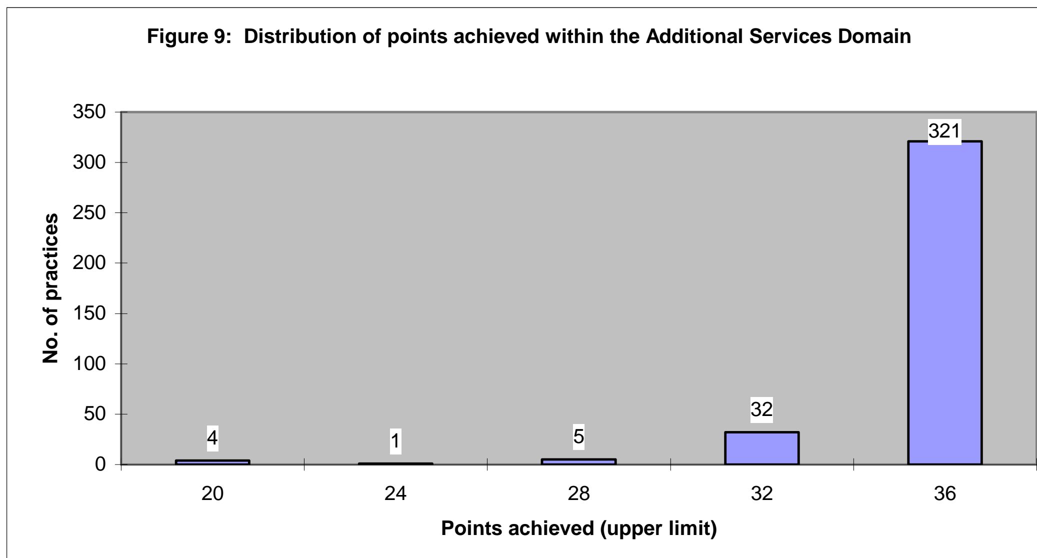


Figure 8 below shows the overall percentage achievement within each area of the organisation domain. General practices achieved a higher percentage of points within practice management (94.6%) and lower percentage of points within information for patients (80.6%).

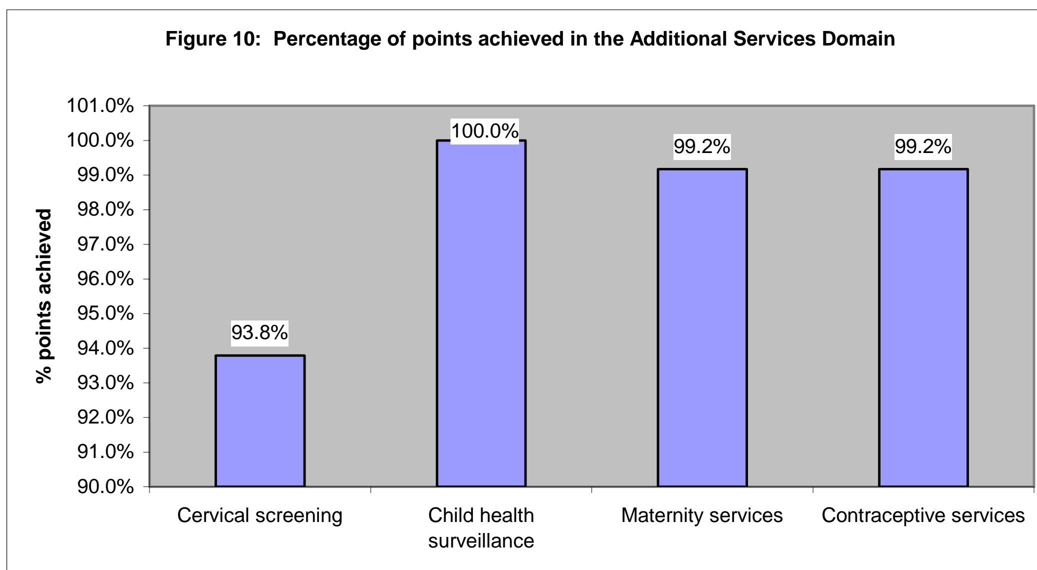


4.4.3 Additional Services Domain

Figure 9 below shows the distribution of points achieved in the patient experience domain. Amongst practices, 321 (88%) achieved between 32 and 36 points, with 180 of those practices achieving the full 36 points. An average of 96 points was achieved by practices and overall 96% of points were achieved in this domain.



Practices achieved all points available for the child health surveillance indicator. The lowest percentage achievement was 93.8% within the cervical screening indicators, but again each of the additional services areas had a different number of indicators and points available.



4.4.4 Patient Experience Domain

The distribution of points achieved in the patient experience domain is shown in Figure 11 below. Maximum achievement of 100 points was achieved by 334 (92%) practices. An average of 97.4 points were achieved by general practices.

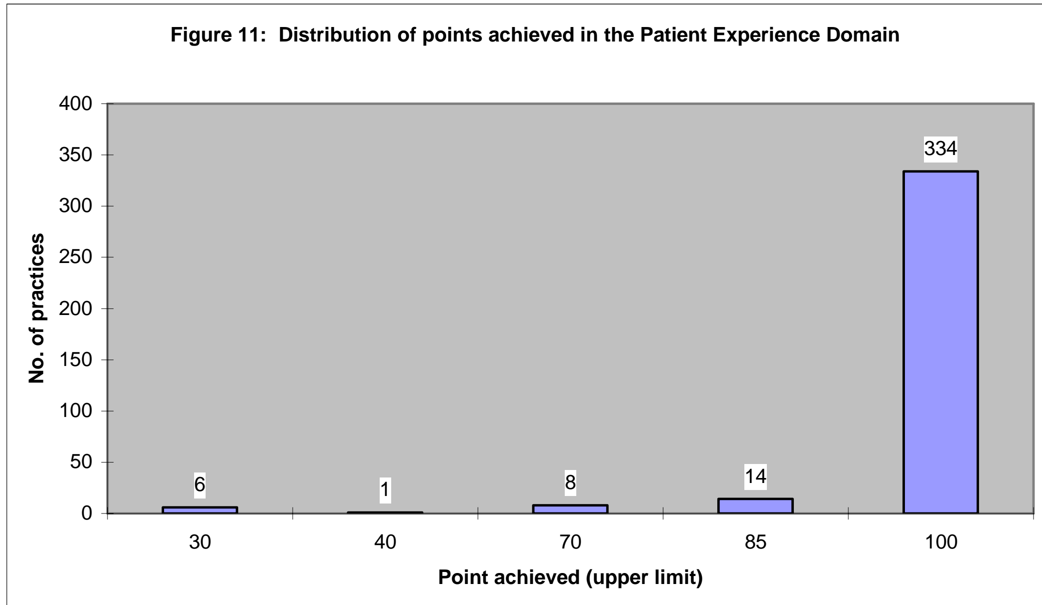
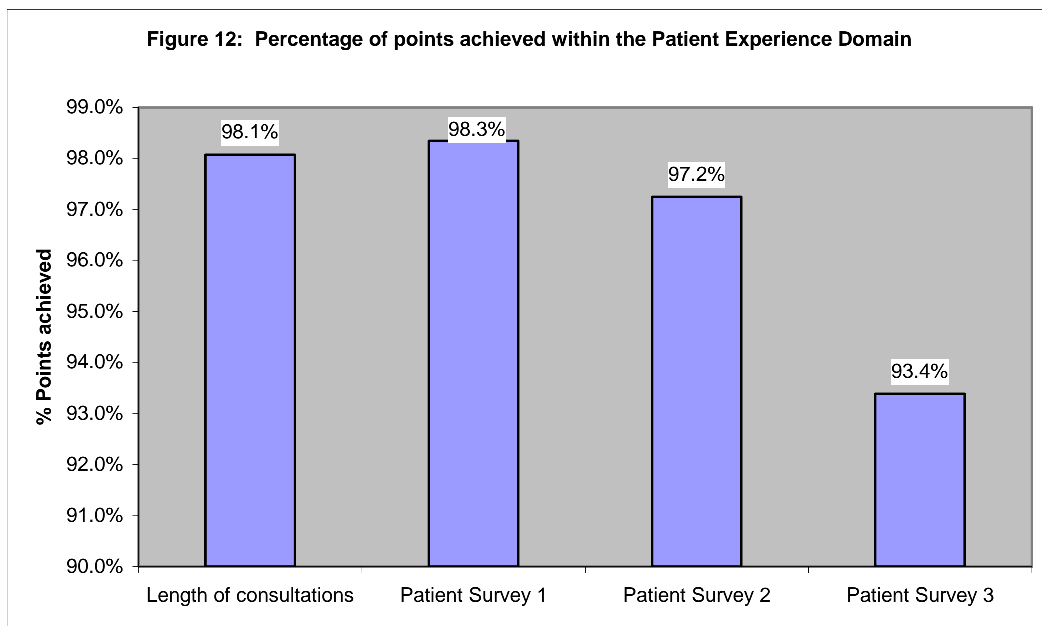
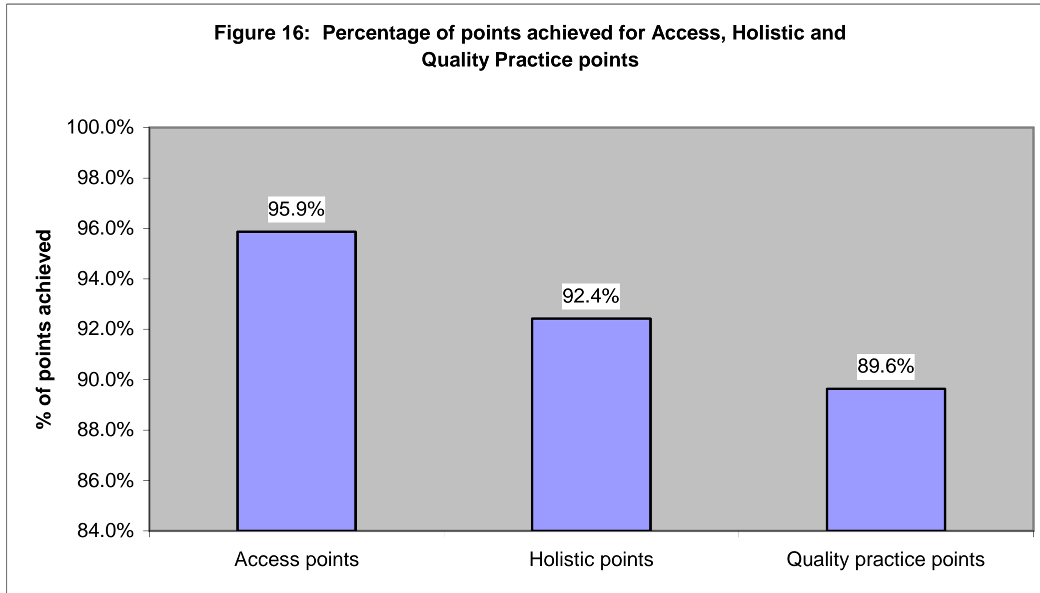


Figure 12 below shows the percentage of points achieved in each of the patient experience indicators. A different number of points were available for each indicator but highest percentage achievement of points was for the Patient Survey 1 indicator at 98.3%, closely followed by the Length of Consultation indicator at 98.1%.



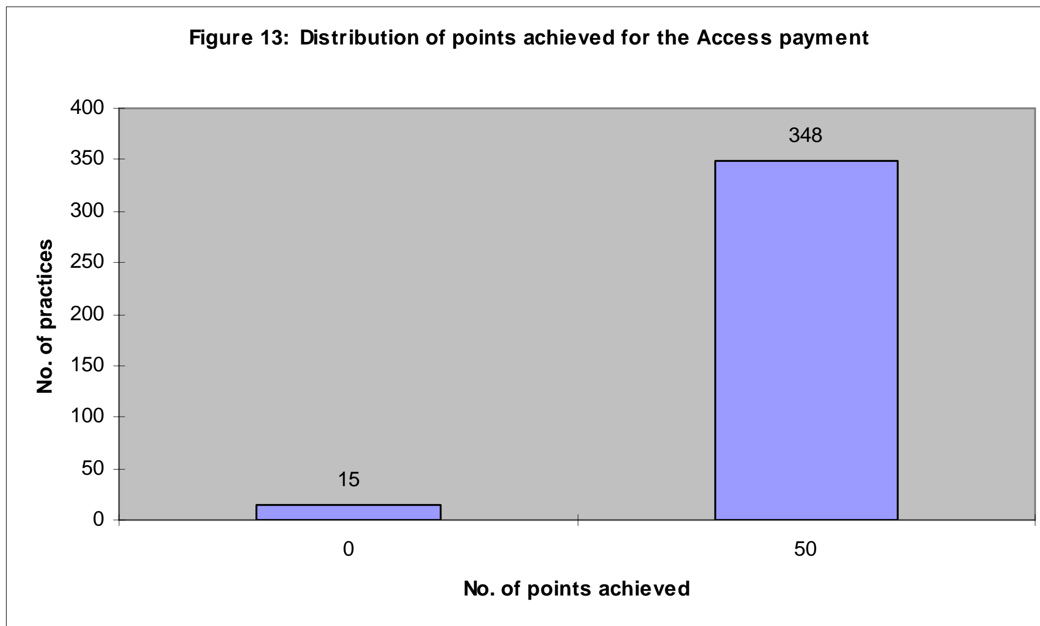
4.5 Access, Holistic and Quality Practice points

A summary of achievement of points for the access, holistic and quality practice areas is shown in Figure 16. Overall, a higher percentage of points were achieved for the access bonus (95.9%) than for the quality practice points (89.6%).



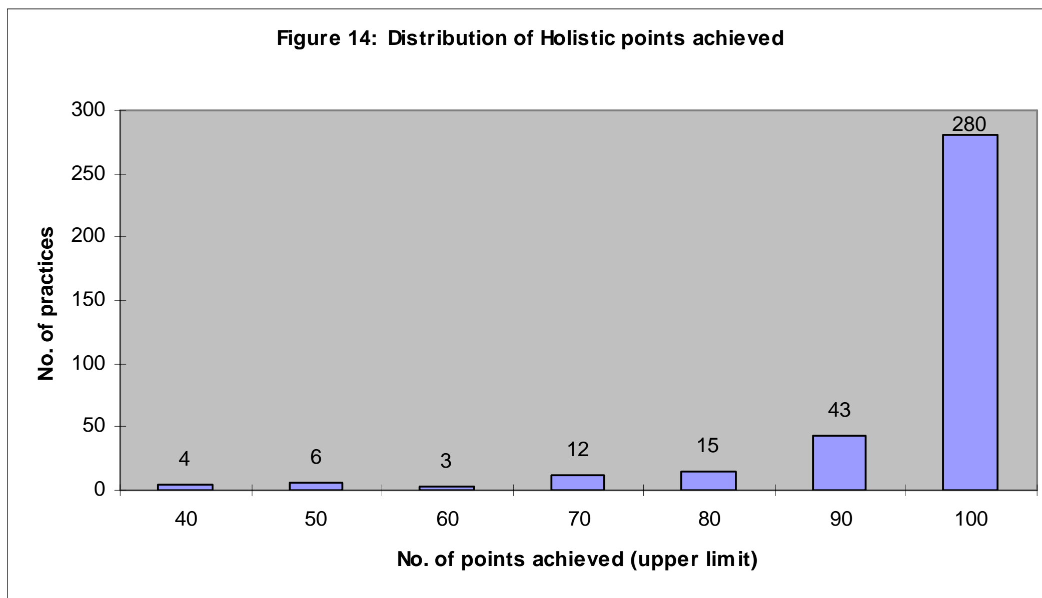
4.5.1 Access points

Figure 13 below shows that 348 general practices or 95.9% achieved the access points. At Health Board level the percentage achievement amongst practices ranged from 85.5% in the Southern Board to 100% achievement in the Northern Board. At LHSCG level, all practices within twelve of the fifteen LHSCGs achieved maximum points.



4.5.2 Holistic points

Figure 14 shows the distribution of holistic points achieved amongst practices. Over three quarters (77%) of practices achieved between 90 and 100 points, with maximum points being achieved by 91 of those practices (25.1%). The percentage achievement at Health Board level ranged from 90.7% in the Eastern Board to 95.7% in the Northern Board. At LHSCG level the percentage achievement amongst practices ranged from 84.5% at Ards LHSCG to 98.2% at East Antrim LHSCG.

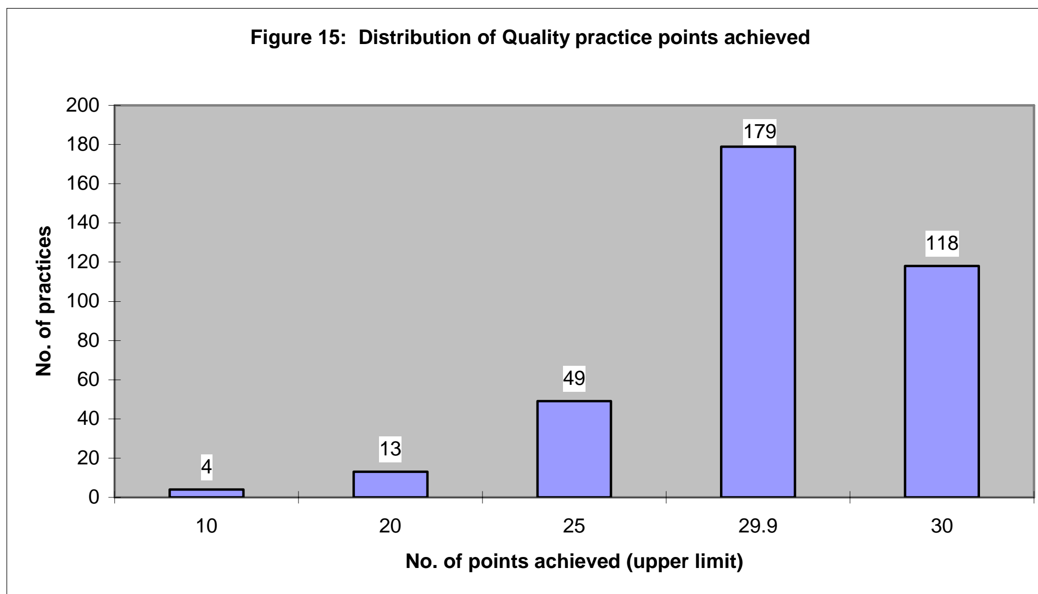


This score is calculated from achievement across other clinical indicators and ranges from zero to 100. The process is defined as follows:

The scale of the holistic care payment is calculated by considering the proportion of points achieved in each of the 10 clinical areas. The proportion of points achieved for the third lowest clinical area determines the proportion scored of the total 100 holistic care points available.

4.5.3 Quality practice payment points

The distribution of quality practice points is shown in Figure 15. As shown, maximum points were achieved by 118 general practices (32.5%). At Health Board level the achievement of quality practice points ranged from 87.5% in the Eastern Board to 93.6% in the Western Board. At LHSCG level the percentage achievement ranged from 79.9% in North & West Belfast LHSCG to 94.8% in Mid Ulster LHSCG.



This score is calculated from achievement across other non-clinical indicators and ranges from zero to 30. The process is defined as follows:

The scale of the quality practice payments is calculated by considering the proportion of points achieved in each of the non-clinical areas (organisational, additional services and patient experience). The proportion of points achieved for the third lowest area determines the proportion scored of the total 30 points available for the quality practice payment.

4.6 Prevalence Summary

The table below shows the percentage prevalence for the 10 clinical domain areas. The prevalence is based on disease register counts at 14 February 2005 and total list sizes at January 2005.

Of the disease areas collected by QOF, cancer diagnosed after 1 April 2003 is the least prevalent (0.40%) and hypertension is the most prevalent (10.30%) amongst patients. Further work on prevalence is available on request and a prevalence summary report is available on the DHSSPS website using the following link:
http://www.dhsspsni.gov.uk/hss/gp_contracts/documents/raw_disease.pdf

Clinical Disease Area	NI Prevalence
Cancer	0.44%
Mental Health	0.65%
Epilepsy	0.74%
Stroke	1.41%
Chronic Obstructive Pulmonary Disease (COPD)	1.46%
Hypothyroidism	2.52%
Diabetes	2.87%
Coronary Heart Disease (CHD)	4.17%
Asthma	5.71%
Hypertension	10.29%

To estimate how many patients are affected by at least one of these conditions we cannot simply add the prevalence figures together. Many patients are likely to suffer from co-morbidity, that is, to have been diagnosed with more than one of these conditions.

It is important to note the details of which patients were to be included on each disease register. For example, the cancer register refers to patients diagnosed after 1 April 2003, the diabetes register includes only patients aged 17 and over, the epilepsy register includes only patients aged 16 and over and the asthma register includes only those with asthma who have been prescribed asthma-related drugs in the past 12 months. Refer to Annexe E of the Statement of Financial Entitlement for full details of each register using the following link:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-docs/gms-statement-annexeE-disease.pdf

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 in terms of disease prevalence and information about general practices. However, it is important to note the limitations of using the QOF data to make further inferences and conclusions.

The following points should be noted:

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

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

- The data collected for the clinical domain on disease prevalence contains a count of patients on each disease register only, no age-specific or patient-specific data is held. So it is essential to note that it is raw data that has been published, particularly when looking at comparisons of Board and LHSCG level data.

- The PCAS system does not hold information on co-morbidity or patients with more than one disease. Many patients are likely to have been diagnosed with more than one condition however, it is not correct to simply add prevalence figures together as no patient-specific data is held.

- Each general practice's points achievement 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. Practices may have had different standards in terms of recording diagnoses and other administrative procedures.

6. QOF Links

Supporting GMS contract documentation including pre-ballot documents:
http://www.dhsspsni.gov.uk/hss/gp_contracts/contract.asp

Supporting GMS legislation:
http://www.dhsspsni.gov.uk/hss/gp_contracts/legislation.asp

GMS Statement of Financial Entitlements 2004/05 – N Ireland:
http://www.dhsspsni.gov.uk/hss/gp_contracts/financial.asp

GMS Resource Allocation Formula:
http://www.dhsspsni.gov.uk/hss/gp_contracts/eqia.asp

NHS Confederation:
http://www.nhsconfed.org/gms/

British Medical Association:
http://www.bma.org.uk/ap.nsf/content/splashpage

Report on Raw Disease Prevalence for Northern Ireland:
http://www.dhsspsni.gov.uk/hss/gp_contracts/documents/raw_disease.pdf

Detailed List of QOF Indicators:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-docs/qof-Indicators.pdf

Descriptions of Numerators and Denominators:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-docs/gms-statement-annexeE.pdf

Disease Register Details:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-docs/gms-statement-annexeE-disease.pdf

Summary of Domains:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-docs/summary-Domains-link.pdf

Practice Lookup Database:
http://www.dhsspsni.gov.uk/hss/gp_contracts/qof-practice/practice-addresses-apr05.pdf

Quality & Outcomes Framework Achievement Data – England
http://www.ic.nhs.uk/services/qof/data/

Quality & Outcomes Framework Achievement Data – Scotland
http://www.isdscotland.org/isd/info3.jsp?pContentID=3313&p_applic=CCC&p_service=Content.show&