ystadegau ar gyfer cymru
statistics for wales

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General Medical Services Contract: Quality and Outcomes Framework statistics for Wales, 2012-13

This release presents a summary of data from the national General Medical Services (GMS) Quality and Outcomes Framework (QOF) during 2012-13. The Quality and Outcomes Framework (QOF) is a system of financial incentives. It is about rewarding contractors for good practice (and its associated workload) through participation in an annual quality improvement cycle. Whilst it is voluntary all practices in Wales participated in 2012-13.

The QOF was first implemented in April 2004, and the financial year 2012-13 therefore represents the ninth year of the QOF. The 2012-13 data is illustrated in terms of achievement, exception reporting and the number of patients on disease registers i.e. prevalence. Achievement is measured against a range of clinical indicators and a range of indicators relating to practice organisation and management. The data reported is derived from the national 'CM Web' software as at 30 June 2013. Note that not all of the data is comparable to previous years since the points available have changed for some indicators. Also, some indicators are not included in the exception analysis because for definitional reasons they are not comparable to other indicators.

Statistics on the underlying achievement and historical achievement are also shown. The underlying achievement relates to the proportion of patients that received the specified care as opposed to points achievement which relates to whether the proportion of patients receiving the specified care is above a certain threshold. For the historical achievement it must be noted that due to changes in the business rules and Read codes the achievement for any year may not be exactly comparable to other years.

See Key Quality Information pages for more information. More detailed tables are provided in StatsWales and in the practice level spreadsheet. 389 (82.6 per cent) of the 471 practices in Wales achieved 950.0 or more of the 1,000 points available. Only 7 practices (1.5 per cent) achieved fewer than 800.0 points.

Key results

- In 2012-13, 389 (82.6 per cent) of the 471 practices in Wales achieved 950 or more of the 1,000 QOF points. In 2011-12, 413 (87.1 per cent) of practices achieved this level. However changes to some of the indicators this year mean the two percentages are not comparable.
- Three quarters of practices (353 practices) achieved 641 or more of the 669 potential points in the clinical domain, the major part of QOF.
- The largest single condition disease register, in terms of the number of patients as a percentage of all patients on practice lists, was hypertension (15.5 per cent).

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1. Introduction

1.1. The national Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. The rules governing the reporting of data within the clinical domain are contained within the technical documents entitled the 'QOF Dataset and Business Rules' which can be found at: http://www.pcc.nhs.uk/business-rules-v18-0

1.2. The QOF is about resourcing and then rewarding good practice. The QOF measures achievement against 148 indicators. Practices score points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

1.3. Not all indicators in this release are consistent with 2012-13. Where indicators have been amended, either in relation to the activity being measured, the frequency with which the activity should be completed or where a linked indicator has been changed, the indicator has been renumbered. For example, the 2009-10 diabetes DM23 HbA1c target changed in 2011-12, therefore, the indicator identifier changed to DM26. For clarity DM24 and DM25 were also renumbered to keep the three target indicators grouped together.

1.4. There were changes to the QOF indicators in 2012-13 from 2011-12. These changes included the retirement of previous indicators, introduction of new indictors, including two new clinical areas (Peripheral Arterial Disease and Osteoporosis), and definitional changes to existing indicators. Note that these changes have an impact on the total numbers of available points to both the clinical and organisation domain.

2. Achievement

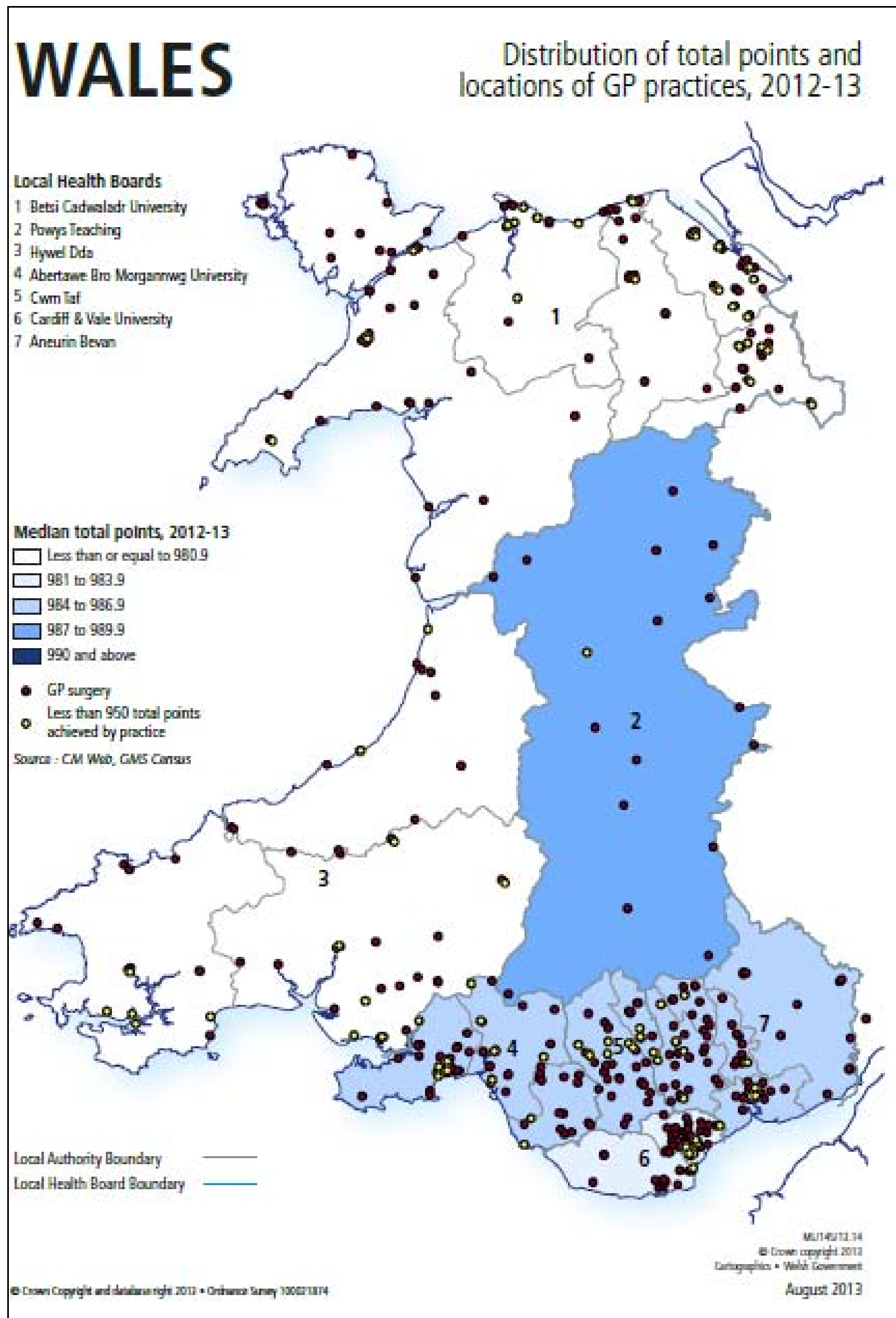
2.1 Contents of the framework

The QOF contains four main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement:

- **Clinical domain**: 96 indicators in 22 areas (Secondary prevention of coronary heart disease, Cardiovascular disease – primary prevention, Heart failure, Stroke and Transient Ischaemic Attack, Hypertension, Diabetes mellitus, Chronic obstructive pulmonary disease, Epilepsy, Hypothyroid, Cancer, Palliative care, Mental health, Asthma, Dementia, Depression, Chronic kidney disease, Atrial fibrillation, Obesity, Learning disabilities, Smoking, Peripheral arterial disease, and Osteoporosis). Indicators in the clinical domain are worth up to a maximum of 669 points (66.9 per cent of the total).
- **Organisational domain**: 42 indicators in 6 areas (records and information, information for patients, education and training, Medicines management, Practice, quality and productivity and practice management). Indicators in the organisational domain are worth up to 254 points (25.4 per cent of the total).
- **Patient experience domain**: 1 indicator in 1 area (length of consultations), worth up to 33 points (3.3 per cent of the total)
- **Additional services domain**: 9 indicators in 4 areas (cervical screening, child health surveillance, maternity services and contraceptive services), worth up to 44 points (4.4 per cent of the total).

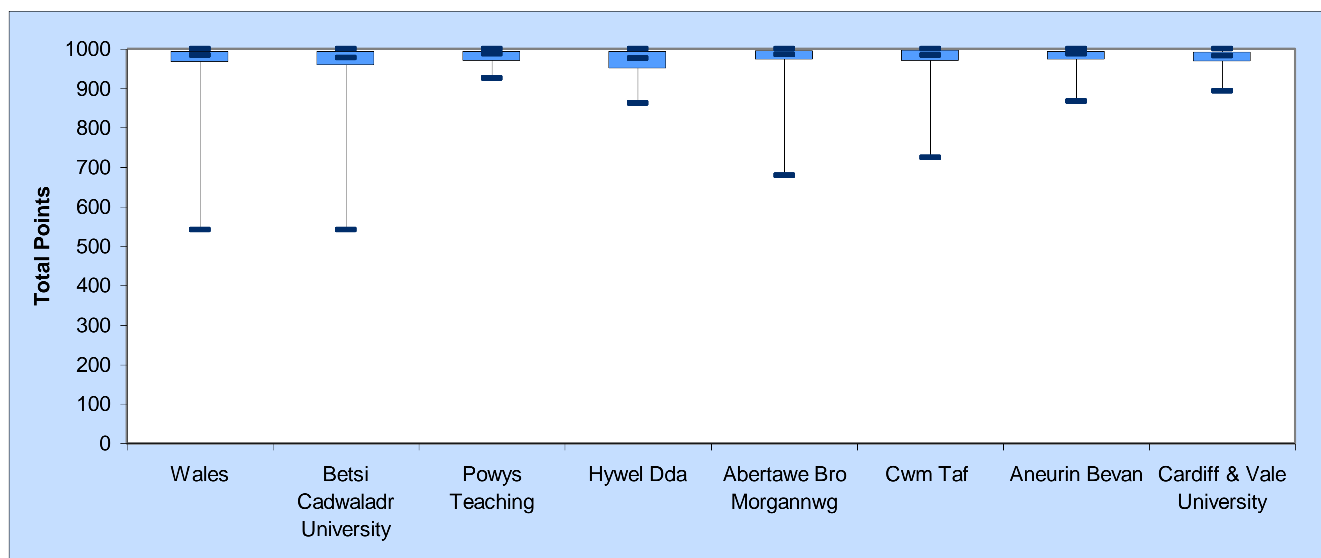
2.2 Overall achievement

Map 1: Distribution of total points and locations of GP practices



It is important to note that the shading indicates the median total points for the Health Board. The shading does not reflect the total points of the individual practices.

Chart 1: Distribution of total points achieved by practices



Source: CM Web

389 (82.6 per cent) of the 471 practices in Wales achieved 950.0 or more of the 1,000 points available. Only 7 practices (1.5 per cent) achieved fewer than 800.0 points.

The range of achievement for practices is illustrated in this release by the use of box plots. The boxes show the range from the lower to upper quartiles (50 per cent of practices will lie between these limits); this is referred to as the inter-quartile range. The middle value, the median, is shown as a horizontal bar in the box, while the vertical lines show the range from the minimum to maximum values. For example, Chart 1 shows that in Wales 50 per cent of practices scored between 965.8 points and 994.0 points and that the maximum points scored in a practice was 1,000 points and the minimum was 541.5 points. Note that the vertical scales differ for Charts 1, 2, 4, 5.

Within Health Boards the median total points were all between 975.5 (Hywel Dda) and 987.0 (Powys Teaching). Betsi Cadwaladr University had the widest range in values with a maximum of 1000.0 points and minimum of 541.5 points. The inter-quartile range is the difference between the 75th and 25th percentile and this shows how spread out are the total points of the middle 50 per cent of practices. Hywel Dda had the widest inter-quartile range of 949.8 points to 993.7 points.

2.3 Domain level achievement

The average number of points achieved by practices in Wales for each QOF domain was as follows:

Table 1: Domain level achievement

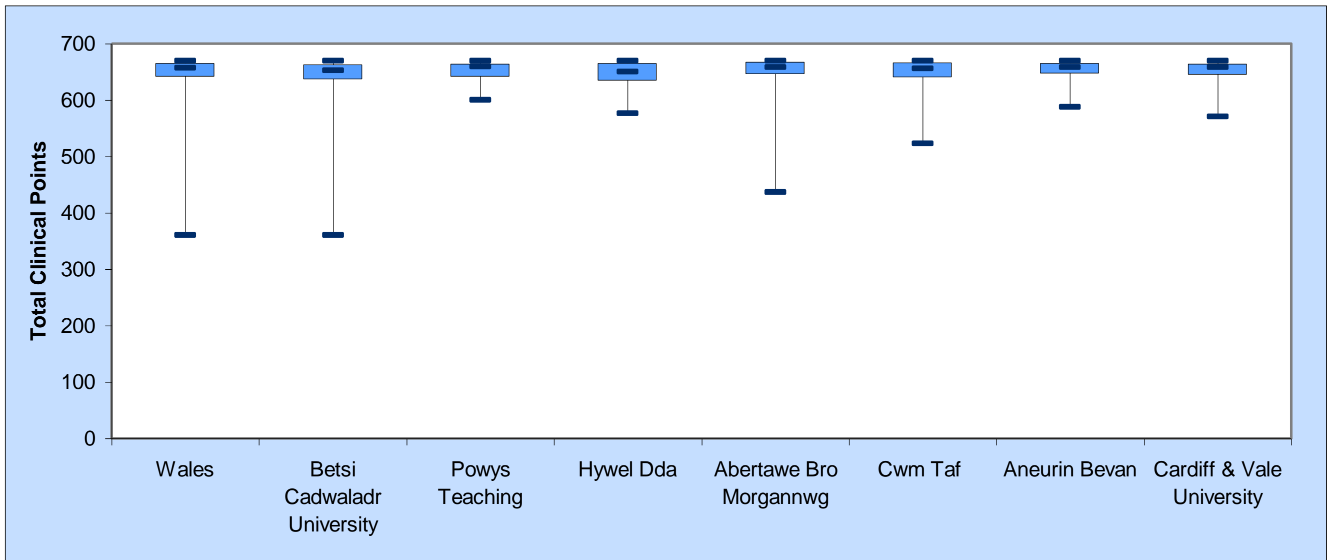
	2010-11		2011-12		2012-13	
Domain	Average points per practice	Maximum points available	Average points per practice	Maximum points available	Average points per practice	Maximum points available
Clinical	681	697.0	647	661.0	647	669.0
Organisational	162	167.5	253	262.0	247	254.0
Patient Experience	73	91.5	33	33.0	33	33.0
Additional Services	43	44.0	43	44.0	43	44.0
All domains	**960**	**1,000.0**	**975**	**1,000.0**	**970**	**1,000.0**

Source: CM Web

As Table 1 shows there have been a reallocation of points between domains in 2012-13. Patient experience has only one indicator whilst the organisation domain includes Quality and Productivity indicators.

2.4 Clinical domain

Chart 2: Distribution of total points achieved in the clinical domain by practices

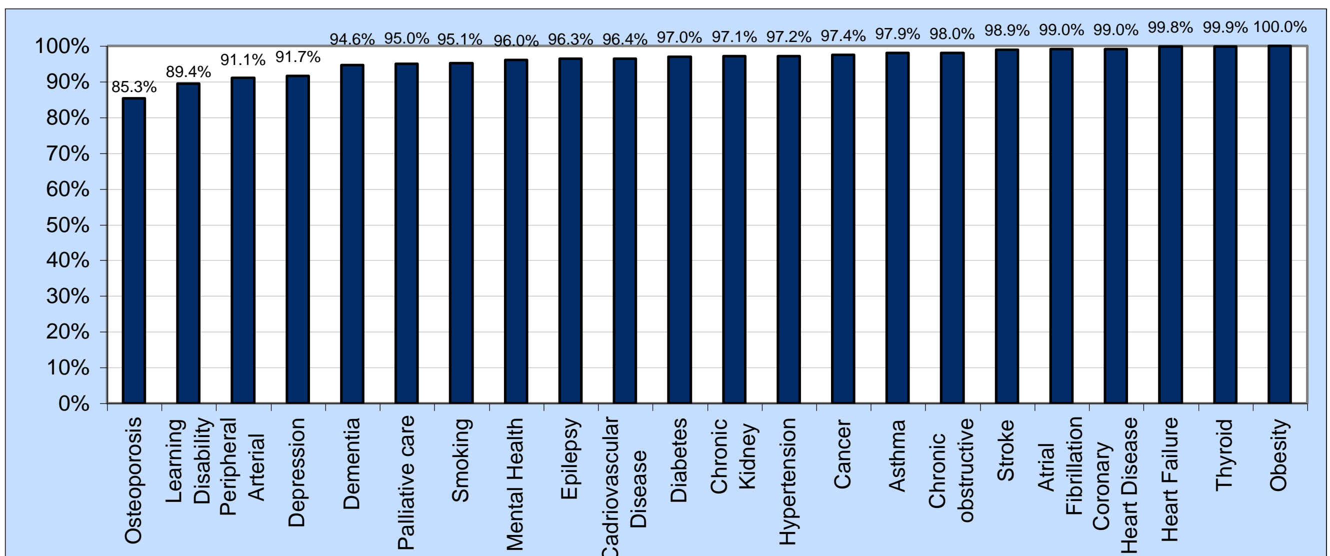


Source: CM Web

Within the clinical domain, three quarters of practices (353 practices) achieved 641.1 or more points out of a maximum 669.0 points.

The widest range in clinical points was in Betsi Cadwaladr University from 359.8 points to 669.0 points. The narrowest range was in Powys Teaching from 599.8 points to 669.0 points. When looking at the middle 50.0 per cent of practices the widest range of clinical points (inter-quartile range) was in Hywel Dda from 633.8 points to 665.1 points and the narrowest range was in Aneurin Bevin from 646.4 points to 665.0 points.

Chart 3: Mean practice score as a percentage of maximum points available by disease area, Wales (a)



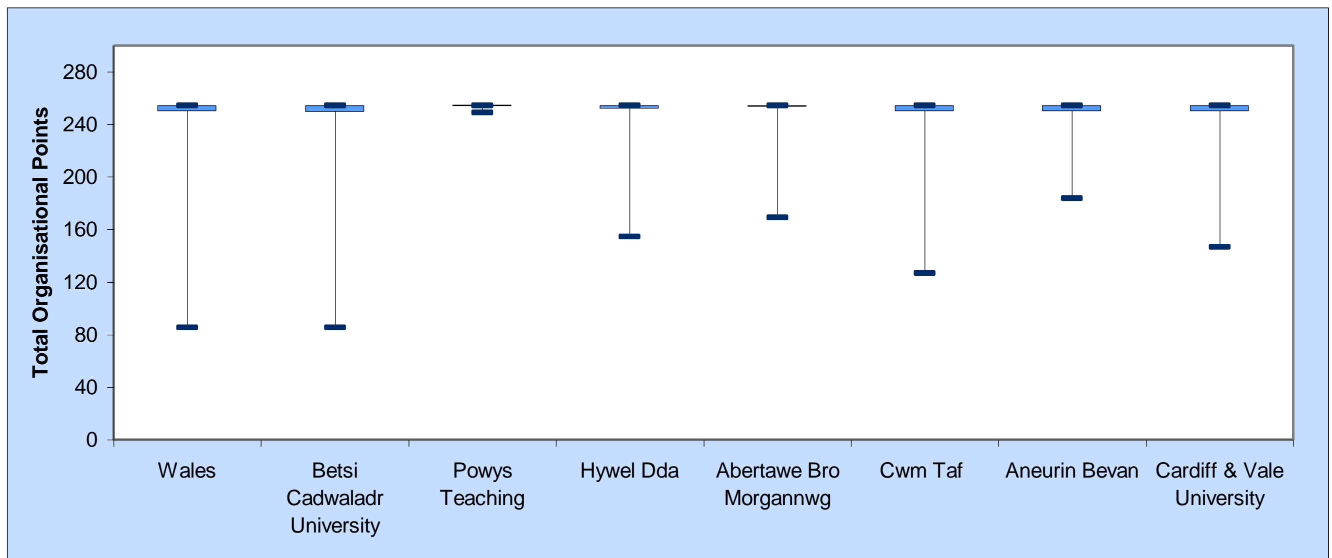
Source: CM Web

(a) See Notes, Disease Areas, for definitions

In many disease areas nearly all practices achieved 100.0 per cent of the possible points. Exceptions to this are in the disease area of Osteoporosis, where the mean practice score was 85.3 per cent. However osteoporosis is a new disease area in 2012-13. Obesity was the only disease area to have achieved a mean score of 100.0 per cent.

2.5 Organisational domain

Chart 4: Distribution of total points achieved in the organisational domain by practices



Source: CM Web

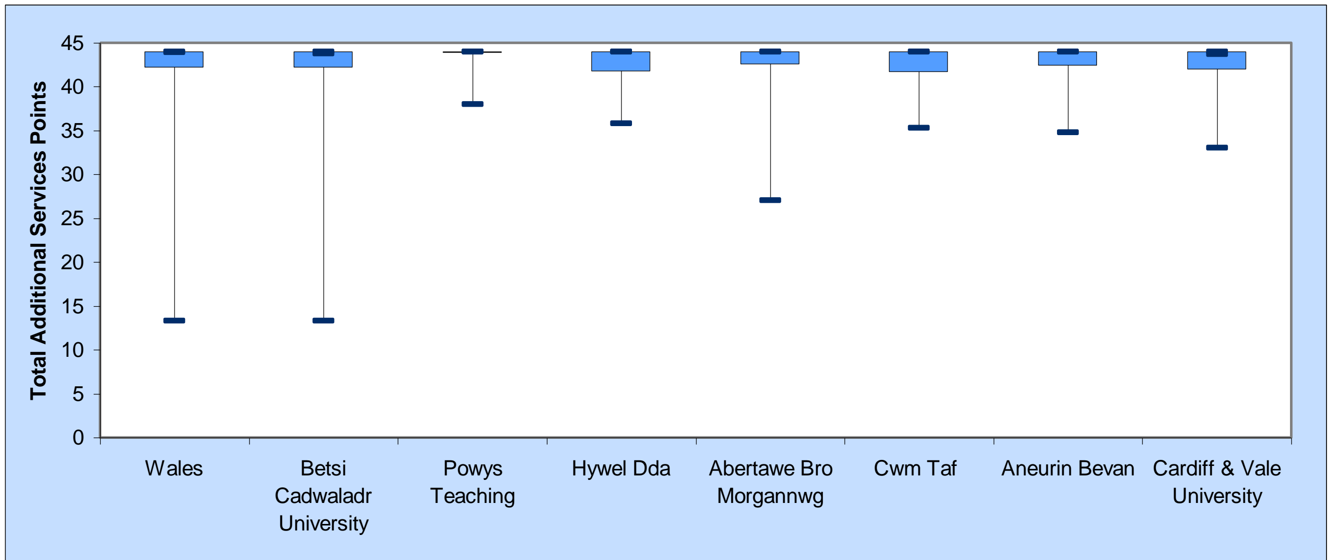
Two thirds of practices (309 practices) achieved all of the possible 254.0 points in this domain. With the exception of a small number of practices, scores in this domain were very close together. The widest range in organisational points was in Betsi Cadwaladr University from 85.0 points to 254.0 points. The narrowest range was in Powys Teaching from 249.0 points to 254.0 points. The widest inter-quartile range was in Betsi Cadwaladr University from 249.1 points to 254.0 points and the narrowest inter-quartile range was in Powys.

2.6 Patient Experience

There was only one indicator for in the patient experience domain. 468 (99.4 per cent) of practices achieved 33 points, the maximum available.

2.7 Additional services domain

Chart 5: Distribution of total points in the additional services domain by practices



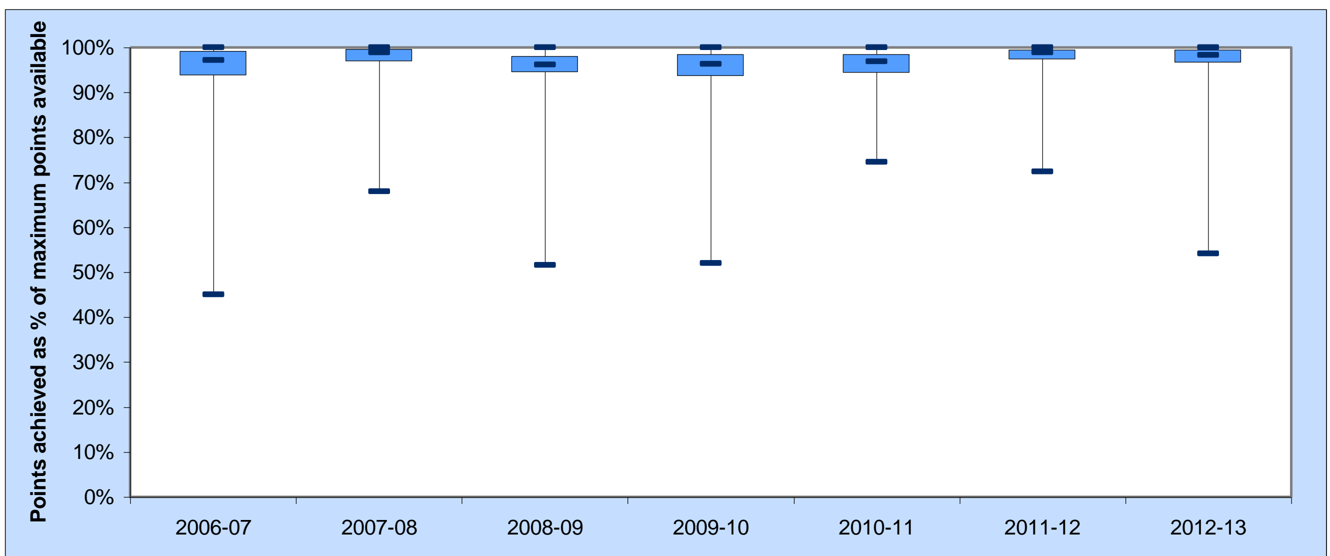
Source: CM Web

Maximum points (44.0 points) for Additional services, in the areas of cervical screening, child health surveillance, maternity services and contraceptive services, were achieved by 47.3 per cent of practices. While Betsi Cadwaladr University had the widest range of total additional services points from 13.3 points to 44.0 points, Cwm Taf and Hywel Dda had the widest inter-quartile range from 41.7 points to 44.0 points.

2.8 Historical achievement

The achievement by Welsh practices in each domain and overall for the last seven years is shown below as data prior to 2006-07 is not available. It must be noted that due to changes in the business rules and Read codes the achievement for any year is not exactly comparable to other years (See notes for further information on Read codes).

Chart 6: Historical achievement, total points



Source: CM Web

For each year from 2006-07 the maximum total points actually achieved was the maximum available points. This displays that for each of the years from 2006-07 there were practices which achieved the maximum available points.

The range between maximum and minimum points achieved has widened slightly in 2012-13 compared with 2011-12. In 2012-13 the minimum points achieved was 54.2 per cent (a decrease from 72.3 per cent). The median total points achieved slightly decreased from 98.8 per cent of the total in 2011-12 to 98.4 per cent in 2012-13.

Chart 7: Historical achievement, clinical points

Source: CM Web

In 2012-13 the median percentage of maximum points achieved was 98.2 per cent, a very slight decrease from the previous year at 99.0 per cent. The range between the highest and lowest scoring practices was wider in 2012-13 than in the previous year (53.8 per cent of possible points to 100.0 per cent). Comparing the years since 2006-07 the achievement of clinical points the 25th percentile has never been lower than 94.0 per cent. This means that since 2006-07 at least 75.0 per cent of practices have scored at least 94.0 per cent of the clinical points in each year.

2.9 Underlying achievement

The Quality and Outcomes Framework monitors practice across a variety of disease groups including several major chronic conditions which are the focus of Welsh Government policy. The dataset provides a wealth of information about practice and achievement throughout Wales.

With 96 clinical indicators, and many others relating to the organisation and management of GP practices, this dataset can be used for a large variety of analyses. To illustrate the value and power of the data a single indicator for each of a number of major disease areas is presented together with indicators relating to patients' general health. The bars in Charts 8 to 13 show the median (middle) practice value within by Health Boards for 2011-12 and 2012-13.

The achievement in terms of points relates to whether the proportion of patients on a disease register receiving the specified care is above a threshold to award points. The underlying achievement in contrast relates to the proportion of patients that receive specified care irrespective of points thresholds.

Therefore the formula for underlying achievement is

$$\text{UnderlyingAchievement} = 100 \times \frac{\text{IndicatorNumerator}}{\text{IndicatorDenominator}}$$

Cardiovascular disease

Cardiovascular disease is the most common cause of death in Wales. It is a major cause disability and hospital admission. The Heart Disease Delivery Plan seeks to minimise the incidence of preventable heart disease and to ensure that those affected by any kind of heart disease have timely access to high quality services. Early identification and effective treatment of risk factors are priorities to reduce the risk of heart disease. The management of high blood pressure and raised cholesterol are examples of this approach. The following indicators are presented to illustrate the treatments provided to GPs' patients:

QOF incentivises the routine measurement of blood pressure for patients aged 45 years or more on the practice list. Where high blood pressure is identified a formal cardiovascular risk assessment is offered.

Description	Indicator
Percentage of practices where blood pressure is recorded for at least 80% of patients aged 45 or over.	RECORD17

Patients who have had a new diagnosis of hypertension and are not already on the CHD, diabetes, or stroke/TIA registers are also identified by practices and given lifestyle advice as follows:

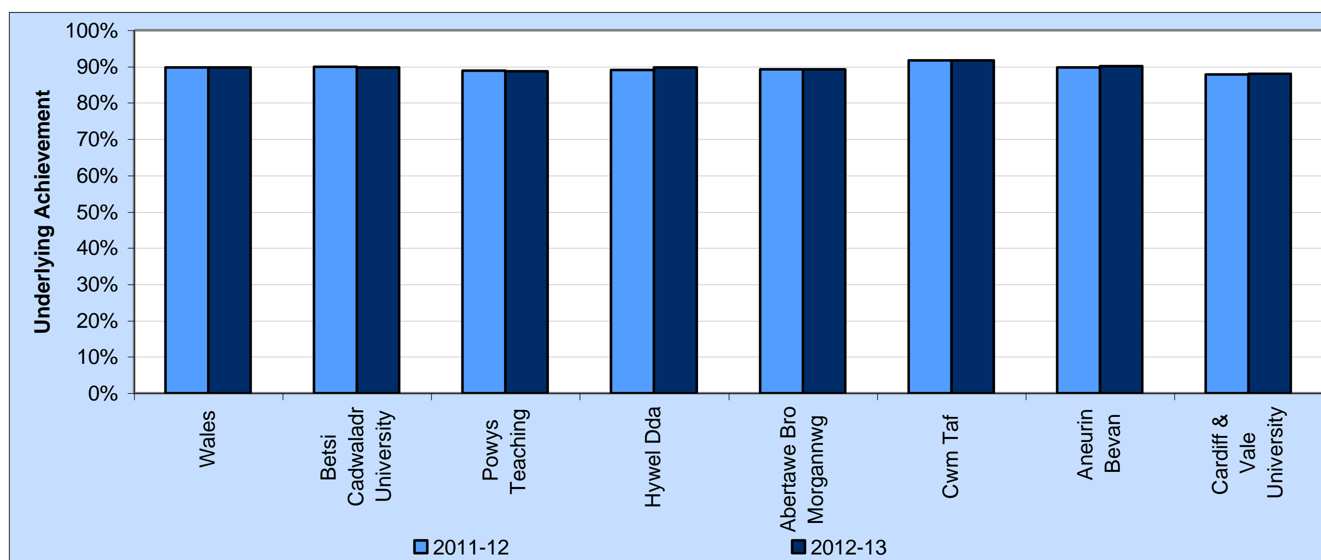
Description	Indicator
Percentage of patients diagnosed with hypertension who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	PP02

Where cardiovascular disease has been identified, cholesterol management is monitored. This approach is termed secondary prevention and outcomes can be achieved through lifestyle advice and the use of drug therapy. For all patients recorded on the CHD register (patients who have been diagnosed with coronary heart disease):

Description	Indicator
Percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.	CHD08

The bars in Charts 8 to 11 show the median (middle) practice value within by Health Boards for 2012-13 and 2011-12, illustrating these indicators.

Chart 8: Cardiovascular disease: records and information (RECORD 17)

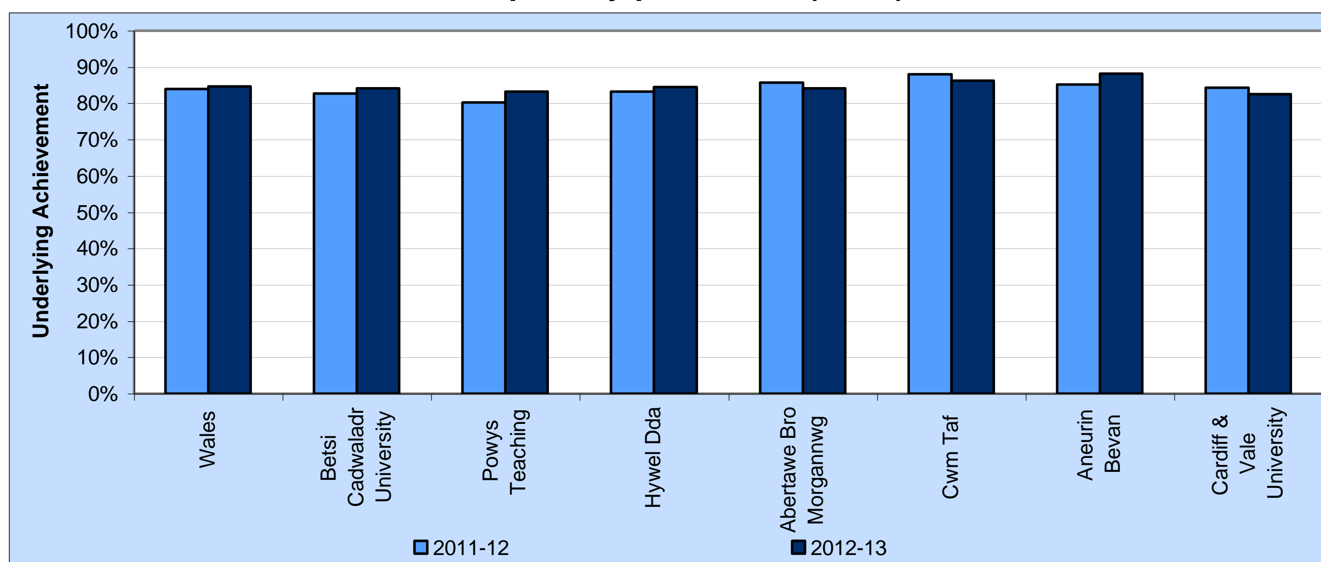


Source: CM Web

Nine out of ten Welsh patients aged 45 or over had a record of their blood pressure in 2012-13. The median value for Wales in 2012-13 was 89.7 per cent of patients aged 45 or over, the same as in 2011-12. The average (median) increased slightly between 2011-12 and 2012-13 for Hywel Dda, Cardiff and Vale University, and Aneurin Bevan Health Boards, but overall there was little change.

Cardiff and Vale University had the widest range of underlying achievement for 2012-13 from 66.3 per cent to 95.8 per cent (not shown in chart), meaning that in a single practice in Cardiff and Vale, 66.3 per cent of patients aged 45 or over had a record of their blood pressure.

Chart 9: Cardiovascular Disease: primary prevention (PP02)



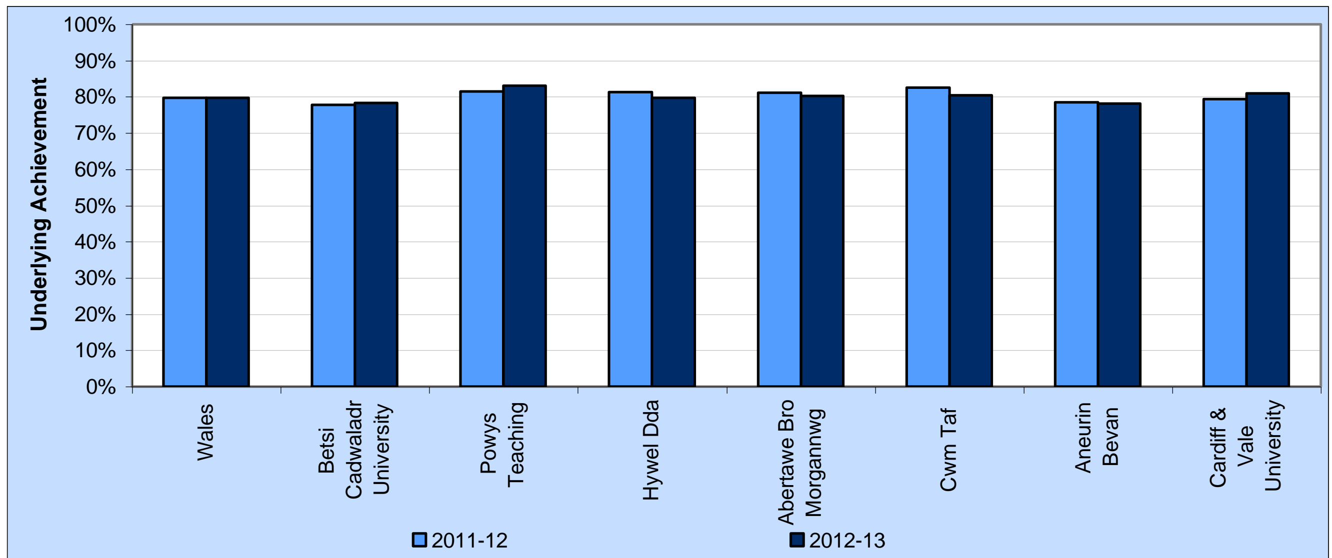
Source: CM Web

Eight out ten patients with a new diagnosis of hypertension in Wales (i.e. those on the cardiovascular disease – primary prevention register) were given lifestyle advice. The average (median value) for Wales in 2012-13 was 84.7 per cent of patients on the register were given lifestyle advice in the preceding 15 months for, increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet, 0.7 percentage points higher than in 2011-12. The average (median) percentage given lifestyle advice increased slightly in four Health Boards but fell between 2011-12 and 2012-13 for Abertawe Bro Morgannwg University, Cardiff and Vale University, and Cwm Taf Health Boards

Looking at the difference between the median underlying achievement for 2011-12 and 2012-13, Hywel Dda changed the least in terms of percentage points, from 83.3 per cent to 84.5 per cent. Powys Teaching had the widest difference in percentage points changing from 80.2 per cent to 83.3 per cent.

A small number of practices had very low values for this indicator but they tended to be practices where the numbers on the register were low.

Chart 10: Cardiovascular disease: secondary prevention (CHD08)



Source: CM Web

Eight out of ten patients diagnosed with coronary heart disease had their cholesterol levels controlled to 5mmol/l or less. The average (median value) for Wales in 2012-13 was 79.6 per cent of patients with CHD had their last total cholesterol measured as 5mmol/1 or less, 0.1 percentage points lower than in 2011-12. The average (median) decreased between 2011-12 and 2012-13 for Hywel Dda, Abertawe Bro Morgannwg University, Cwm Taf, and Aneurin Bevan Health Boards but again there was little change from year to year.

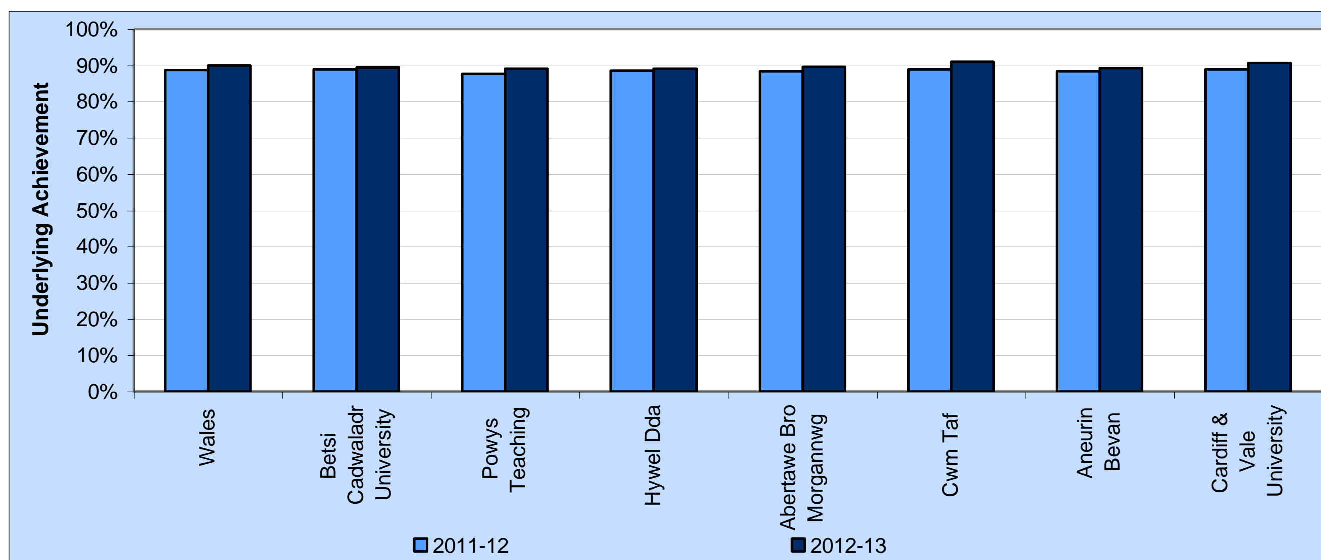
Looking at the difference between the median underlying achievement for 2011-12 and 2012-13, Aneurin Bevan and Betsi Cadwaladr University changed the least in terms of percentage points, ranging from 78.4 per cent to 78.2 per cent and 77.8 per cent to 78.3 per cent respectively. Cwm Taf changed the most in terms of percentage points, from 82.6 per cent to 80.4 per cent.

The practice where fewest patients (53.7 per cent) had their cholesterol controlled in this way was in Betsi Cadwaladr University.

Transient Ischemic Attacks (TIAs) and Stroke

Transient ischemic attacks (TIAs) and Stroke are manifestations of cardiovascular disease. The Stroke Delivery Plan seeks to improve the identification and management of high blood pressure to reduce risk of first stroke or recurrence.

Chart 11: TIAs and Stroke (STROKE06)



Source: CM Web

Chart 11 shows stroke indicator, STROKE06, defined as "The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less.

The average (median value) for Wales in 2012-13 was 89.9 per cent of patients with a history of TIA or stroke had their last blood pressure reading recorded at 150/90 or less, 1.3 percentage point higher than 2011-12. The median increased between 2011-12 and 2012-13 in every Health Board.

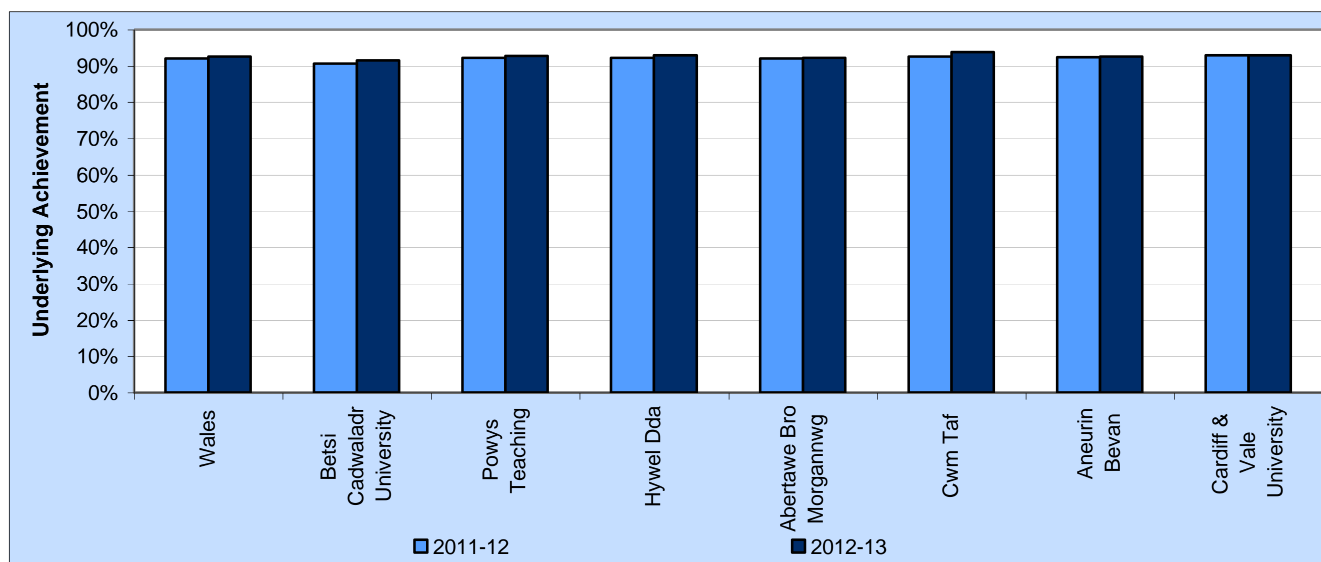
Looking at the differences between the median underlying achievement for 2011-12 and 2012-13, Hywel Dda changed the least in terms of percentage points from 88.6 per cent to 89.0 per cent. The largest change in percentage points was Cwm Taf from 88.9 per cent to 91.0 per cent.

Although in Abertawe Bro Morgannwg University the average (median) value was 89.6 per cent in 2012-13, the minimum practice value was 68.2 per cent of patients on the register.

Diabetes

The Diabetes Delivery Plan establishes the outcomes needed to improve diabetes health care in Wales. This includes action to minimise the risk of complications. The National Diabetes Audit suggests that regular foot assessment is one aspect of care where improvements are required to ensure consistent service provision. QOF supports regular foot examination and risk classification to inform future surveillance and to identify when expert review is required.

Chart 12: Diabetes (DM29)



Source: CM Web

Chart 12 shows Diabetes indicator, DM29, defined as "The percentage of patients with diabetes 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.

Nine out of ten patients aged 17 or over with diabetes had a record of foot examination. The average (median value) for Wales in 2012-13 was 92.6 per cent of patients with diabetes with a record of a foot examination and risk clarification. In 2011-12 the median was slightly lower at 92.1 per cent. The median slightly increased between the two years in six of the Health Boards, but again there was very little change; Cardiff and Vale University's median remained unchanged.

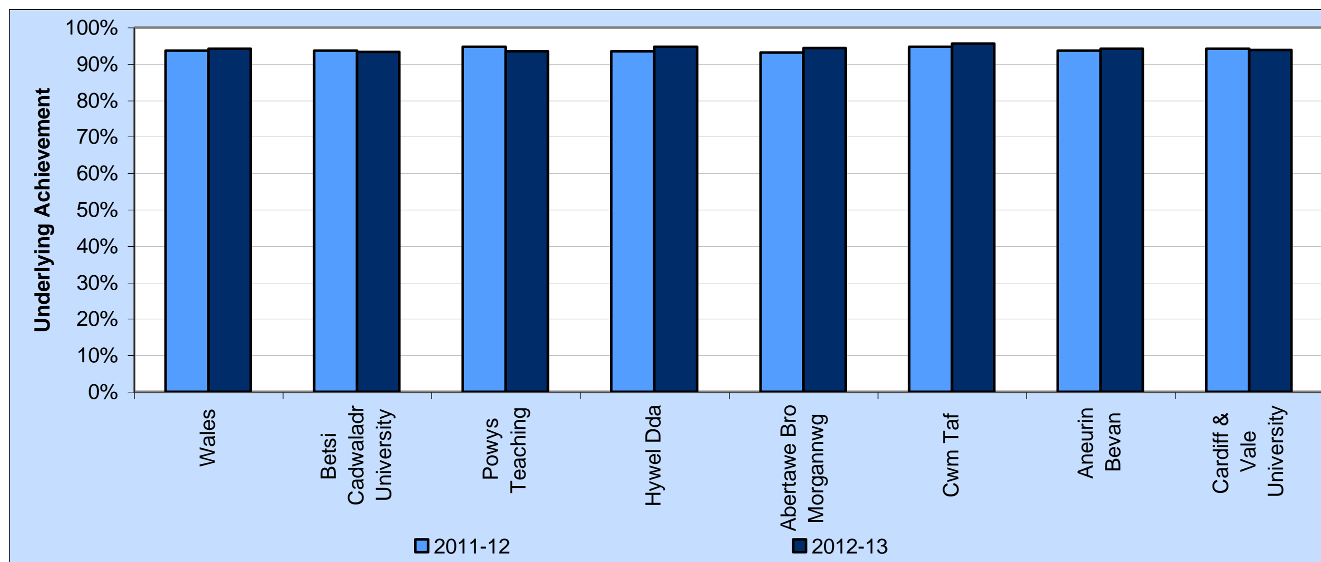
Looking at the difference between the median underlying achievement for 2011-12 and 2012-13, Cwm Taf saw the largest change in percentage points, from 92.6 per cent in 2011-12 to 93.9 per cent in 2012-13.

As with the preceding indicators a small number of practices recorded low proportions of patients treated; in this case the practice with the lowest value was in Cwm Taf in 2012-13.

Respiratory/Health protection

Chronic Obstructive Pulmonary Disease is a common and disabling condition. Most acute exacerbations are triggered by community-acquired respiratory infections. Although Influenza vaccination is recommended for all persons with COPD, current immunization rates fall below the national target levels. This is therefore a priority for improvement.

Chart 13: Chronic Obstructive Pulmonary Disease (COPD08)



Source: CM Web

Chart 13 shows Chronic Obstructive Pulmonary Disease indicator, COPD08, defined as "Percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March".

The average (median value) for Wales in 2012-13 was 94.2 percent of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March, 0.5 percentage points higher than 2011-12. The median for COPD08 fell in 3 out of the 7 HBs from 2011-12 to 2012-13. The exceptions were for Abertawe Bro Morgannwg University, Cwm Taf, Aneurin Bevan and Hywel Dda Health Boards, where it was slightly higher.

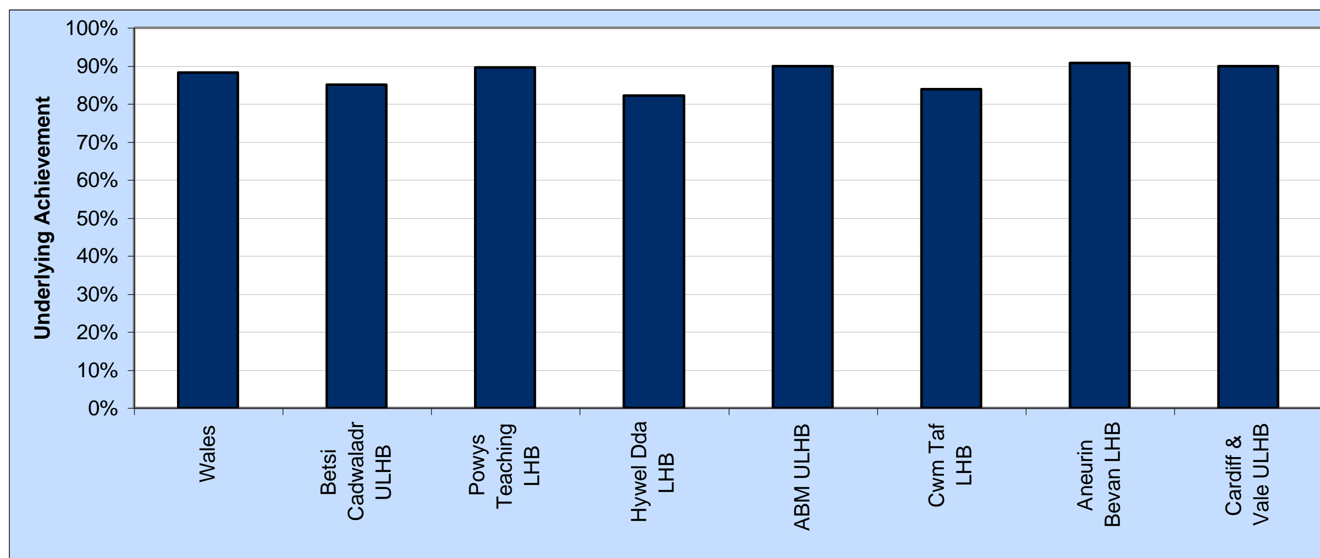
Looking at the difference between the median for 2011-12 and 2012-13, the largest change in percentage points was Powys Teaching where it fell from 94.8 per cent in 2011-12 to 93.4 per cent in 2012-13. Betsi Cadwaladr University saw the smallest change with a small fall from 93.7 per cent in 2011-12 to 93.4 per cent in 2012-13.

Note that the exception rate for COPD08 is generally high and was 16.7 per cent in 2012-13. More information on exceptions can be seen in section 3, Chart 15, which discusses exception reporting, that is, where practices are entitled, under the contract, to exclude certain patients from the indicator calculation; high exception rates are a feature of COPD indicators especially.

Smoking

Smoking rates remain high in many areas of Wales despite strong evidence of risk with a range of health conditions including cardiovascular and respiratory diseases and complications for conditions such as diabetes. There is evidence that patients do respond when doctors and other health professionals advise them to stop smoking. QOF therefore encourages practices to ensure that smoking status is discussed and advice and support provided where appropriate.

Chart 14: Smoking (SMOKE08)



Source: CM Web

New smoking indicators were introduced in 2012-13 including a new register of patients. A smoking indicator, SMOKE08, is defined as "The Percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months".

Of the 559,500 patients aged 15 recorded as current smokers, 466,800 (83 per cent) of these patients were offered support and treatment; conversely, 92,700 patients were not offered support and treatment in the preceding 27 months.

The median for Wales in 2012-13 was 88.2 percent of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months". Betsi Cadwaladr University had the widest range of underlying achievement (not shown in the above chart) in 2012-13 from 38.8 per cent to 100.0 per cent.

3. QOF exceptions and exclusions

Definitions:

Detailed QOF achievement data is contained in tables on StatsWales. The following definitions will help in their interpretation:

Indicator **denominators** are the numbers of patients from the appropriate disease register who are counted for QOF achievement against a specific QOF indicator. (The indicator **numerator** is the number of those in the denominator who meet the specific indicator success criteria.) Differences between an indicator denominator and the number on a register can be due to indicator definition. Some indicators refer to subsets of patients on a disease register, for example they may refer only to patients who smoke.

Due to potential differences in the classification of exceptions and exclusions, direct comparison of exception and exclusion rates is not possible between Welsh QOF data and the QOF data of other UK countries.

Exceptions:

The GMS contract sets out valid exception criteria. Patient exception reporting applies to those indicators in the clinical domain of the QOF where level of achievement is determined by the percentage of patients receiving the designated level of care. Exception reporting does not apply to obesity, learning disabilities and palliative care indicators. Exception reporting also applies to one cervical screening indicator in the additional services domain. See Key Quality Information for more detail.

The indicators PP1, PP2, and COPD15 are not included in the exception rate analysis because for definitional reasons they are not comparable to other indicators or registers as they include a time constraint of diagnosis or treatment.

For each indicator the exception rate is the exceptions expressed as a percentage of excluded and non-excluded patients and is calculated as follows:

$$\text{Exception Rate} = 100 \times \frac{\text{Number of Exceptions}}{(\text{Number of Exceptions} + \text{Indicator Denominator})}$$

Where differences between an indicator denominator and the number on a register are not due to indicator definition, this is due to **exceptions**, as described above.

Exclusions:

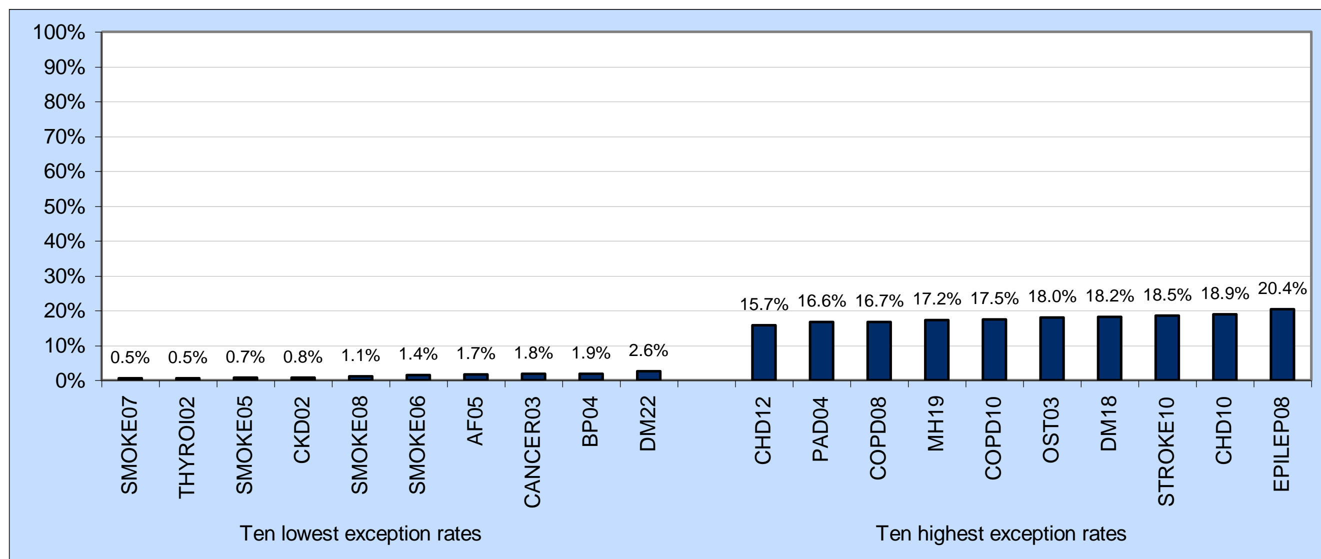
Patients who are on the disease register, but not included in the indicator denominator for definitional reasons, are referred to here as exclusions. An example of exclusion is where for heart failure only a small proportion of the patients (new diagnoses) on the heart failure register are relevant to indicator HF02.

The exclusion rate, the percentage of patients on the register who are for definitional reasons not included in the indicator, is calculated as follows:

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

The normal relationship between registers, denominators, exclusions and exceptions is therefore:
Register = Denominator + Exclusions + Exceptions

Chart 15: Exception rates - 10 indicators with highest rates and 10 with lowest rates (1)



Source: CM Web

(1) A full list of disease areas and indicator codes is provided in the Notes section.

Chart 15 provides an illustration of the range of values for exception rates by showing the indicators that had the 10 highest and 10 lowest rates of exception reporting. The highest exception rate was EPILEP08 AT 20.4 per cent and the lowest exception rate was for SMOKE07 at 0.5 per cent. Note that for some indicators these rates may be based on small numbers.

4. Prevalence

Table 2 below shows reported disease prevalence information for the 22 disease areas of the QOF since 2006-07. Peripheral Arterial Disease, Smoking status, and Osteoporosis are new disease registers in 2012-13. A full description of registers can be found in the Notes section.

For QOF purposes, prevalence is defined as a percentage of patients on a practice list:

$$100 \times \frac{\text{Number of patients on disease register}}{\text{Number of patients registered with the practice}}$$

The age profiles of patients registered with GP practices will vary a great deal. Some practices will have a large proportion of elderly people and others more young people than the average. In order for the prevalence data to be more meaningful the prevalence rates by age and sex are shown in Charts 16. The source of this data is the Audit+ system. This system provides practices with a number of tools that allow them to manage their patient registers. The extracted data is locally analysed at each practice and then the aggregated results of those analyses are sent to a central NHS Wales repository and presented in the web based system AuditWeb.

While all 471 practices submitted data for QOF 2012-13 the age specific data is only available for 458 practices from the Audit + system; therefore the age-standardised prevalence charts below are based on these 458 practices. It is important to note that neither prevalence estimate in this section are necessarily the same as the prevalence in the general population since for some disease registers only specific age groups are included (diabetes (17+), chronic kidney disease (18+), epilepsy (18+), etc.). Please see the notes for more information on QOF indicators and criteria for inclusion on a disease register.

Table 2: Reported disease prevalence rates

Percentage

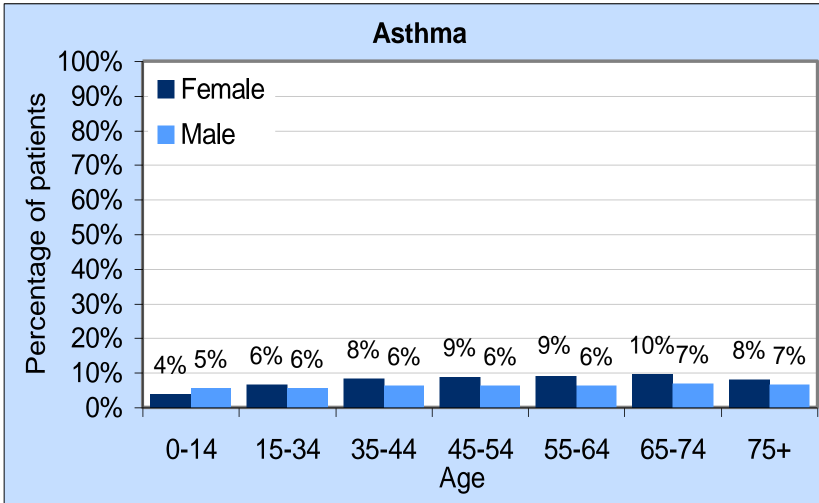
Register (a)	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Asthma	6.5	6.4	6.6	6.7	6.7	6.9	7.0
Atrial Fibrillation	1.6	1.6	1.7	1.7	1.7	1.8	1.8
Cancer	0.9	1.1	1.3	1.5	1.7	1.9	2.1
Cardiovascular Disease (PP)	-	-	-	0.6	1.2	1.6	2.2
Chronic Kidney Disease (b)	2.3	2.9	3.1	3.3	3.4	3.5	3.6
Chronic Obstructive Pulmonary Disease	1.9	1.9	2.0	2.0	2.0	2.1	2.1
Coronary Heart Disease	4.3	4.2	4.2	4.1	4.0	4.0	3.9
Dementia	0.4	0.4	0.5	0.5	0.5	0.5	0.6
Depression 01 (patients with diabetes and/or CHD)	7.6	7.7	7.8	7.9	8.1	8.2	8.3
Depression 0405 (new cases of depression) (c)	7.3	7.6	8.2	8.7	9.0	9.5	-
Depression 0607 (new cases of depression) (c)	-	-	-	-	-	-	4.5
Diabetes Mellitus (d)	4.2	4.4	4.6	4.9	5.1	5.3	5.4
Epilepsy (e)	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Heart Failure	1.0	0.9	0.9	0.9	0.9	0.9	0.9
Heart Failure (due to Left Ventricular Dysfunction)	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Hypertension	14.3	14.6	14.9	15.1	15.4	15.5	15.5
Hypothyroidism	3.1	3.3	3.4	3.5	3.6	3.7	3.8
Learning Disabilities (f)	0.3	0.3	0.3	0.4	0.4	0.4	0.4
Mental Health	0.7	0.7	0.8	0.8	0.8	0.8	0.9
Obesity	9.6	9.6	9.7	10.1	10.4	10.4	10.3
Osteoporosis (g)(h)	-	-	-	-	-	-	0.1
Palliative Care	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Peripheral Arterial Disease (g)	-	-	-	-	-	-	0.7
Smoking register (patients with chronic conditions)	22.3	23.9	25.2	25.5	25.8	26.0	26.4
Smoking status register (patients aged 15 or over with recorded smoking status) (g)	-	-	-	-	-	-	83.7
Stroke and Ischaemic Attacks	2.0	2.0	2.0	2.0	2.1	2.1	2.0

Source: CM Web

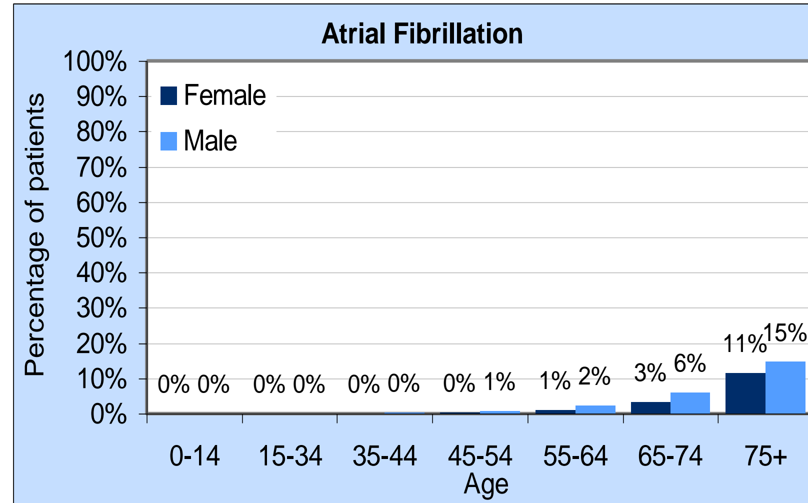
(a) Refer to Notes for full description of registers.
(b) Chronic Kidney Disease register only includes patients aged 18 years and over.
(c) The Depression0405 register includes patients diagnosed with depression ever. The Depression0607 register includes patients diagnosed with depression since 1st April 2006.
(d) Diabetes register only includes patients aged 17 and over.
(e) Epilepsy Register only includes patients aged 18 years and over.
(f) Learning Disability register only includes patients aged 18 years and over.
(g) New registers for 2012-13.
(h) Osteoporosis register only includes patients aged 50 years and over.

Charts 16: Prevalence charts

The disease charts display the age-specific prevalence for each disease area, that is, the proportion of patients each age and sex group who are recorded on each disease register in Audit+. The data is at 31 March 2013 and is from 458 practices. Note that this data reflects QOF registers at 2011-12 year end as Audit+ due to ongoing procurement of a replacement. The following graphs exclude 27 patients whose "age" and "sex" was unknown.



Source: Audit+



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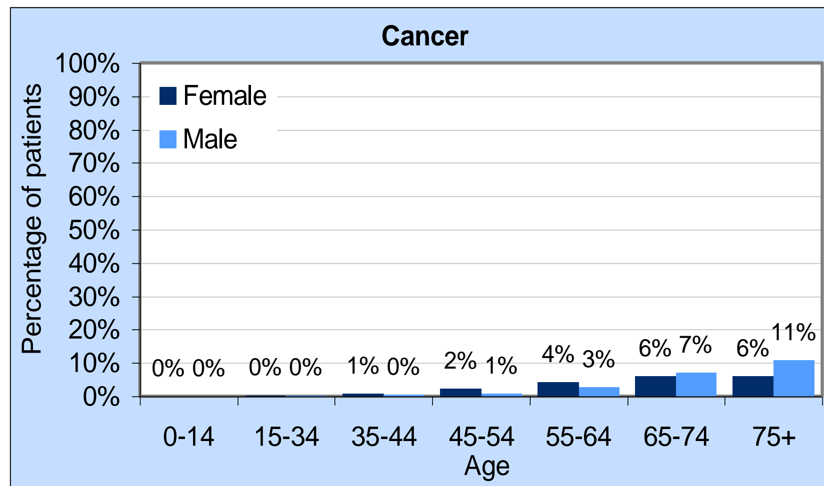

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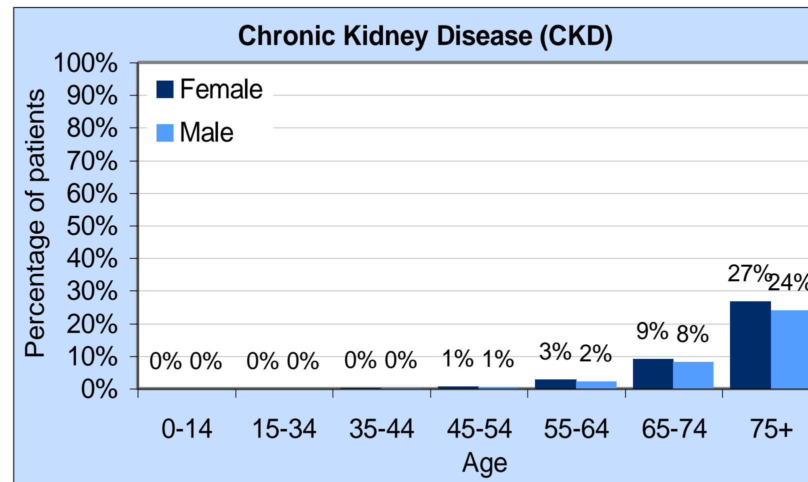

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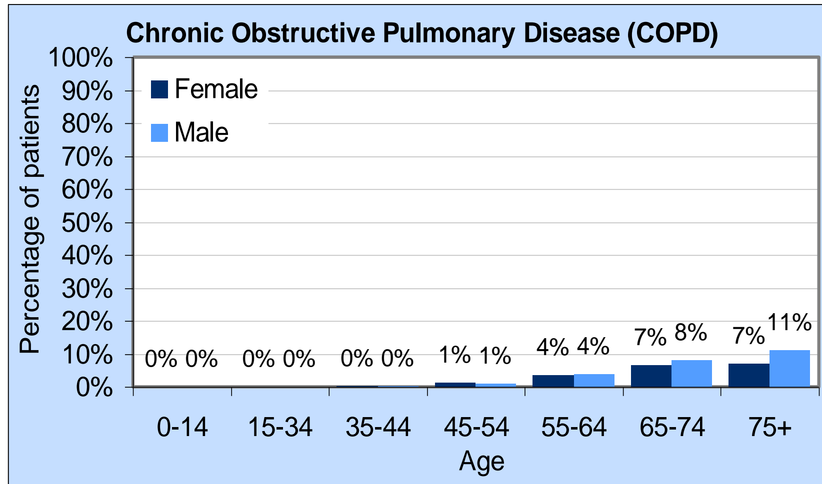

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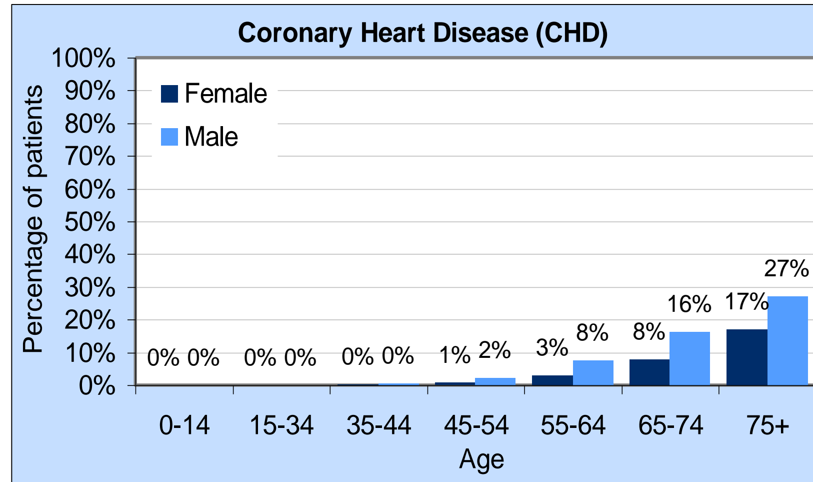

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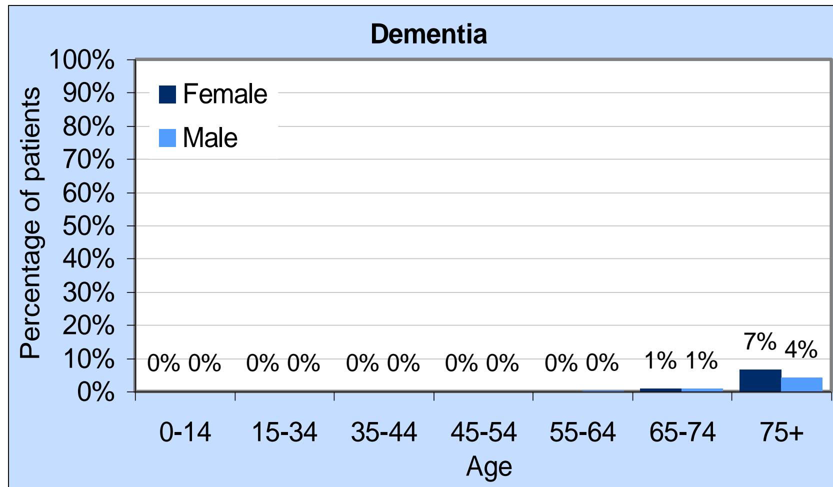

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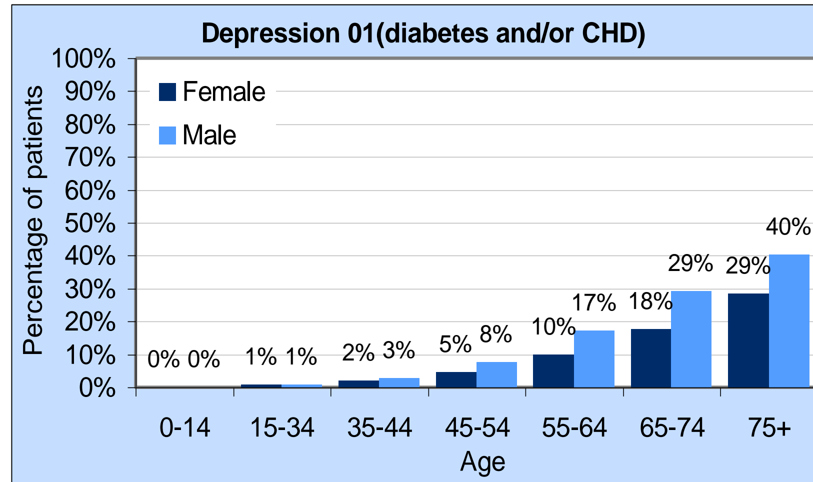

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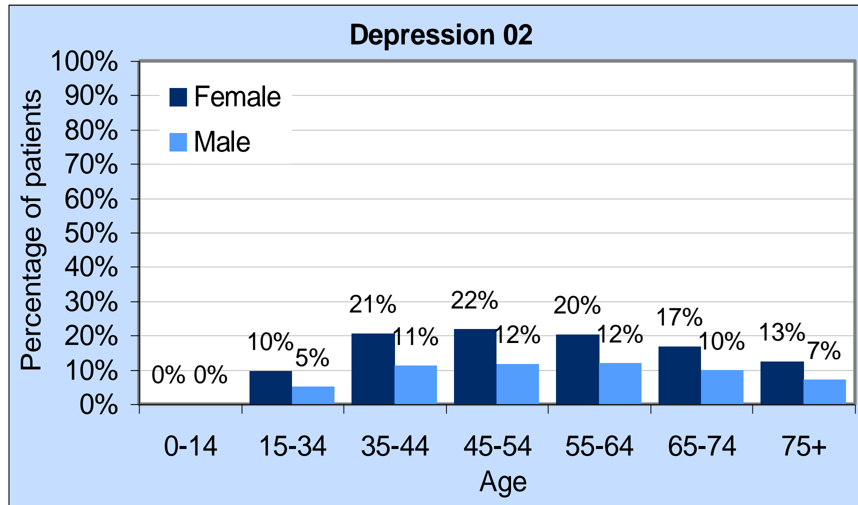

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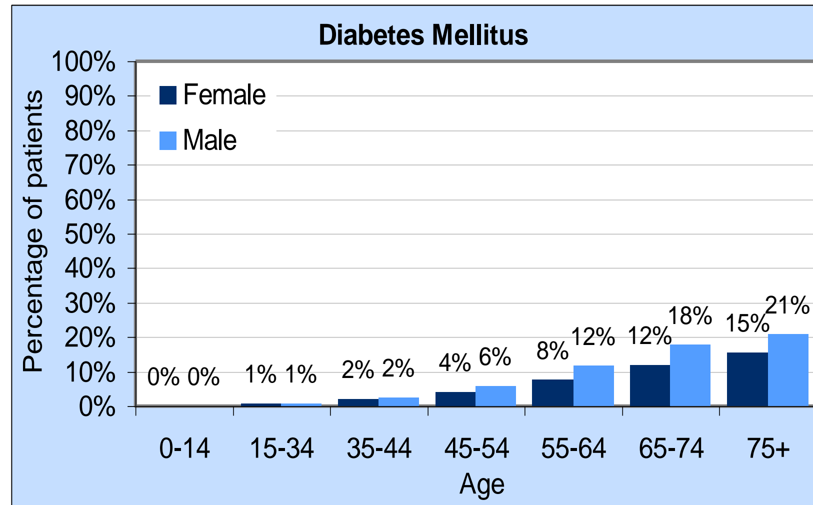

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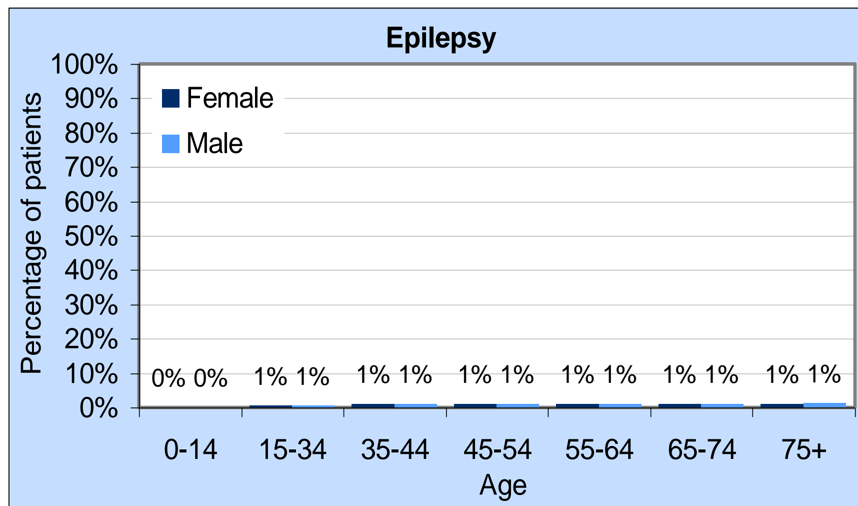

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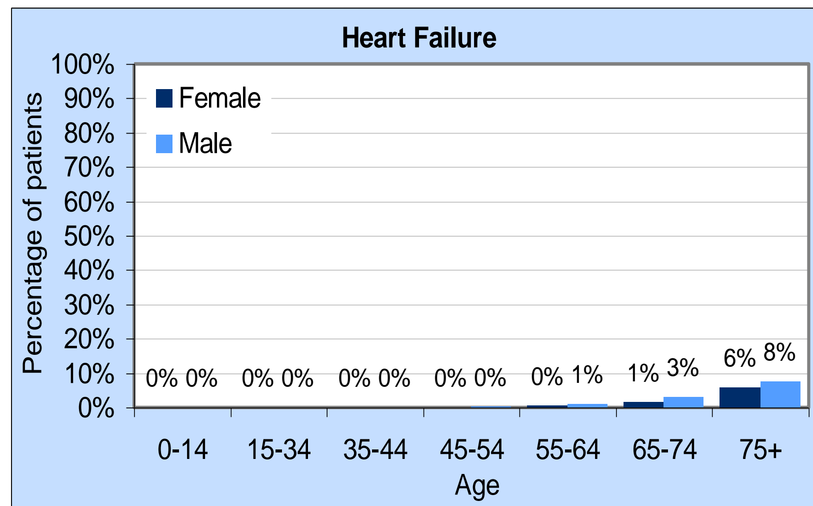

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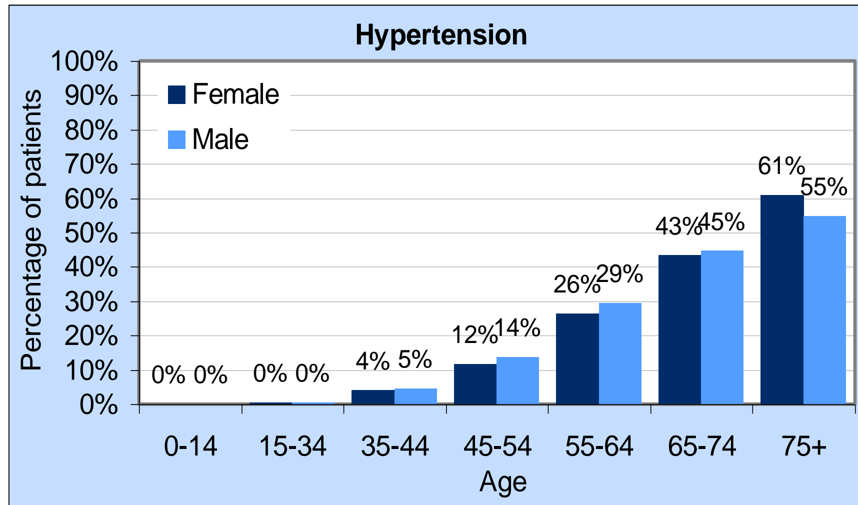

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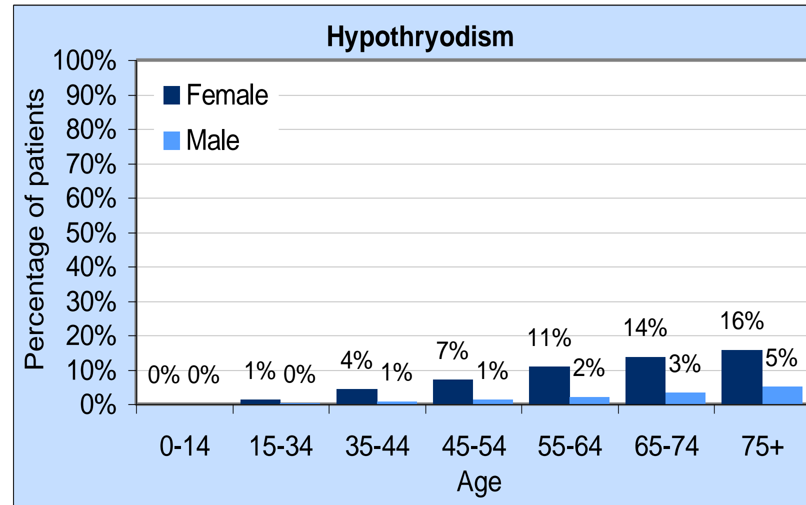

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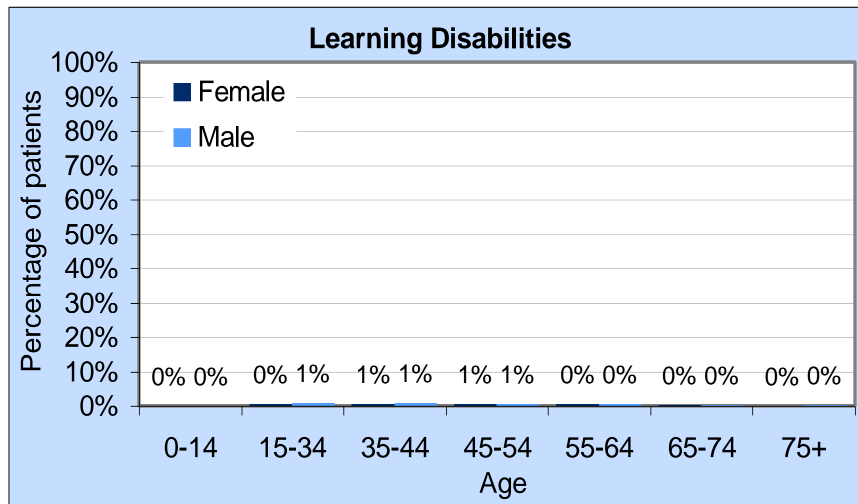

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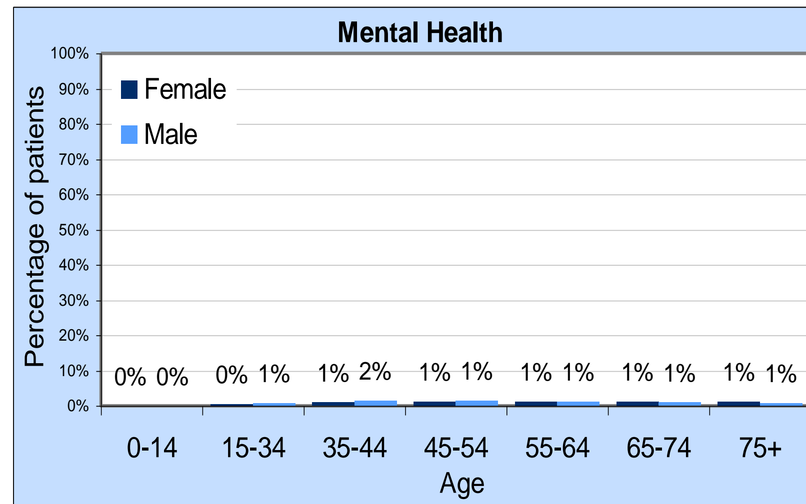

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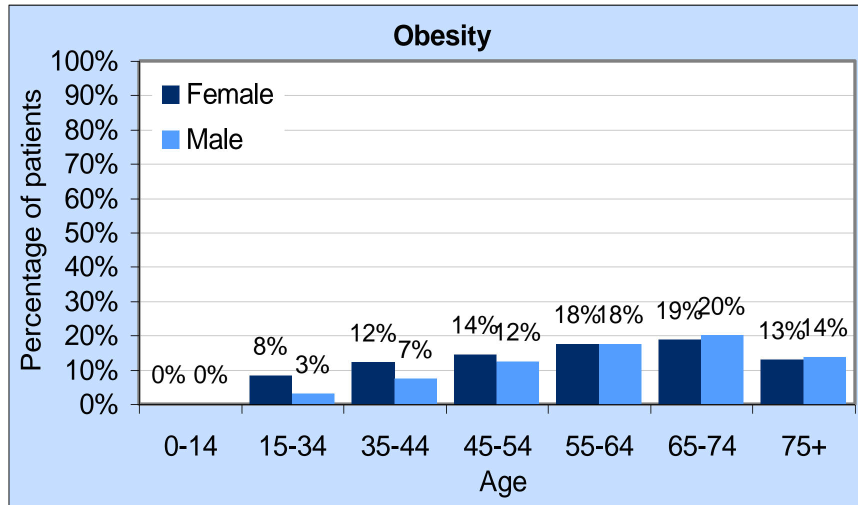

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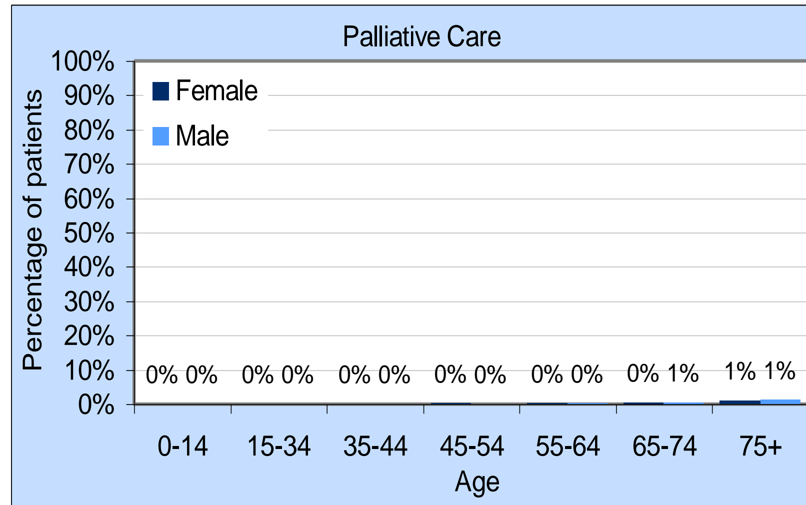

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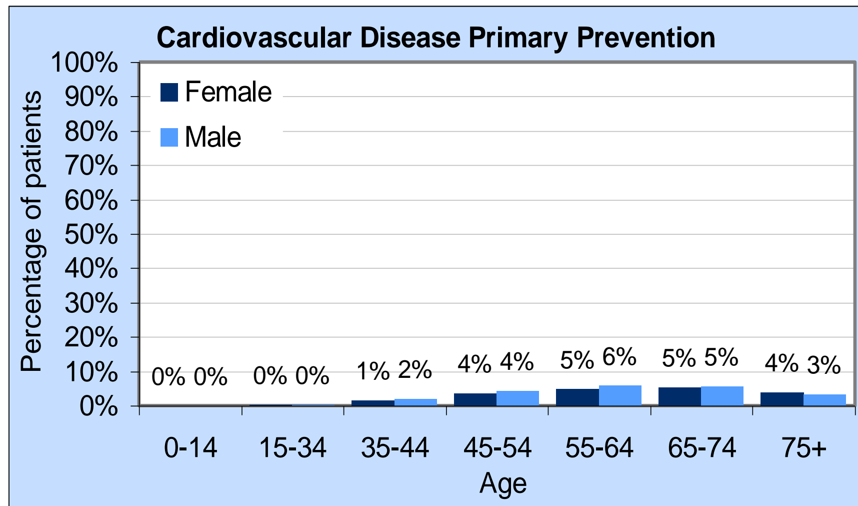

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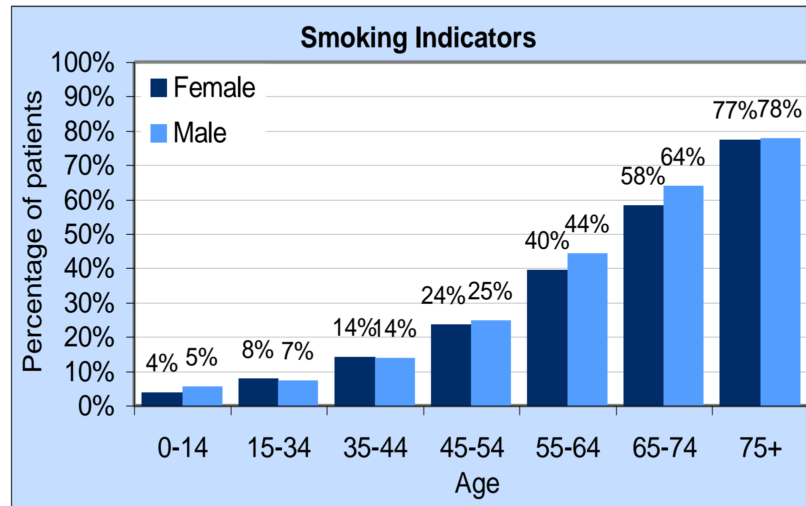

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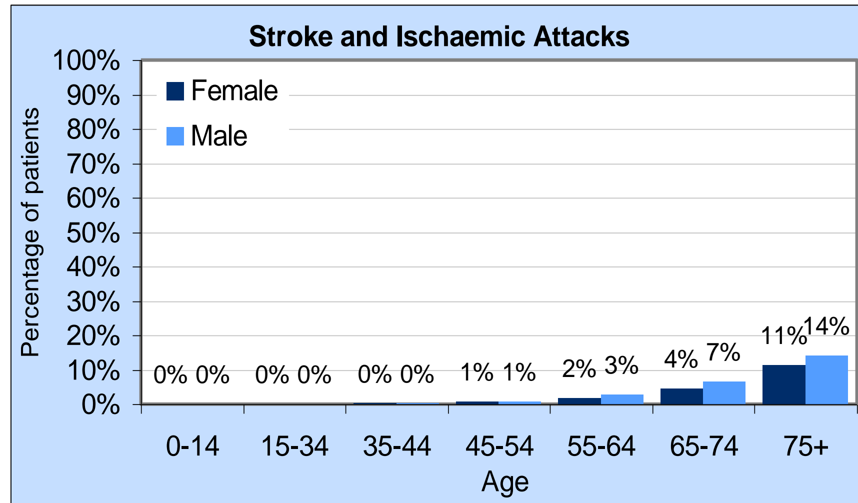

Source: Audit+

Users may find a Statistical Article comparing conditions measured – QOF, with those recorded – the Welsh Health Survey, available at:
http://wales.gov.uk/docs/statistics/2012/120822healthconditionsen.pdf

Notes

Disease areas

Descriptions of the 2012-13 disease areas are listed below:

Disease Area	Register description	QOF indicators
Coronary Heart Disease (CHD)	Patients diagnosed with CHD ever	CHD01, 06, 08, 09, 10, 12, 14
Cardiovascular disease – primary prevention (PP)	Patients that have been added to the Hypertension register since 1st April 2009 that are not on the CHD register AND are not on the Stroke/TIA register AND have not been diagnosed with unresolved Diabetes Mellitus AND have not been diagnosed with Pulmonary Vascular Disease AND have not been diagnosed with Familial Hypercholesterolemia AND have a recording of CKD stage 1-2 not superseded by a CKD stage 3-5 diagnosis	PP01, 02
Heart Failure	Patients diagnosed with Heart Failure ever	HF01, 02
Heart Failure (Due to Left Ventricular Dysfunction)	Patients diagnosed with Heart failure ever AND Left Ventricular Dysfunction ever	HF03-04
Stroke and Transient Ischaemic Attack (TIA)	Patients diagnosed with stroke and/or TIA ever	STROKE01, 06, 07, 08, 10, 12, 13
Hypertension	Patients diagnosed with hypertension ever where "Hypertension Resolved" has not been recorded following latest diagnosis	BP01, 04, 05
Diabetes Mellitus	Patients aged 17 and over diagnosed with Type 1 or Type 2 Diabetes where "Diabetes Resolved" has not been recorded following latest diagnosis	DM02, 10, 13, 15, 17, 18, 21, 22, 26, 27, 28, 29, 30, 31, 32
Chronic Obstructive Pulmonary Disease	Patients diagnosed with COPD ever	COPD08, 10, 13, 14, 15
Epilepsy	Patients aged 18 and over diagnosed with Epilepsy ever receiving Epilepsy medication within 6 months of QOF reference date	EPILEPSY05, 06, 08, 09
Hypothyroidism	Patients diagnosed with Hypothyroidism ever receiving Hypothyroidism medication within 6 months of QOF reference date (31st March)	THYROID01, 02
Cancer	Patients diagnosed with cancer since April 2003 excluding non-melanotic skin cancers	CANCER01, 03
Palliative care	Patients recorded as receiving Palliative Care since 1st April 2008	PC02, 03
Mental Health	Patients diagnosed with schizophrenia, bipolar disorders or other psychoses; or patients currently being treated with lithium	MH08, 10, 11, 12,13, 16, 17, 18, 19, 20
Asthma	Patients diagnosed with Asthma currently being treated with an Asthma related drug	ASTHMA01, 08-10
Dementia (DEM)	Patients diagnosed with Dementia ever	DEM01, 02, 04
Depression 01	Patients on the Diabetes and/or CHD register	DEP01
Depression 0607 (new cases of depression)	Patients diagnosed with Depression ever	DEP06-07
Chronic kidney disease (CKD)	Patients aged 18 and over diagnosed with stage 3 to 5 CKD	CKD01-03, 05, 06
Atrial fibrillation (AF)	Patients diagnosed with Atrial Fibrillation	AF01, 05, 06, 07

Obesity (OB)	Patients aged 16 and over with an Obesity diagnosis recorded within 15 months of the QOF reference date or for whom the latest BMI reading recorded within 15 months of the QOF reference date is 30 or greater	OB01
Learning disability (LD)	Patients aged 18 and over diagnosed with a Learning Disability ever	LD01, 02
Smoking (patients with chronic conditions)	Patients on the CHD register and/or Stroke/TIA register and/or Hypertension register and/or DM register and/or COPD register and/or Asthma register and/or CKD register and/or diagnosed with Psychosis, Schizophrenia or Bipolar disease	SMOKE05-06
Smoking status register (patients aged 15 or over with recorded smoking status)	Patients aged 15 and over whose notes recorded smoking status in the preceding 27 months.	SMOKE07-08
Peripheral arterial disease (PAD)	Patients diagnosed with Peripheral arterial disease	PAD01, 02, 03, 04
Osteoporosis: secondary prevention of fragility fractures (OST)	Patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone sparing agent. Patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent.	OST01, 02, 03

Further information about QOF indicators can be found here:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063

Patient exceptions

Practices may exclude specific patients from data collected to calculate QOF achievement scores. For example, patients with specific diseases can be excluded from individual QOF indicators if a patient is unsuitable for treatment, is newly registered with the practice, is newly diagnosed with a condition, or in the event of informed dissent.

The GMS Statement of Financial Entitlements (SFE)[1] includes the following:

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
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

[1] GMS Statement of Financial Entitlements, Annex D Quality and Outcomes Framework Guidance, available from http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6070

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-upon 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 heart failure due to 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. Practices should report the number of exceptions for each indicator set and individual indicator. Exception codes have been added to systems by suppliers. Practices will not be expected to report why individual patients were exception-reported. Practices may be called on to justify why they have excepted patients from the QOF and this should be identifiable in the clinical record.

Note that the number of exceptions and the sum of the denominators refer to patient records associated with the indicators not individual patients who may occur more than once.

Prevalence

Note that many patients may suffer from more than one of these conditions. However since patient level data is not required for QOF central payment purposes and is not stored on CM Web it is not possible to identify those who appear on more than one register.

Age Specific Prevalence

The source of the age specific prevalence is a General Medical Practice based software utility called "Audit +".

i. Audit+ is a centrally funded analysis tool which is available to GP practices in Wales. Audit+ is non-mandatory which enables a GP practice to choose whether or not to use this analysis tool.
ii. Audit+ is an analysis tool which is available to most GP practices in Wales. Audit+ runs on top of the Informatica Clinical Audit Platform (iCAP), a comprehensive software platform for building solutions to primary care problems that require automated general practice data extraction.
iii. Audit+ provides practices with a number of tools that allow them to manage their patient registers as defined in an audit specification. These tools allow the practices to browse patients and easily identify those that require attention, to graphically view any patient treatment and outcome targets that may have been set for the audit and to export patient list data for internal uses such as mail merges using a word processor or custom analysis in a spreadsheet. The extracted data is locally analysed at each practice and then the aggregated results of those analyses are sent to a central NHS Wales repository and presented in the web based system AuditWeb.
iv. Counts of patients on QOF disease registers by 10 year age groups and sex have been obtained from the aggregated Audit Web system derived from Audit+.

Comparative analysis

These published data will provide a potentially rich source of information on the provision of primary care services. However, it must be recognised that levels of QOF "achievement" will be related to a variety of local circumstances, and should be interpreted in the context of those circumstances.

Users of these data should be particularly careful to undertake comparative analysis on this basis. In particular:

i. The ranking of practices on the basis of QOF points achieved, either overall or with respect to areas within the QOF, may be inappropriate. QOF points do not reflect practice workload issues (for example, around list sizes and disease prevalence). Practice QOF payments include adjustments for such factors.

ii. The comparative analysis of practice or HB level QOF achievement may also be inappropriate without taking account of the underlying social and demographic characteristics of the populations concerned. The delivery of services will be related, for example, to population age/sex, ethnicity or deprivation characteristics that are not included in the QOF data collection processes.

iii. Information on QOF achievement, as represented by QOF points, should also be interpreted with respect to local circumstances around general practice infrastructure. In undertaking comparative or explanatory analysis, users of the data should be aware of any effect of the numbers of partners (including single handlers), local recruitment and staffing issues, issues around practice premises, and local IT issues.

iv. Similarly users of the data should be aware that different types of practice may serve different communities. Comparative analysis should therefore take account of local circumstances, such as numbers on practice lists of student populations, drug users, homeless populations, asylum seekers etc.

v. The information does not allow analysis of the extent to which service delivery improved during the year, and that it is possible that relatively low-scoring practices could actually have seen significant improvements. Any such analysis can only be undertaken in the light of local circumstances.

vi. Underlying all this is the fact that the QOF data reported upon is highly dependent on diagnosis and recording within general practices on their clinical information systems.

Key Quality Information

- The Quality and Outcomes Framework (QOF) is a system of financial incentives. It is about rewarding contractors for good practice (and its associated workload) through participation in an annual quality improvement cycle.

- For more information on the survey in relation to QOF see: http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063

Data coverage

The published tables, and this statistical release, cover data for Wales relating to:

- QOF achievement in terms of points achieved and underlying achievement
- Disease "prevalence", that is, patients registered on individual disease registers
- Exceptions and exclusions, that is, patients who for reasons set out in the QOF rules are not included in the achievement calculations

QOF achievement data for 2012-13 is presented for 471 general practices in Wales. This includes practices that had data automatically extracted by the CM Web system in June 2013, and data adjustments for the year 2012-13 submitted between April and June 2013. The 2012-13 disease prevalence tables are based on prevalence recorded on CM Web at 30 June 2013. The data presented is raw (unadjusted) disease prevalence as recorded by the practices. The age-specific prevalence data is from Audit + as at 31 March 2013.

Level of detail

There are no patient-specific data within CM Web.

Practice list sizes

The 2012-13 QOF data use practice list sizes that have been derived from the practice clinical system as at 31 March 2013. These list sizes will be different from those that were supplied to CM Web from National Health Applications and Infrastructure Services (NHAIS), the national general practice payments system for the purposes of prevalence and list size adjustments in QOF payment calculations. List sizes will not agree with list size data published in other Statistical Releases.

This section provides a summary of information on this output against five dimensions of quality: Relevance, Accuracy, Timeliness and Punctuality, Accessibility and Clarity, and Comparability.

Relevance

The statistics are used both within and outside the Welsh Government to monitor health trends and as a baseline for further analysis of the underlying data. Some of the key users are:

- Ministers and the Members Research Service in the National Assembly for Wales;
- Health Boards;
- Local Authorities;
- GP Practices;
- The Department for Health and Social Services in the Welsh Government;
- Other areas of the Welsh Government;
- National Health Service and Public Health Wales;
- General Medical Council and other professional organisations;
- The research community;
- Students, academics and universities;
- Individual citizens and private companies.

These statistics will be used in a variety of ways. Some examples of these are:

- advice to Ministers;
- to inform debate in the National Assembly for Wales and beyond;
- to contribute to the Quality and Outcomes Framework;
- to make publically available data on GP services in Wales.

Accuracy

Statisticians within the Welsh Government review the data and query any anomalies with the NHS Wales Informatics Service before tables are published. The figures in this release reflect the final position as at the end of the 2012-13 financial year, and are correct as at 1 July 2013.

Timeliness and Punctuality

This release has met the previously announced date of publication.

Accessibility and Clarity

This statistical release is pre-announced and then published on the Statistics section of the Welsh Government website. It is accompanied by more detailed tables on StatsWales, a free to use service that allows visitors to view, manipulate, create and download data. Please select "GMS Contract" at the navigation screen of the following site:

https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity

Comparability

There were changes to the QOF indicators in 2012-13 from 2011-12. These changes included the retirement of previous indicators, introduction of new indictors, including two new clinical areas (Peripheral Arterial Disease and Osteoporosis), and definitional changes to existing indicators. Note that these changes have an impact on the total numbers of available points to both the clinical and organisation domain.

The key changes in 2012-13 were:

- the retirement of seven indicators (CHD13, AF4, QP1, QP2, QP3, QP4, QP5) releasing 45 points to fund new and replacement indicators.
- the replacement of seven indicators with eight NICE recommended replacement indicators, focusing on six clinical areas namely Diabetes, Mental Health, Asthma, Depression, Atrial Fibrillation and Smoking.
- the introduction of nine new NICE recommended clinical indicators, including two new clinical areas (Atrial Fibrillation, Smoking, PAD and Osteoporosis).
- the introduction of three new organisational indicators for improving Quality and Productivity which focus on accident and emergency attendances.
- amendments to indicator wording for CHD9, CHD10, CHD14, STROKE12, DM26, DM27, DM28 and DEM3.
- inclusion of telephone reviews for Epilepsy 6.

In addition to above, a number of other changes were agreed. These further miscellaneous changes can be found at:

http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF2013.aspx

Also statistics collected in each United Kingdom country may differ in terms of achievement, prevalence and exception statistics and the detailed guidance available from each country's website should be consulted before using these statistics as comparative measures.

Further Information

Further information about QOF can be found on the NHS Wales GMS contract webpage:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063

QOF Publications in other UK countries

England:
http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework

Scotland:
http://www.isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework/

Northern Ireland:
http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof.htm

Feedback

We actively encourage feedback from our users. If you have any comments or require further information please contact us on the details below.

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Appendix 1 – Descriptions of 2012-13 QOF indicators

Clinical Domain

Coronary Heart Disease (CHD)

CHD 1: The practice can produce a register of patients with coronary heart disease.
CHD 6: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less.
CHD 8: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.
CHD 9: The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded).
CHD 10: The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded).
CHD 12: The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March.
CHD14: The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti platelet therapy, beta-blocker and statin (unless a contraindication or side effects are recorded)

Cardiovascular disease – primary prevention (PP)

PP 1: In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool.
PP 2: The percentage of people diagnosed with hypertension, (diagnosed after 1 April 2009) who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Heart Failure (HF)

HF 1: The practice can produce a register of patients with heart failure.
HF 2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment.
HF 3: The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contra-indication.
HF 4: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

Stroke and Transient Ischaemic Attack (TIA)

STROKE 1: The practice can produce a register of patients with stroke or TIA.
STROKE 13: The percentage of new patients with a stroke or TIA who have been referred for further investigation.
STROKE 6: The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less.
STROKE 7: The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months.
STROKE 8: The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.
STROKE 12: The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded).
STROKE 10: The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March.

Hypertension (BP)

BP 1: The practice can produce a register of patients with established hypertension.
BP 4: The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months.
BP 5: The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less.

Diabetes mellitus (DM)

DM32: The practice can produce a register of all patients aged17 years and over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.
DM 2: The percentage of patients with diabetes whose notes record BMI in the previous 15 months.
DM 26: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.
DM 27: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
DM 28: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
DM 21: The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months.
DM 29: The percentage of patients with diabetes 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.
DM 10: The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months.
DM 30: The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less
DM 31: The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less
DM 13: The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria).
DM 22: The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months.

DM 15: The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists).
DM 17: The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less.
DM 18: The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March.

Chronic Obstructive Pulmonary Disease (COPD)

COPD 14: The practice can produce a register of patients with COPD.
COPD 15: The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry.
COPD 10: The percentage of patients with COPD with a record of FeV1 in the previous 15 months.
COPD 13: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.
COPD 8: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March.

Epilepsy

EPILEPSY 5: The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy.
EPILEPSY 6: The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months.
EPILEPSY 8: The percentage of patients age 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months.
EPILEPSY 9: The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months

Hypothroidism

THYROID 1: The practice can produce a register of patients with hypothyroidism.
THYROID 2: The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months.

Cancer

CANCER 1: The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'.
CANCER 3: The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis.

Palliative care (PC)

PC 3: The practice has a complete register available of all patients in need of palliative care/support irrespective of age.
PC 2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.

Mental Health (MH)

MH 8: The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses.
MH 11: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months

MH 12: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months
MH13: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months
MH19: The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months.
MH20. The percentage of patients aged 40 years and older with schizophrenia, bipolar affective disorder and other psychoses who have a record blood glucose or HbA1c in the preceding 15 months.
MH16. The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
MH17: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.
MH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.
MH 10: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.

Asthma

ASTHMA 1: The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months.
ASTHMA 8: The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility.
ASTHMA 10: The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months.
ASTHMA 9: The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions.

Dementia (DEM)

DEM 1: The practice can produce a register of patients diagnosed with dementia.
DEM 2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months.
DEM4: The percentage of patients with a new diagnosis of dementia recorded between 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 6 months before or after entering on to the register.

Depression (DEP)

DEP 1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions.
DEP6: In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care.
DEP7. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed.

Chronic kidney disease (CKD)

CKD 1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).
CKD 2: The percentages of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months.
CKD 3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less.
CKD 5: The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded).
CKD 6: The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months.

Atrial Fibrillation (AF)

AF 1: The practice can produce a register of patients with atrial fibrillation.
AF5: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1)
AF6: In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy.
AF7: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy.

Obesity (OB)

OB 1: The practice can produce a register of patients aged 16 and over with a Body Mass Index (BMI) greater than or equal to 30 in the previous 15 months.

Learning disabilities (LD)

LD1: The practice can produce a register of patients aged 18 years and over with learning disabilities.
LD2: The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register).

Smoking

SMOKING 5: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months
SMOKING 6: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months.
SMOKING 7: The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months.
SMOKING 8.:The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months.

Peripheral Arterial Disease (PAD)

PAD1: The practice can produce a register of patients with peripheral arterial disease.
PAD2: The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken.
PAD3: The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.
PAD4: The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less.

Osteoporosis: secondary prevention of fragility fractures (OST)

OST1: The practice can produce a register of patients: 1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012.
OST2: The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.
OST3: The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent.

Organisational Domain

Records and Information

Records 3: The practice has a system for transferring and acting on information about patients seen by other doctors out of hours.
Records 8: There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded.
Records 9: For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum standard 80 per cent.
Records 11: The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients.
Records 13: There is a system to alert the out-of-hours service or duty doctor to patients dying at home.
Records 15: The practice has up-to-date clinical summaries in at least 60% of patient records.
Records 17: The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients.
Records 18: The practice has up-to-date clinical summaries in at least 80% of patient records.
Records 19: 80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice.
Records 20: The practice has up-to-date clinical summaries in at least 70% of patient records.

Information for Patients

Information 5: The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

Education and Training

Education 11: There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months.
Education 5: There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months.
Education 6: The practice conducts an annual review of patient complaints and suggestions to

ascertain general learning points which are shared with the team.
Education 7: The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include: • any death occurring in the practice premises • new cancer diagnoses • deaths where terminal care has taken place at home • any suicides • admissions under the Mental Health Act • child protection cases • medication errors. • a significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different (near miss).
Education 8: All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal.
Education 9: All practice-employed non-clinical team members have an annual appraisal.
Education 10: The practice has undertaken a minimum of three significant event reviews within the last year.

Practice Management

Management 1: Individual healthcare professionals have access to information on local procedures relating to Child Protection.
Management 2: There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used.
Management 3: The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance.
Management 5: The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO.
Management 7: The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: • A defined responsible person • Clear recording • Systematic pre-planned schedules • Reporting of faults.
Management 9: The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment.
Management 10: There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access.

Medicines Management

Medicines 2: The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis.
Medicines 3: There is a system for checking the expiry dates of emergency drugs on at least an annual basis.
Medicines 4: The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays).
Medicines 6: The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing.
Medicines 8: The number of hours from requesting a prescription to availability for collection by

the patient is 48 hours or less (excluding weekends and bank/local holidays).
Medicines 10: The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.
Medicines 11: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%.
Medicines 12: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%.

Quality and Productivity

QP 6: The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO.
QP 7: The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.
QP 8: The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2013.
QP 9: The practice meets internally to review the data on emergency admissions provided by the PCO.
QP 10: The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.
QP 11: The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2013.
QP12: The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practice is appropriate, in light of the patterns on accident and emergency attendance.
QP13: The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements to the PCO.
QP14: The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013.

Patient Experience Domain (PE)

PE 1: Length of consultations. The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.

Additional Services Domain

Cervical Screening (CS)

CS 1: The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years.
CS 5: The practice has a system for informing all women of the results of cervical smears.
CS 6: The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years.
CS 7: The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates.

Child Health Surveillance (CHS)

CHS 1: Child development checks are offered at intervals that are consistent with national guidelines and policy.

Maternity Services (MAT)

MAT 1: Antenatal care and screening are offered according to current local guidelines.

Contraceptive Services (SH)

SH 1: The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.
SH 2: The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months. (Payment stages 50-90%).
SH 3: The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (Payment stages 50-90%).

Appendix 2 - Statswales tables views

QOF points by domain and register:
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/QualityAndOutcomesFrameworkPoints-by-LocalHealthBoard-Register

QOF disease registers:
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister

Appendix 3 - Programme for Government Indicators

TR060: Percentage of practices who have regular review meetings to discuss the needs of patients on the palliative care register

TR061: Percentage of the population in Wales, aged 65 years or over, who are registered with dementia

TR062: Percentage of practices where there has been a medications review in the preceding 15 months (for all patients prescribed 4 or more repeat medicines)
Further information on the Programme for Government can be found at
http://wales.gov.uk/about/programmeforgov/?lang=en