QUALITY & OUTCOMES FRAMEWORK STATISTICS FOR NORTHERN IRELAND 2006/07

This bulletin summarises the third year of Quality & Outcomes Framework (QOF) achievement data from general practices relating to April 2006 to March 2007. A revised set of indicators was introduced from April 2006. This includes some new domains, new indicators and revised points. The source of this data is the Payment Calculation and Analysis System (PCAS), a Northern Ireland IT system used by general practices to support the QOF payment process.

Summary

- The average total QOF points achieved in Northern Ireland was 977.8 (97.8%) of the 1,000 points available.
- Of the clinical registers collected for QOF which can be used to measure actual prevalence, prevalence was highest for hypertension (11.65%) and lowest for learning disabilities (0.32%).
- The average points achieved in the four main domains was 642.8 points (98.1%) for clinical, 173.2 points (95.7%) for organisational, 107.4 points (99.5%) for patient experience and 35.2 points (97.9%) for additional services.

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1. Introduction

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 and explanation of the QOF can be found at
http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof.htm
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.

Figures are based on submissions made with reference to March 2007 for the complete financial year April 2006 to March 2007. Any adjustments made by the Health Boards in the period April to June 2007 are included. This publication uses the most up-to-date figures for each practice as at 30 June 2007.

The 2006/07 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 2007. 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.

Note that in the previous 2 years of QOF publications, data was reported at practice level, Health & Social Services (HSS) Board level and Local Health and Social Care Group (LHSCG) level. Pending the determination of new structures under the Review of Public Administration, LHSCG level has been excluded. Once the new commissioning configurations are in place, tables can be produced and added to the website.

2. Prevalence Data in the Quality & Outcomes Framework

Overview

An important feature of the QOF is the establishment of registers from which prevalence can be calculated. From April 2006, nine new registers were introduced and 2 previous registers were redefined.

For Northern Ireland reporting of PCAS information on these web pages, DHSSPS is reporting raw (unadjusted) prevalence – that is, the number on a register on 14 February 2007 as a proportion of patients on a practice list as at 1 January 2007. Prevalence reports are available at http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/pc-prevalence-reports.htm

A more detailed explanation of how prevalence is used within the calculation for QOF payments is available at
http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/qof_context.htm .

3. Content of 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: 80 indicators in 19 areas (Asthma; Atrial Fibrillation; Cancer; Chronic Kidney Disease; Chronic Obstructive Pulmonary Disease; Coronary Heart Disease; Dementia; Depression; Diabetes; Epilepsy; Heart Failure; Hypertension; Hypothyroidism; Learning Disabilities; Mental Health; Obesity; Palliative Care and Smoking and Stroke/Transient Ischaemic Attack) worth up to a maximum of 655 points (65.5% of the total).

- Organisational Domain: 43 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 181 points (18.1% of the total).

- Patient Experience Domain: 4 indicators in 2 areas (Patient Survey and Consultation Length) worth up to a maximum of 108 points (10.8% of the total).

- Additional Services Domain: 8 indicators in 4 areas (Cervical Screening; Child Health Surveillance; Maternity Services and Contraceptive Services) worth up to a maximum of 36 points (3.6% of the total).

Other Payment Points

- Holistic care payment: measures achievement across the clinical domain – worth up to 20 points (2% of the total).

- The Quality Practice payment has been removed from QOF and the points redistributed elsewhere.

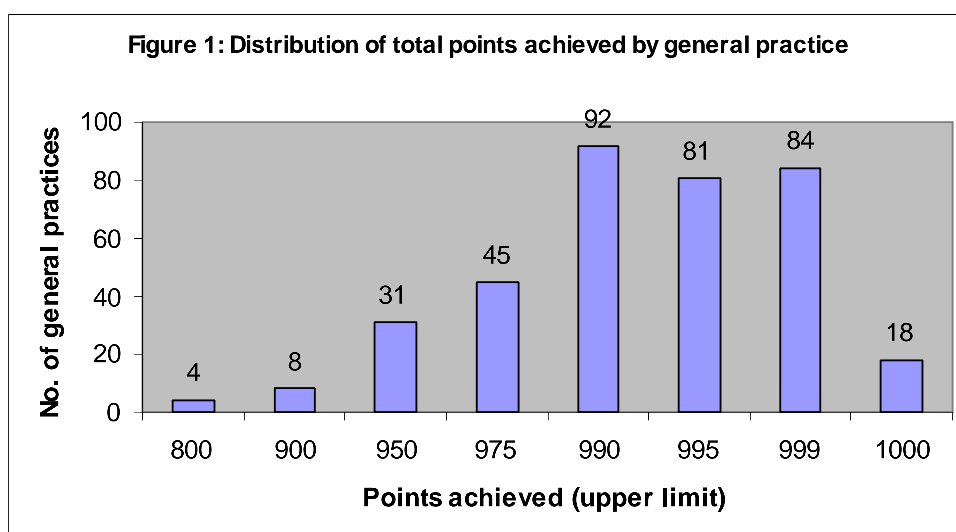
- The Access points have been removed from QOF and this is now solely a Directed Enhanced Service.

4. Overall Achievement in the Quality & Outcomes Framework

4.1 Summary at Northern Ireland Level

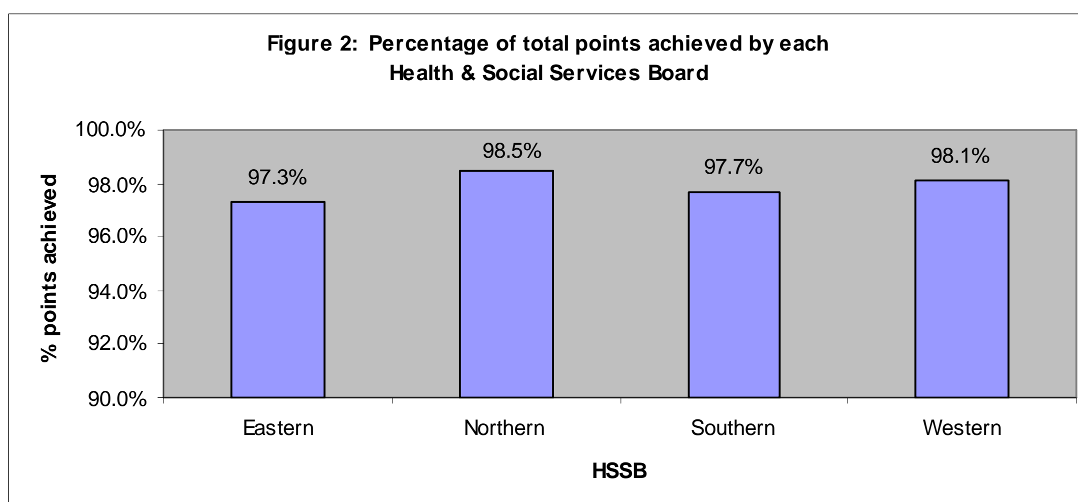
In Northern Ireland, QOF achievement data was received from 363 general practices. Overall, the average achievement of points in Northern Ireland was 977.8 of the 1,000 points available (97.8%). 17 practices achieved the maximum points of 1,000. The median score achieved was 990.1 points.

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 1,000) counts those practices who had achieved more than 999 points or equal to 1,000 points of which there are 18 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 972.8 points (97.3%) in the Eastern HSSB to 985.3 points (98.5%) in the Northern HSSB. Section 6 looks at comparisons across the 3 years of QOF by HSSB; all Boards maintaining their level of achievement since 2005/06.



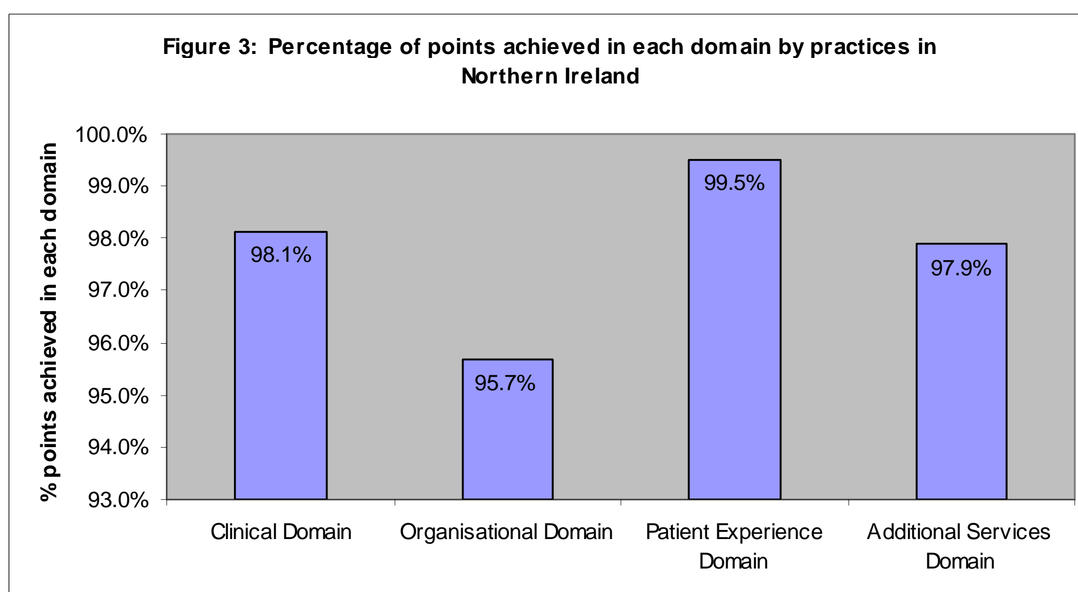
4.3 Domain Level Achievement

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

Domain	Average points achieved
Clinical	642.3
Organisational	173.2
Patient Experience	107.4
Additional Services	35.2

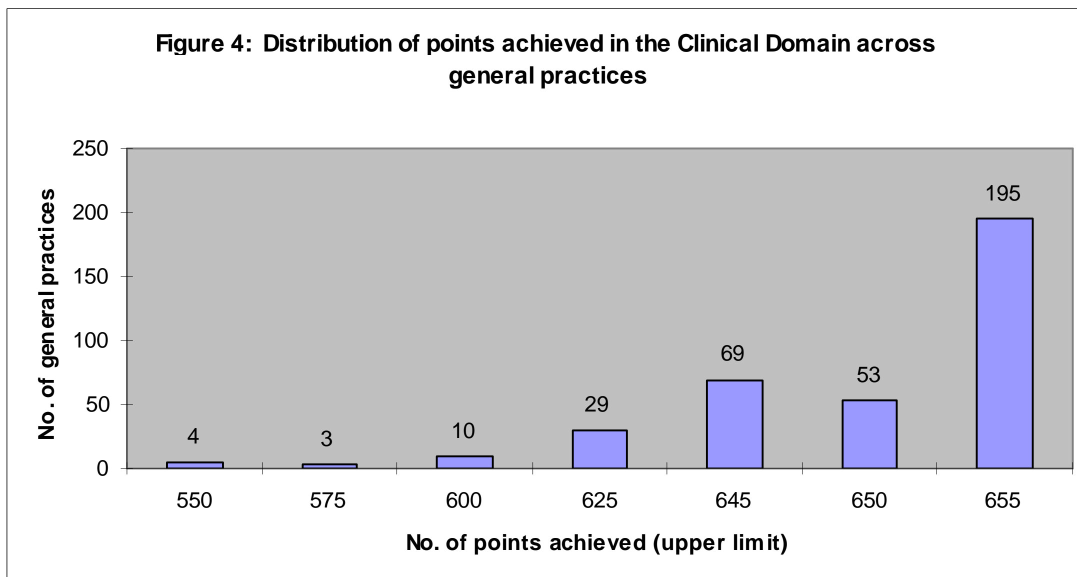
Note that each domain has a different number of indicators as well as a different number of points available.

Figure 3 below shows the percentage of available points achieved in each domain for 2006/07. Section 6 looks at comparisons across the 3 QOF years for each domain.



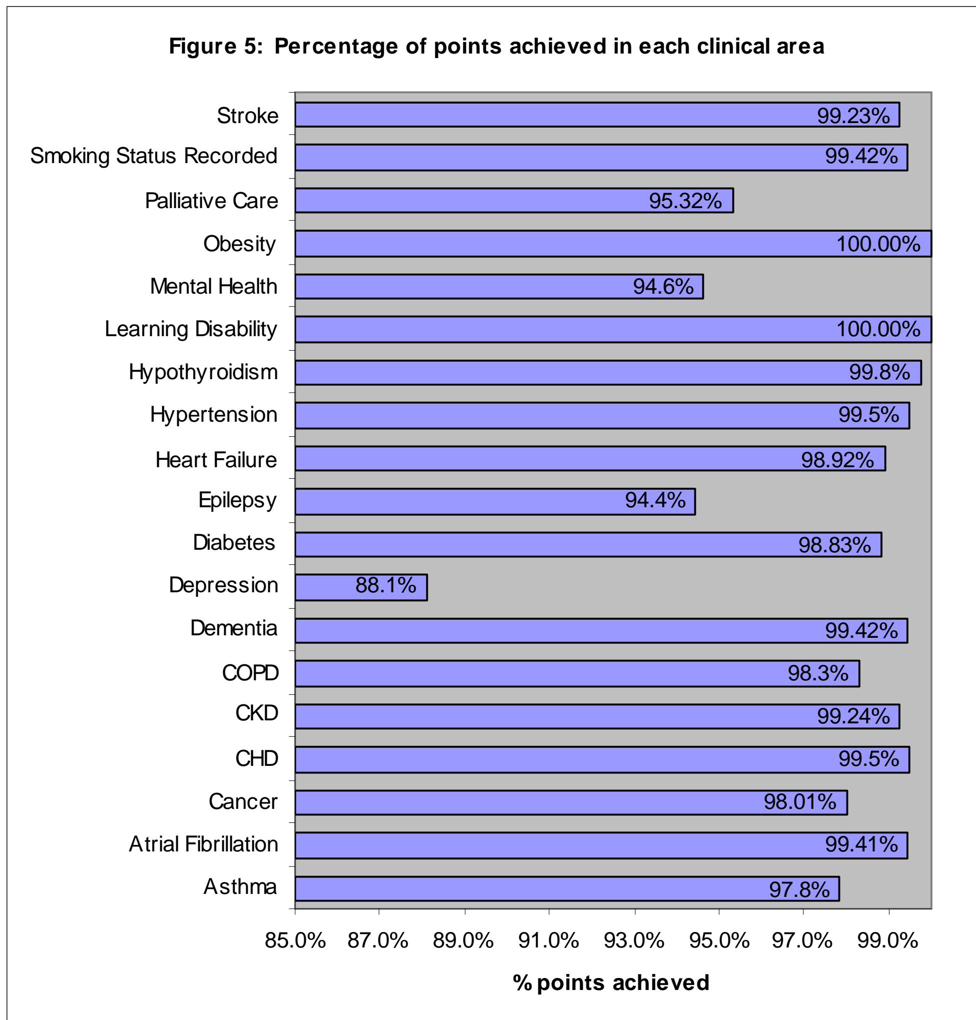
4.3.1 Clinical Domain

Figure 4 below shows the distribution of points achieved across general practices in the clinical domain. As shown, 195 general practices (53.7%) achieved over 650 points. Of those 195 practices, 84 achieved the full 655 points. The average points achieved in this domain were 642.8 (98.1% of the total available).



Clinical Domain areas

There are 19 areas within the clinical domain. Figure 5 shows the percentage of points achieved within each disease area.



Full achievement points were attained in the obesity and learning disability areas. The next highest percentage points achieved were in the hypothyroidism, hypertension and CHD disease areas and the lowest in the depression, epilepsy and mental health areas. Again it is important to note that there are a different number of indicators and points available for each disease area.

4.3.2 Organisational Domain

Figure 6 below shows the distribution of points achieved within the organisational domain. The average number of points achieved was 173.2 (95.7%). 31 general practices achieved the maximum 181 points available, however 220 (60.6%) achieved over 175 points. 302 practices (83.2%) achieved over 170 organisational points.

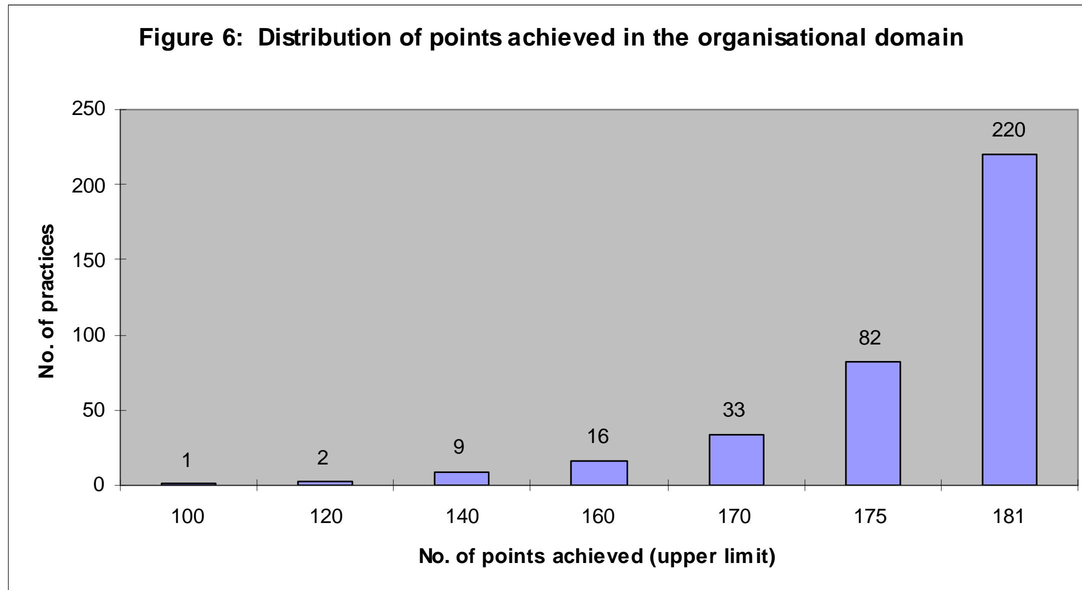
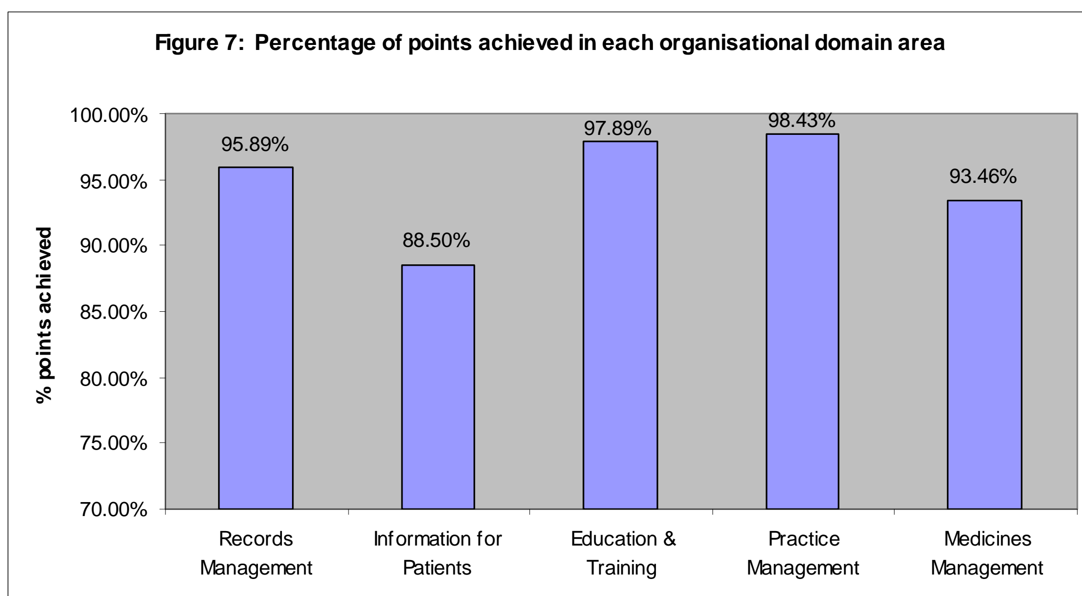
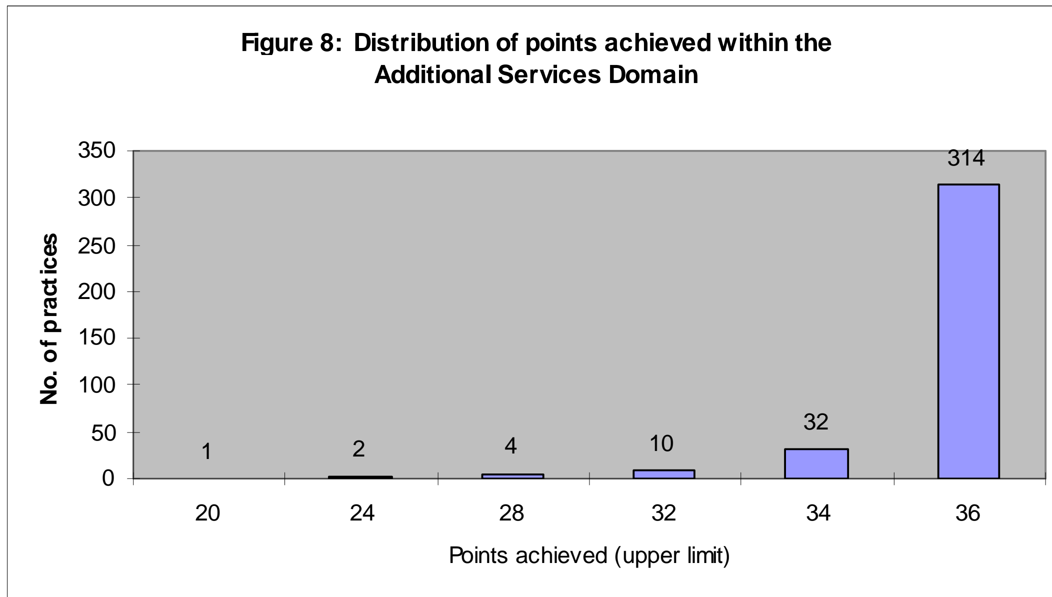


Figure 7 below shows the overall percentage achievement within each area of the organisation domain. General practices achieved a higher percentage of points within practice management (98.43%) and a lower percentage of points within information for patients (88.5%). Note however, that achievement levels for 'Information for Patients' has increased from 80.6% in the first 2 years of QOF to 88.5% in 2006/07.

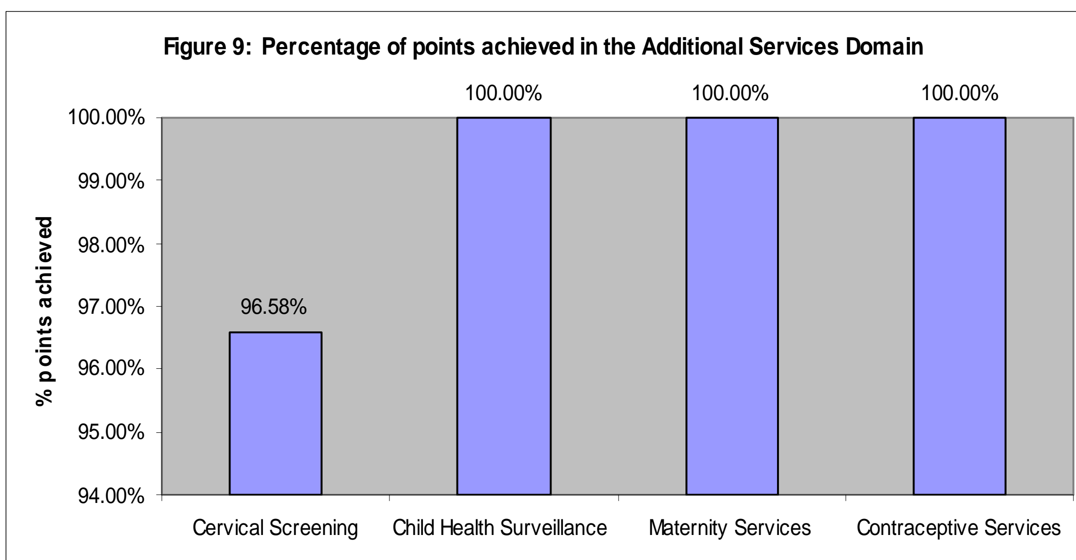


4.3.3 Additional Services Domain

Figure 8 below shows the distribution of points achieved in the patient experience domain. Amongst practices, 314 (86.5%) achieved over 34 points, with 270 of those practices achieving the full 36 points. An average of 35.2 points was achieved by practices and overall 97.9% of points were achieved in this domain.



Practices achieved all points available for 3 out of 4 additional services; cervical screening being the only area where 100% achievement was not attained. Again each of the additional services areas had a different number of indicators and points available.



4.3.4 Patient Experience Domain

The distribution of points achieved in the patient experience domain is shown in Figure 10 below. Maximum achievement of 108 points was achieved by 358 (98.6%) practices. An average of 107.4 points (99.5%) was achieved by general practices.

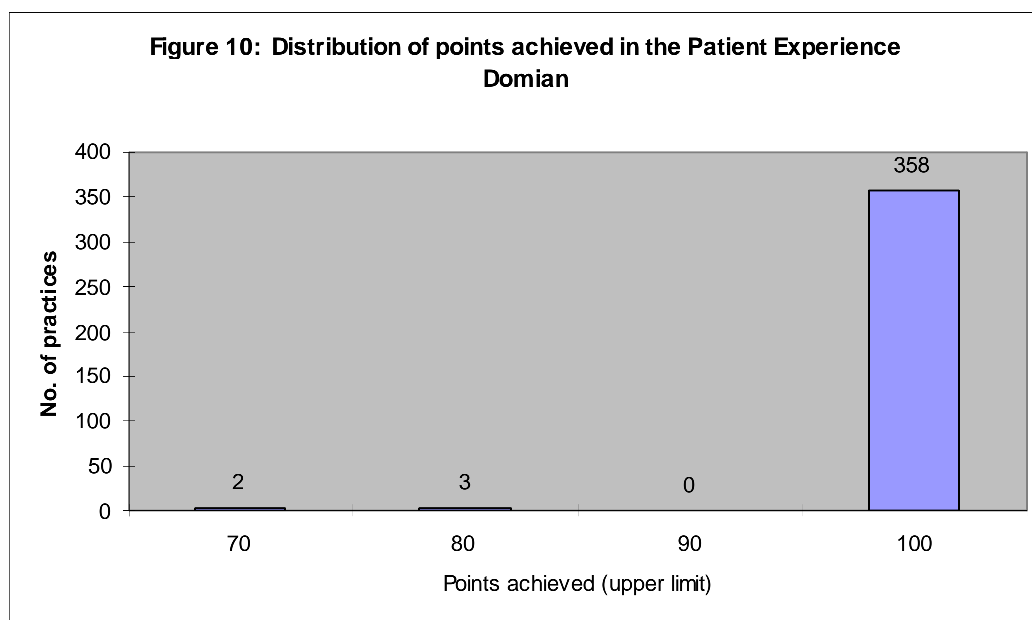
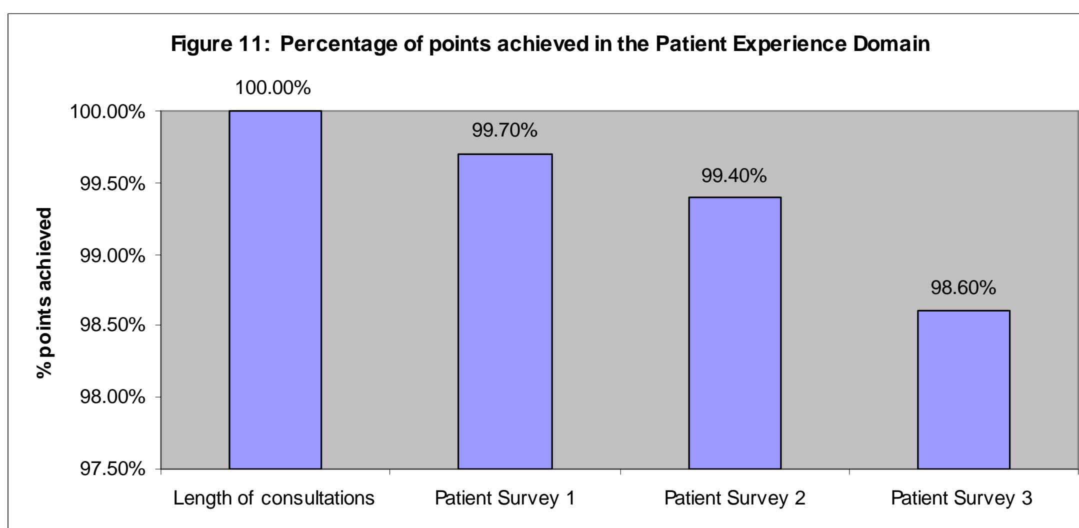
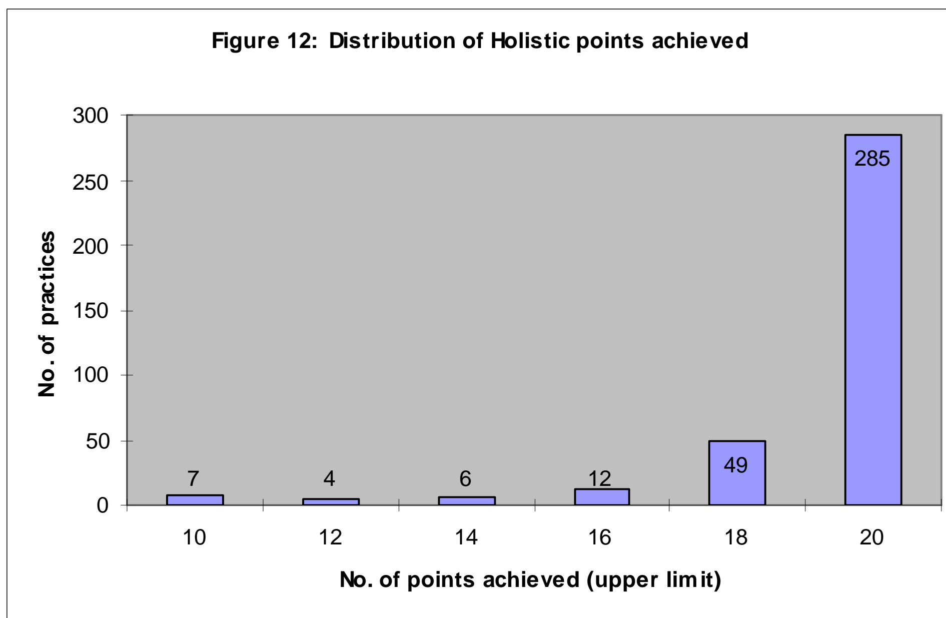


Figure 11 below shows the percentage of points achieved in each of the patient experience indicators. A different number of points were available for each indicator but highest percentage achievement of points was for the length of consultation indicator where full points were achieved.



4.4 Holistic points

Figure 12 shows the distribution of holistic points achieved amongst practices. The majority of practices (92%) achieved over 16 points, with maximum points being achieved by 188 practices. The percentage achievement at Health Board level ranged from 93.0% in the Eastern Board to 97.6% in the Northern Board. Overall achievement in holistic points has fallen from 98.1% in 2005/06 to 95.2% in 2006/07; this payment will be affected by the significant revisions made in the clinical domain given that it is derived from achievement across all the clinical areas.



This score is calculated from achievement across other clinical indicators and ranges from zero to 20. 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 19 clinical areas. The proportion of points achieved for the third lowest clinical area determines the proportion scored of the total 20 holistic care points available.

4.5 Prevalence Summary

The table below shows the percentage prevalence for those clinical registers within the QOF that are appropriate to describe in terms of disease prevalence. The prevalence is based on register counts at 14 February 2007 and total list sizes at January 2007.

A number of revisions were implemented to the QOF in April 2006, most significantly affecting the clinical domain. A number of new clinical areas were introduced and revised definitions were implemented in some areas. No clinical areas have been dropped but note that specific indicators within a clinical area may have been redefined or may no longer exist. Furthermore, new indicators have been introduced in some areas.

QOF registers for 7 clinical areas have maintained consistent definition since April 2004: asthma, cancer, CHD, COPD, hypertension, hypothyroidism and stroke. In terms of diabetes, a small change has been made with regard to the diagnosis codes which make patients eligible for the register. The definition of epilepsy was changed from patients aged 16+ to patients aged 18+.

As of April 2006, the mental health register has been 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'. A specific register has now been introduced to capture conditions assessed for depression.

New registers were introduced in April 2006 for: atrial fibrillation, chronic kidney disease, dementia, heart failure, learning disabilities, obesity, palliative care and conditions assessed for smoking.

Of the 21 registers collected for QOF, 4 of these have been excluded from the table below as these do not actually measure disease prevalence. The depression 1 register is concerned with case finding among diabetes and CHD patients; the smoking register does not allow prevalence to be derived but rather counts of the smoking status of these patients has been recorded; and at this early stage the obesity register will not be a true reflection of obesity prevalence due to being reliant on attendance to a GP and measurements being taken.

Of the registers collected for QOF for which prevalence can be derived, learning disability is the least prevalent (0.32%) and hypertension is the most prevalent (11.65%) amongst patients.

QOF National Prevalence Day at February 2007

Clinical Disease Area	NI Prevalence For QOF Payment Purposes	NI Prevalence for age-specific registers
Coronary Heart Disease (CHD)	4.20%	4.20%
Heart Failure	0.82%	0.82%
Heart Failure due to LVD	0.39%	0.39%
Stroke	1.62%	1.62%
Hypertension	11.65%	11.65%
Diabetes (17+ population)	3.14%	4.04%
Chronic Obstructive Pulmonary Disease (COPD)	1.53%	1.53%
Epilepsy (18+ population)	0.74%	0.98%
Hypothyroidism	2.87%	2.87%
Cancer	0.78%	0.78%
Mental Health	0.75%	0.75%
Asthma	5.78%	5.78%
Dementia	0.53%	0.53%
Chronic Kidney Disease (CKD) (18+ population)	2.31%	3.02%
Atrial Fibrillation	1.25%	1.25%
Learning Disabilities (18+ population)	0.32%	0.41%

Note that for QOF payment purposes, the Adjusted Practice Disease Factors which are used to weight QOF points in each clinical area, the raw prevalence is derived by dividing the count of patients on the register by the total practice list. However, for 4 areas, the register is age-specific (diabetes, epilepsy, chronic kidney disease and learning disabilities).

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 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 18 and over from April 2006 (refined from 16 years 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 D of the Statement of Financial Entitlement for full details of each register using the following link:
http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_finance.htm

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 achievement of points 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 domains on prevalence contains a count of patients on each register only, no age-specific or patient-specific data are held. So it is essential to note that it is raw data that has been published, particularly when looking at comparisons at Board level.

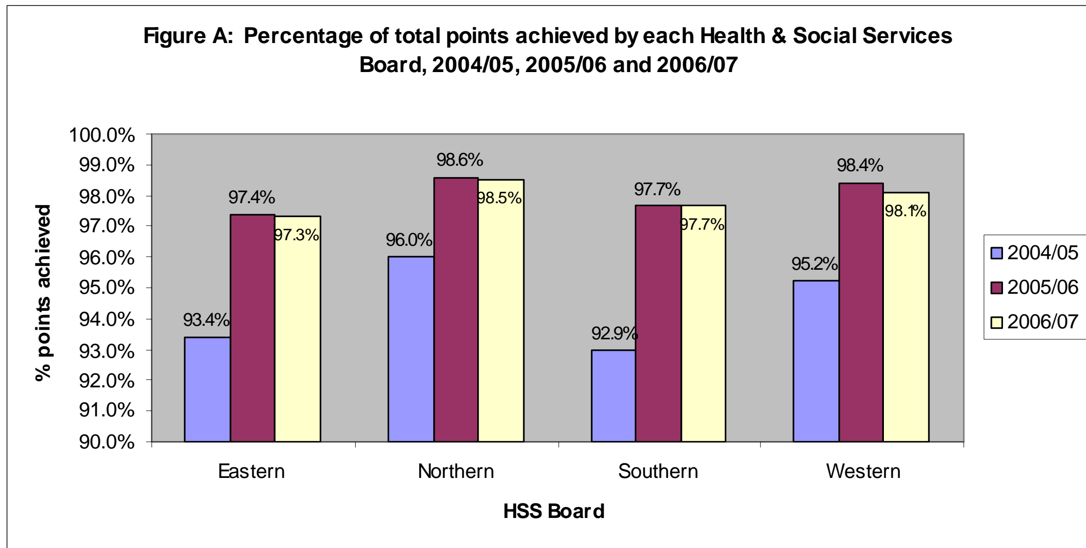
- The PCAS system does not hold information on co-morbidity or patients with more than one condition. Many patients are likely to have been diagnosed with more than one condition however, it is not correct to simply add prevalence figures together as no patient-specific data are held.

- Prevalence figures will not be directly comparable across all years where definitions have been revised (see notes under paragraph 4.5).

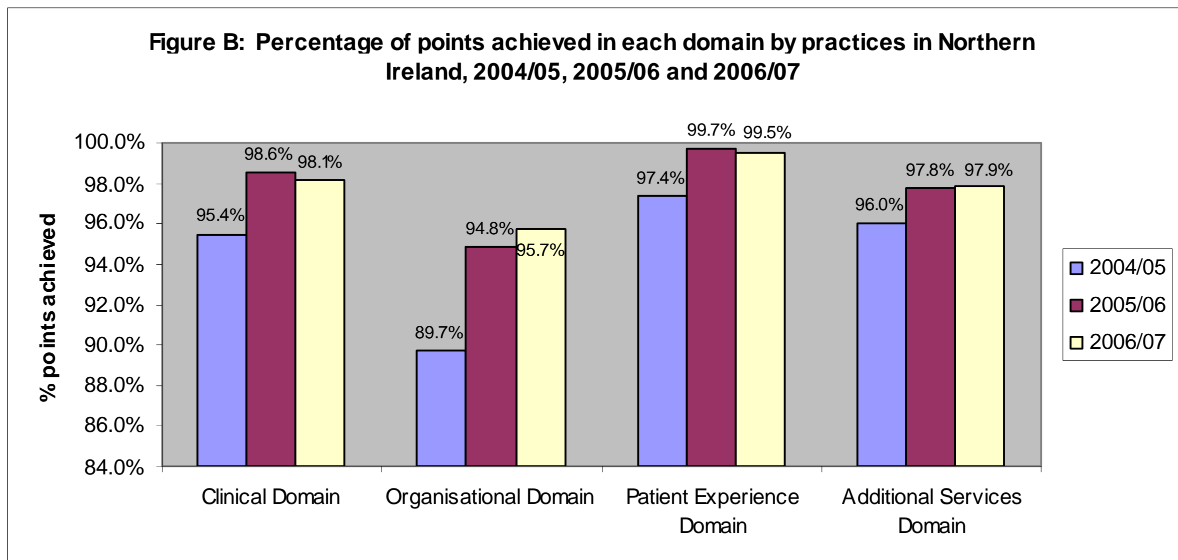
- Each general practice's achievement will be partly dependent on the number of points each practice aspired to. Therefore not all practices will have commenced QOF from the same baseline and not all will have improved to the same extent. Practices may have had different standards in terms of recording diagnoses and other administrative procedures.

6. Comparisons with 2004/05 and 2005/06

Total points achieved by Health & Social Services Board (HSSB)

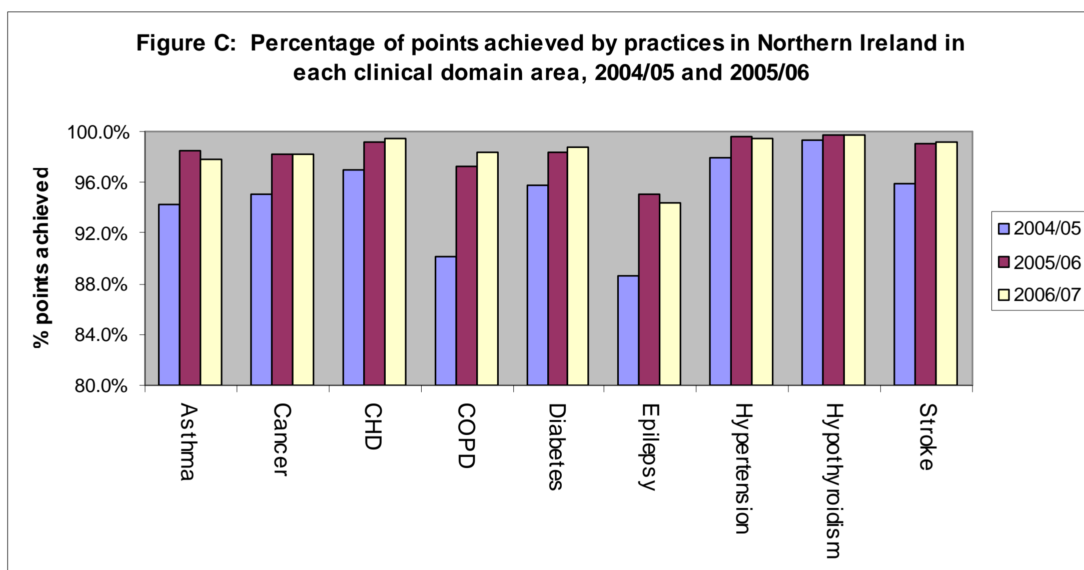


Domain Summary



The clinical domain has seen a very slight decrease in achievement (-0.4%) between 2005/06 and 2006/07; this is to be expected given the significant revisions made to the clinical areas. The organisational domain has seen an increase in achievement (+0.9%). The patient experience domain has seen a slight decrease (-0.2%) in achievement levels but revisions were implemented in April 2006 which tightened the criteria for achieving these indicators which it should be noted require full compliance for points to be awarded.

Clinical Domain



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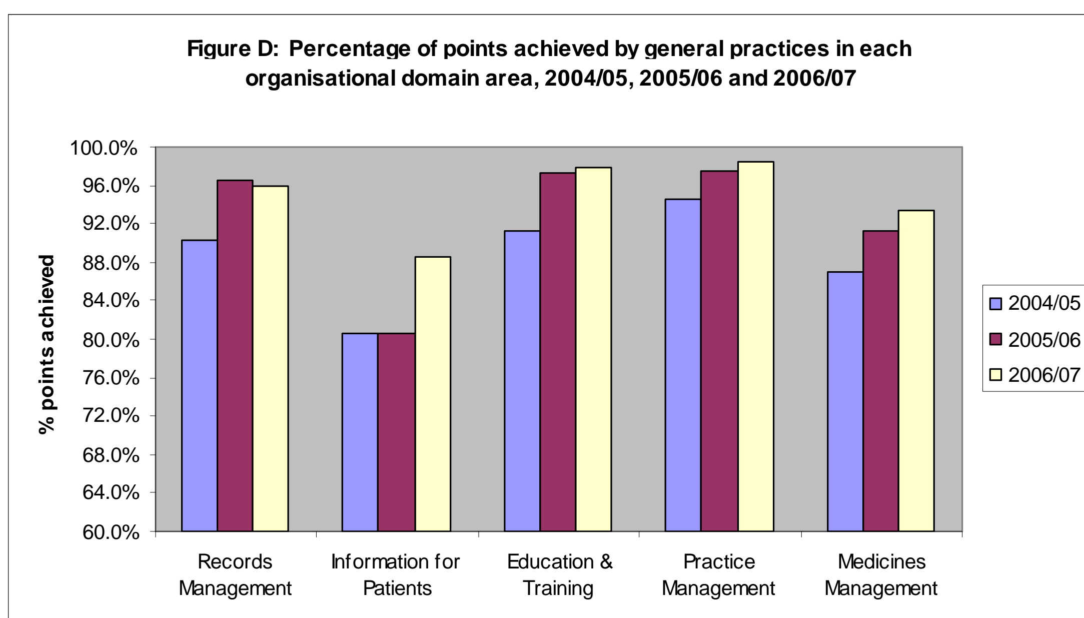
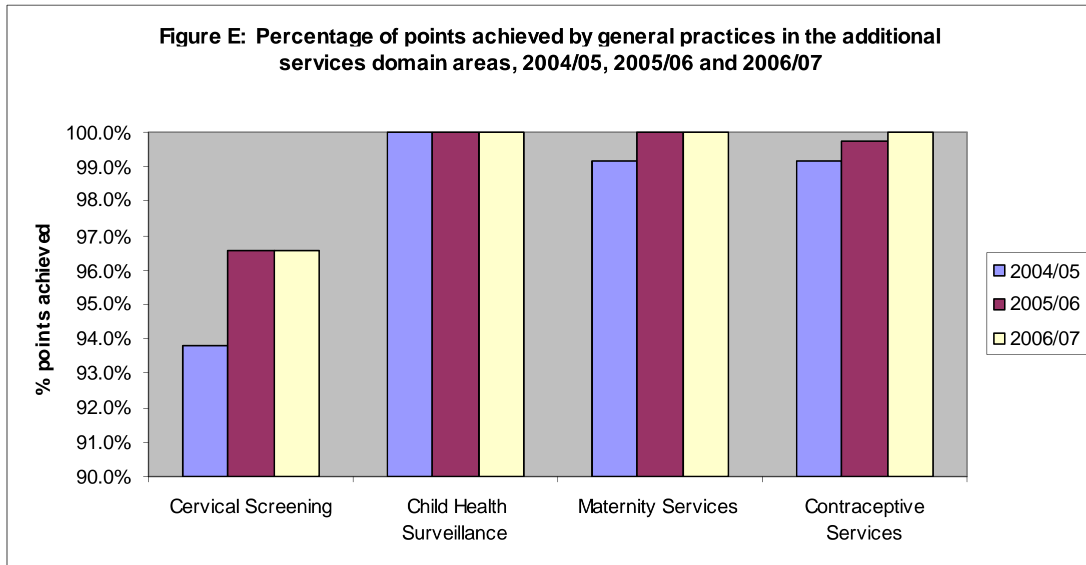
Organisational Domain



Within the organisational domain, all areas have seen improvement in achievement across the 3 years of QOF. Records management and education and training saw a significant improvement between years 1 and 2 which has been maintained into year 3. Practice and medicines management has seen a steady improvement over the 3 years. Information for patients saw no change between year 1 and 2 but achievement has increased by 8% in 2006/07.

Additional Services Domain



Contraceptive services have now reached full achievement in line with child health surveillance and maternity services. The sustained level of achievement in cervical screening rather than improvement may be due to the revisions within this area.

Patient Experience Domain