ystadegau ar gyfer cymru
statistics for wales

First Release
Datganiad Cyntaf

SDR 184/2014

29 October 2014

General medical services contract: Quality and outcomes framework statistics for Wales, 2013-14

This release presents a summary of data from the national General Medical Services (GMS) Quality and Outcomes Framework (QOF) during 2013-14. 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 2013-14.

The QOF was first implemented in April 2004, and the financial year 2013-14 therefore represents the tenth year of the QOF. The 2013-14 data is illustrated in terms of the number of patients on disease registers i.e. prevalence, achievement and exception reporting. 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 2014.

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 as they are not comparable to other indicators. The format of this year's release has changed with the aim of focusing more on services delivered than on points based achievement although all of the data previously published is still available in associated spreadsheets.

For time series charts and tables 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 associated spreadsheets, which includes local health board, cluster, and practice level data.

2013-14 Key results

- The largest single condition disease register, in terms of the number of patients as a percentage of all patients on practice lists, was hypertension (15.6 per cent).
- Amongst the 465 Welsh GP practices, the average total point achieved was 928.9 (95.9 per cent of the maximum 969 points available). 27 (5.8 per cent) practices achieved the maximum 969 points and 19 practices (4.1 per cent) achieved fewer than 800.0 points.
- Amongst Welsh GP practices, the average points achieved, for the clinical domain, was 577.5 (95.6 per cent of the maximum 604 points available).

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1. Introduction

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

Guidance for the QOF in Wales can be found at:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=68248

The QOF is about resourcing and then rewarding good practice. The QOF measures achievement against 138 indicators. Practices score points on the basis of achievement against each indicator, up to a maximum of 969 points.

Not all indicators in this release are consistent with earlier years. NICE operates an online facility which allows stakeholders to comment on current QOF indicators. Comments inform the review of existing QOF indicators against set criteria which include:
- Evidence of unintended consequences;
- Significant changes to the evidence base;
- Changes in current practice.

These comments are fed in to a rolling programme of reviews. The focus for new indicators is provided by NICE Quality Standards.

There were changes to the QOF indicators in 2013-14 from 2012-13. A new disease register was introduced for Rheumatoid arthritis. A new public health domain was introduced and indicators across all domains were renumbered from April 2013. In the guidance they are prefixed by an abbreviation of the category to which they belong, for example the Coronary Heart Disease (CHD) indicator number one becomes CHD001. The addition of zeroes indicates the change from previous years numbering. Note that these changes have an impact on the total numbers of available points for all domains.

Some indicators differ to those that apply in other countries of the UK. Where indicators are the same as in England then the numbering will be the same e.g. AF001. Where the indicator is essentially the same but differs on timeframe (including exception coding) then a 'W' has been added as a suffix, e.g. AF002W. A number of indicators developed through the NICE process have been introduced in Wales but not in England, where this is the case the indicator has been assigned the number 100 to avoid numbering issues in future years e.g. HF100W.

2. Contents of the framework

The QOF contains five main components, known as domains. The five domains are: Clinical Domain, Public Health Domain, Organisational Domain, Patient experience Domain, and Quality and Productivity Domain. 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**: 93 indicators in 20 areas (Atrial Fibrillation, Coronary Heart Disease, Heart Failure, Hypertension, Peripheral Arterial Disease , Stroke and Transient Ischaemic Attack, Diabetes Mellitus, Hypothyroidism, Asthma, Chronic Obstructive Pulmonary Disease, Dementia, Depression, Mental Health, Cancer, Chronic Kidney Disease, Epilepsy, Learning Difficulties, Osteoporosis, Rheumatoid Arthritis, Palliative Care. Indicators in the clinical domain are worth up to a maximum of 604 points (62.3 per cent of the total).

- **Public Health domain**: 18 indicators in 8 areas (Cardiovascular disease, Blood pressure, Obesity, Smoking, Cervical Screening, Child health surveillance; Maternity services, Contraception). Indicators in the Public Health domain are worth a maximum of 157 points (16.2 per cent).

- **Organisational domain**: 16 indicators in 4 areas (Records and information, Education and training, Practice management, Medicines management). Indicators in the organisational domain are worth up to 59 points (6.1 per cent of the total).

- **Patient Experience domain**: 1 indicator in 1 area (Length of consultations), worth up to 33 points (3.4 per cent of the total).

- **Quality and Productivity domain**: 10 indicators in one area, worth up to116 points (12.0 per cent of the total).

Some changes in the structure of this statistical release have been made this year to reflect the changing structure of the QOF in Wales. Data is presented in the following order:

- Recorded prevalence (patients on disease registers)
- Public Health indicators
- Clinical indicators
- Organisational, Patient Experience indicators
- Exceptions
- Health Board variations, Quality and Productivity indicators

Achievement is expressed in terms of the numbers and proportions of patients treated as well as in relation to the points achieved. Data for selected disease registers and indicators is presented throughout to illustrate some of the key statistics which can be derived from this large dataset.

3. Prevalence

QOF registers are collected to reward contractors for good practice, and to encourage GPs to assess and monitor particular conditions. Table 1 below shows reported disease prevalence information for the disease areas of the QOF since 2006-07. 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 profile of patients registered with GP practices will vary a great deal. Some practices have a large proportion of elderly people and others more young people than the average. In past editions of this release prevalence rates by age and sex have been presented using data from the Audit+ system. However due to a re-procurement of the software that took place earlier in the year, the registers have yet to be updated for the 2013-14 business rules.

Table 1: Reported disease prevalence rates

Percentage (%)

Register (a)	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Asthma	6.5	6.4	6.6	6.7	6.7	6.9	7.0	6.9
Atrial Fibrillation	1.6	1.6	1.7	1.7	1.7	1.8	1.8	1.9
Cancer	0.9	1.1	1.3	1.5	1.7	1.9	2.1	2.2
Cardiovascular Disease (PP)	-	-	-	0.6	1.2	1.6	2.2	2.7
Chronic Kidney Disease (b)	2.3	2.9	3.1	3.3	3.4	3.5	3.6	3.6
Chronic Obstructive Pulmonary Disease	1.9	1.9	2.0	2.0	2.0	2.1	2.1	2.2
Coronary Heart Disease	4.3	4.2	4.2	4.1	4.0	4.0	3.9	3.9
Dementia	0.4	0.4	0.5	0.5	0.5	0.5	0.6	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	-
Depression (new cases of depression) (d)	-	-	-	-	-	-		5.0
Diabetes Mellitus (e)	4.2	4.4	4.6	4.9	5.1	5.3	5.4	5.6
Epilepsy (f)	0.7	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	1.0
Heart Failure (due to Left Ventricular Dysfunction) (g)	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.2
Hypertension	14.3	14.6	14.9	15.1	15.4	15.5	15.5	15.6
Hypothyroidism	3.1	3.3	3.4	3.5	3.6	3.7	3.8	3.9
Learning Disabilities (h)	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4
Mental Health	0.7	0.7	0.8	0.8	0.8	0.8	0.9	0.9
Obesity (i)	9.6	9.6	9.7	10.1	10.4	10.4	10.3	10.3
Osteoporosis (j)	-	-	-	-	-	-	0.1	0.2
Palliative Care	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3
Peripheral Arterial Disease	-	-	-	-	-	-	0.7	0.7
Rheumatoid arthritis (k)	-	-	-	-	-	-	-	0.7
Smoking register (patients with chronic conditions)	22.3	23.9	25.2	25.5	25.8	26.0	26.4	26.5
Smoking status register (patients aged 15 or over with recorded smoking status)	-	-	-	-	-	-	83.7	83.7
Stroke and Ischaemic Attacks	2.0	2.0	2.0	2.0	2.1	2.1	2.0	2.0

Source: CM Web

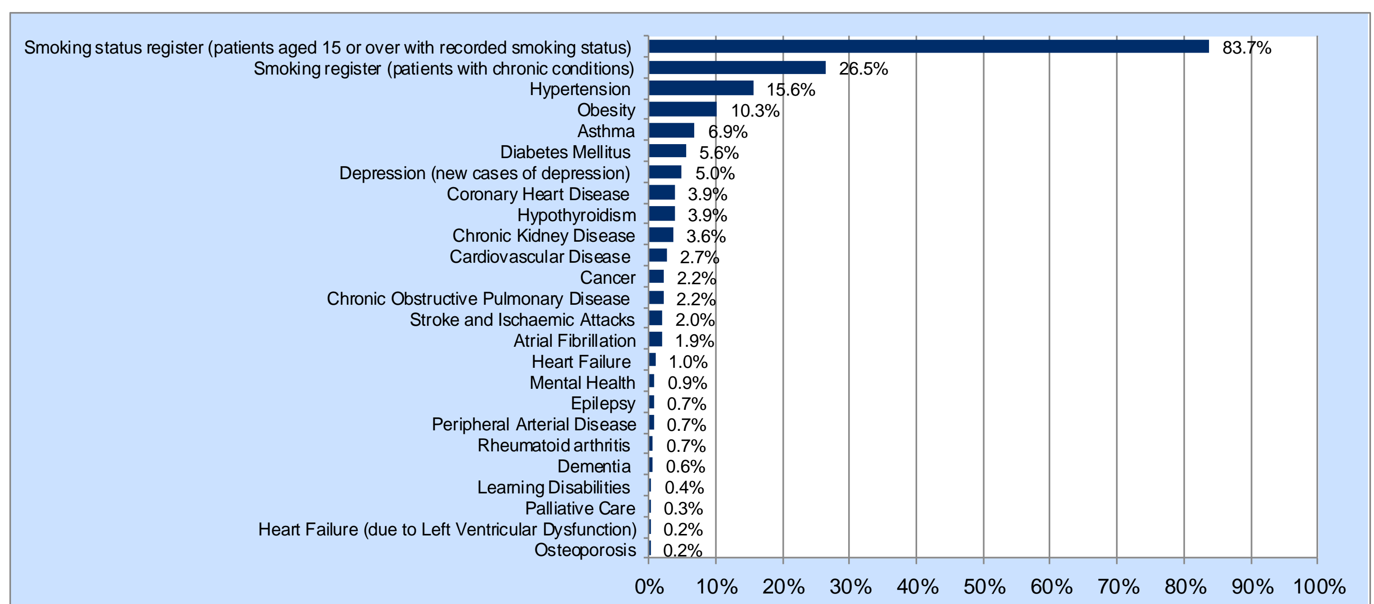
(a) Refer to Notes for full description of registers.
(b) Chronic Kidney Disease register only includes patients aged 18 years and over.
(c) The Depression0405 register includes patients diagnosed with depression ever. The Depression0607 register includes patients diagnosed with depression in the preceding 1 April to 31 March.
(d) The Depression register for 2013-14 includes patients aged 18 and over diagnosed with depression in the preceding 1 April to 31 March.
(e) Diabetes register only includes patients aged 17 and over.
(f) Epilepsy register only includes patients aged 18 years and over.
(g) HF LVD: Note that the rules for patients being recorded on this register changed substantially between 2012-13 and 2013-14.
(h) Learning Disability register only includes patients aged 18 years and over.
(i) Obesity register only includes patients aged 16 and over.
(j) Osteoporosis register only includes patients aged 50 and over.
(k) New disease register for 2013-14; only includes patients aged 16 and over.

From 2006-07 the Hypertension register has recorded the largest number of patients on a single disease register; in 2013-14 more than 493,000 or nearly 16 per cent of all patients were registered. Other large registers of chronic conditions include 177,200 (rounded to the nearest hundred) patients aged 17 or over with diabetes, 219,200 patients of any age with asthma, 122,700 patients of any age with coronary heart disease and 68,400 with Chronic Obstructive Pulmonary Disease (COPD).

QOF also provides some key public health registers: 324,900 people aged 16 or over with a BMI of 30 or over were recorded on the Obesity disease register, one in 10 of the adult population. But note that the Welsh Health Survey shows considerably higher rates of obesity than QOF in the younger age groups for Wales (up to age 64). This may be because obesity is often only picked up by GPs when patients visit the doctor, which is more common amongst older people. Other public health registers record whether patients have been asked about their smoking status and have had their blood pressure checked.

There was a Statistical Article published in August 2012, which compared the data available from the Welsh Health Survey and QOF, which can be found at:
http://wales.gov.uk/docs/statistics/2012/120822healthconditionsen.pdf

Chart 1: Reported disease prevalence rates, 2013-14



Source: CM Web

(a) See footnotes in Table 1.

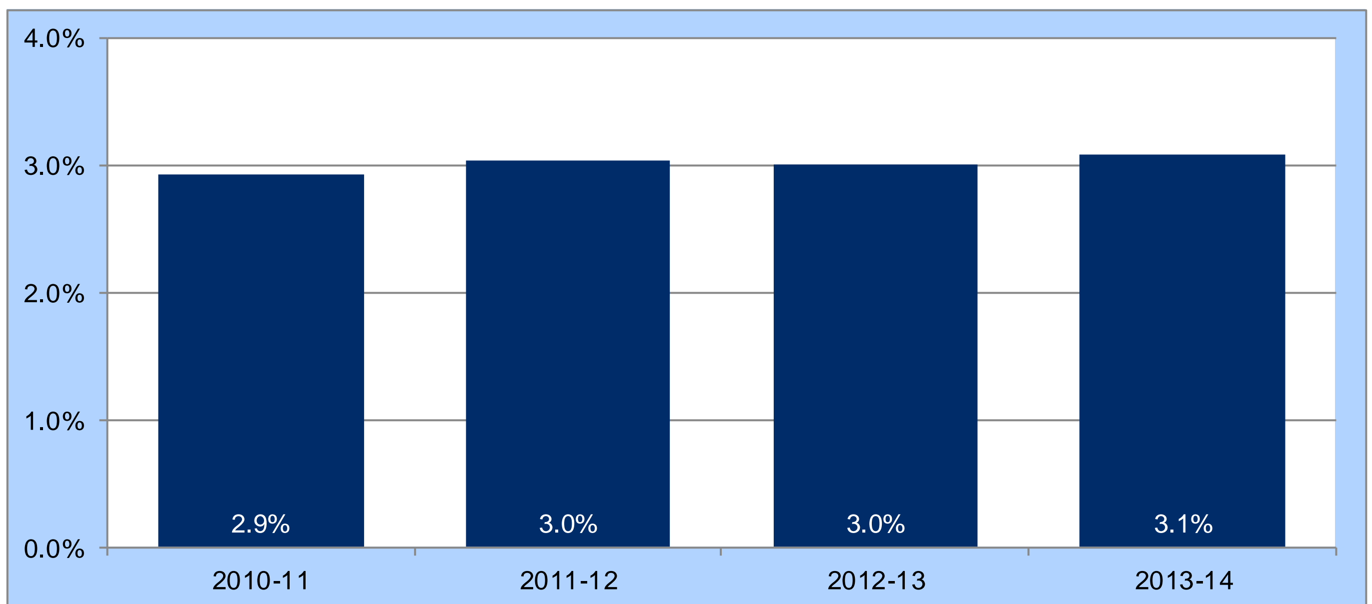
New registers should be treated with caution in the first few years of reporting as they are still being established and validated. In 2012-13 there were two new registers, Osteoporosis and Peripheral Arterial Disease (PAD), and in 2013-14 there was one new register, Rheumatoid Arthritis.

The QOF data does not provide information on co-morbidities and some patients may be recorded on more than one register. Some of the long-standing registers levelled out after the first few years of QOF.

The numbers of patients recorded on other registers such as diabetes and cancer continues to rise, year on year, which can be seen on StatsWales at:
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister

Dementia Register

Chart 2: Percentage of the population in Wales, aged 65 years or over, who are registered with dementia



Source: CM Web

Although the Dementia disease register includes patients of all ages, in practice the majority are aged 65 or over.

Chart 2 shows the proportion of patients on the dementia register as a percentage of the resident population aged 65 or over. In the most recent year, just over 3 per cent of people of this age were recorded on the dementia disease register, the percentage rising slowly over the last few years. This measurement is included as a Programme for Government indicator (TR061) as early recognition of dementia which allows individuals and their families to make plans for future care. See Appendix 3 for further details.

4. Total and domain level achievement

Map 1 shows the location of each GP practice in Wales together with the 'median total points', that is the total for the practice with the middle value, for each Local Health Board in Wales. Note that the shading of the map does not reflect the total points of the individual practices.

Within Health Boards the median total points were all between 956.0 (Cwm Taf University) and 941.4 (Betsi Cadwaladr University). The 'median total points' achieved by practices in Wales was 950.9.

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

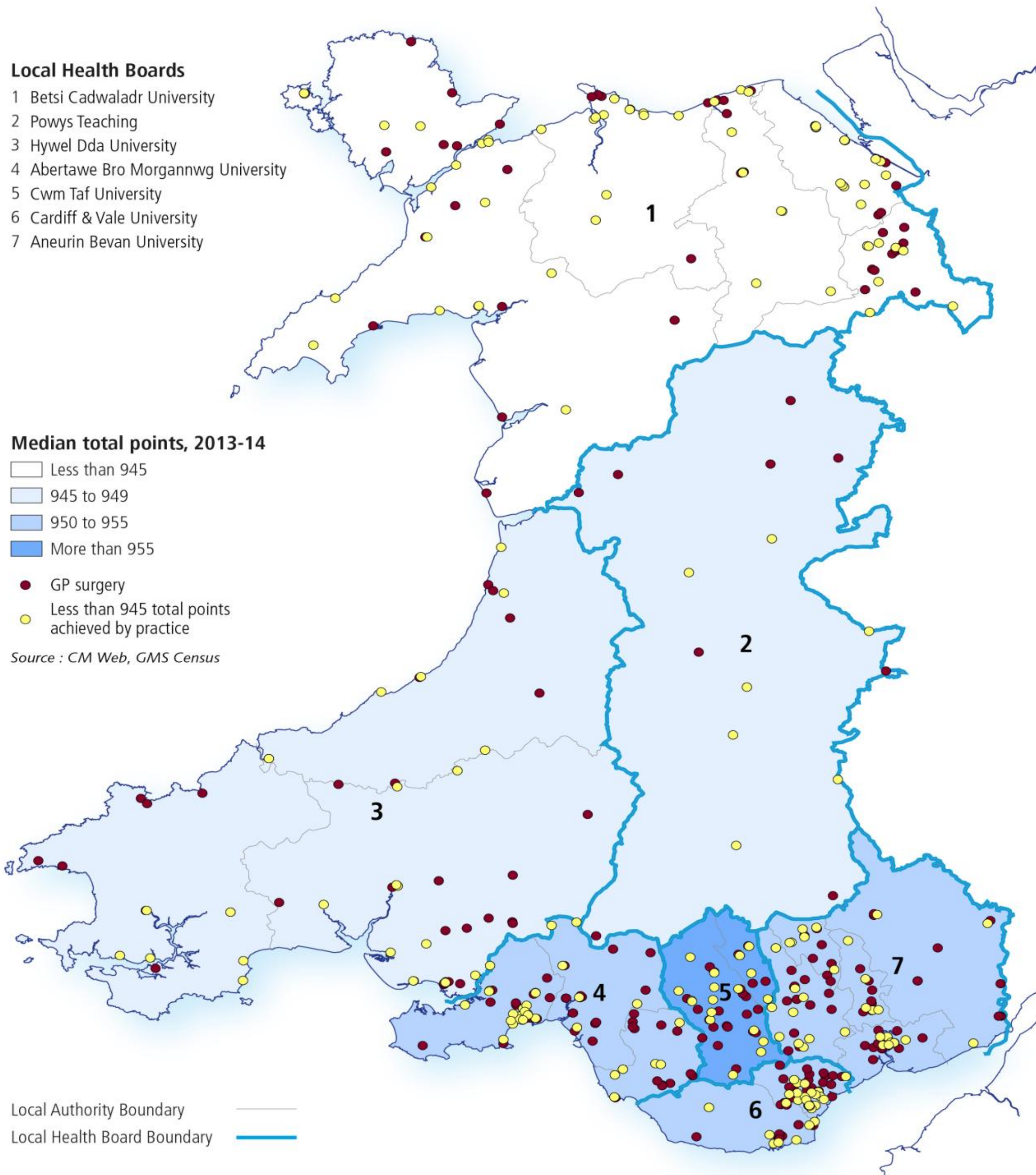
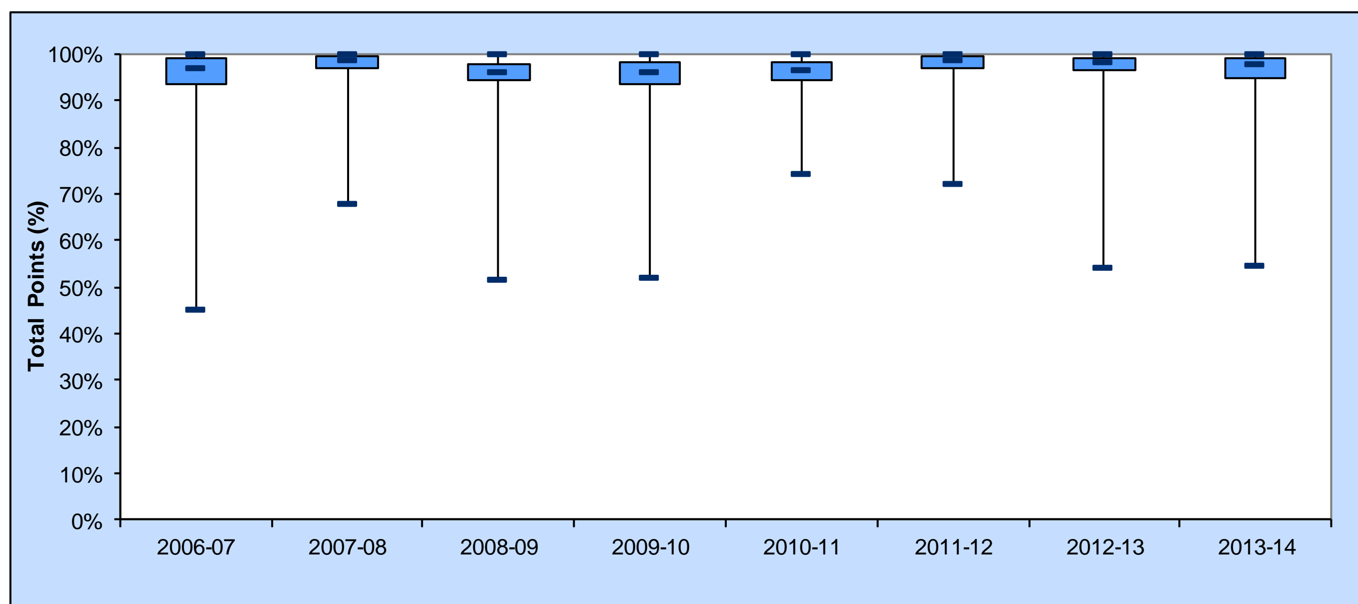


Chart 3: Historical achievement, total points



Source: CM Web

The largely high achievement by Welsh practices overall for the last eight years is shown in Chart 3. 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 the other years (see notes for further information on Read codes).

4.1 Domain level achievement

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

Table 2: Domain level achievement

Domain	2011-12			2012-13			2013-14		
	Points Available	Average points achieved by practices		Points Available	Average points achieved by practices		Points Available	Average points achieved by practices	
		Points	Proportion		Points	Proportion		Points	Proportion
Clinical	661.0	646.6	97.8%	669.0	647.1	96.7%	604.0	577.5	95.6%
Organisational	262.0	253.4	96.7%	254.0	247.2	97.3%	59.0	57.8	97.9%
Public Health (a)	.	.	.	.	.	.	157.0	151.4	96.5%
Patient Experience	33.0	32.8	99.4%	33.0	32.8	99.4%	33.0	32.5	98.5%
Quality and Productivity	.	.	.	.	.	.	116.0	109.6	94.5%
Additional Service (c)	44.0	42.7	97.1%	44.0	42.7	97.1%	.	.	.
All domains	**1000.0**	**975.5**	**97.5%**	**1000.0**	**969.8**	**97.0%**	**969.0**	**928.9**	**95.9%**

Source: CM Web

(a) New domain for 2013-14.
(b) The 'Quality and Productivity' indicators were previously included in the Organisational domain.
(c) Additional service is now a sub-domain of the public health domain.

Amongst Welsh GP practices, the average total points achieved, for all domains, was 928.9 (95.9 per cent of the maximum 969 points available). 27 (5.8 per cent) practices achieved the maximum 969 points and 19 practices (4.1 per cent) achieved fewer than 800.0 points.

The average points achieved, for the clinical domain, was 577.5 (95.6 per cent of the maximum 604 points available).

As Table 2 shows there have been a reallocation of points between domains in 2013-14. Further miscellaneous changes can be found at:
http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/qof-guidance/qof-guidance-previous-revisions

4.2 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.

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 point's thresholds.

Therefore the formula for underlying achievement is

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

Examples of these percentages for selected QOF indicators are used in the following sections. Note that in some years payment thresholds have changed.

5. Public health domain

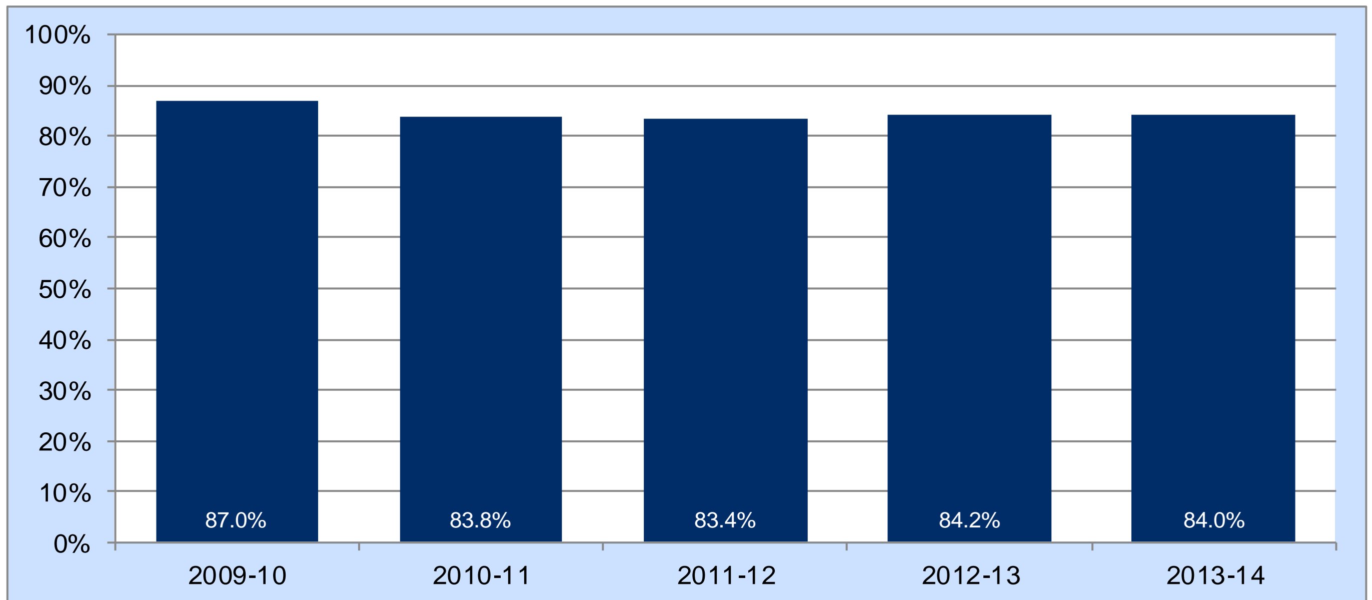
A number of existing indicators have been re-classified as public health indicators; as a group these are about prevention.

The Cardiovascular disease – primary prevention (CVD – PP) register records all patients diagnosed with a first episode of hypertension on or after 1 April 2009, excluding patients with pre-existing coronary heart disease, diabetes, stroke and/or TIA, peripheral arterial disease, familial hypercholesterolemia, diabetes or chronic kidney disease.

Description	Indicator
Percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	CVD-PP002W

Chart 4 below shows, for the last 5 years, the number of patients, expressed as a percentage of those on the CVD – PP register, who have been given lifestyle advice in the previous 15 months relating to increasing their physical activity, smoking cessation, safe alcohol consumption and a healthy diet. The percentage, steady at around 84 per cent in the last 4 years, reflects a total of 68,800 patients provided with this advice in 2013-14.

Chart 4: Percentage of patients on the CVD-PP register who have been given lifestyle advice in the previous 15 months



Source: CM Web

6. Clinical domain

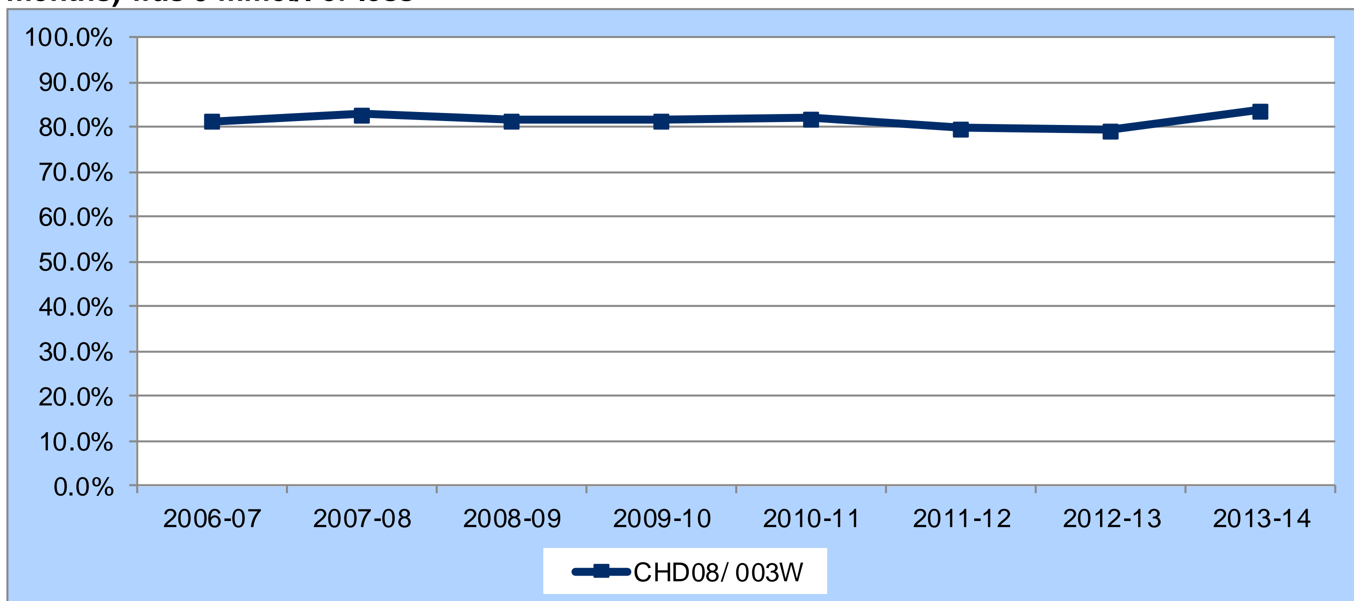
Cardiovascular disease

Cardiovascular disease is the most common cause of death in Wales. It is a major cause of disability, and hospital admission, also contributing to inequalities in health outcomes, with poorest outcomes in the most deprived communities. The Heart Disease Delivery Plan has the stated aim of minimising 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.

Where cardiovascular disease has been identified, risk factors, such as cholesterol management is monitored. This approach is termed secondary prevention and outcomes can be achieved through lifestyle advice and the use of drug therapy.

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.	CHD003W

Chart 5: Percentage of patients with CHD whose last measured total cholesterol (in the last 15 months) was 5 mmol/l or less



Source: CM Web

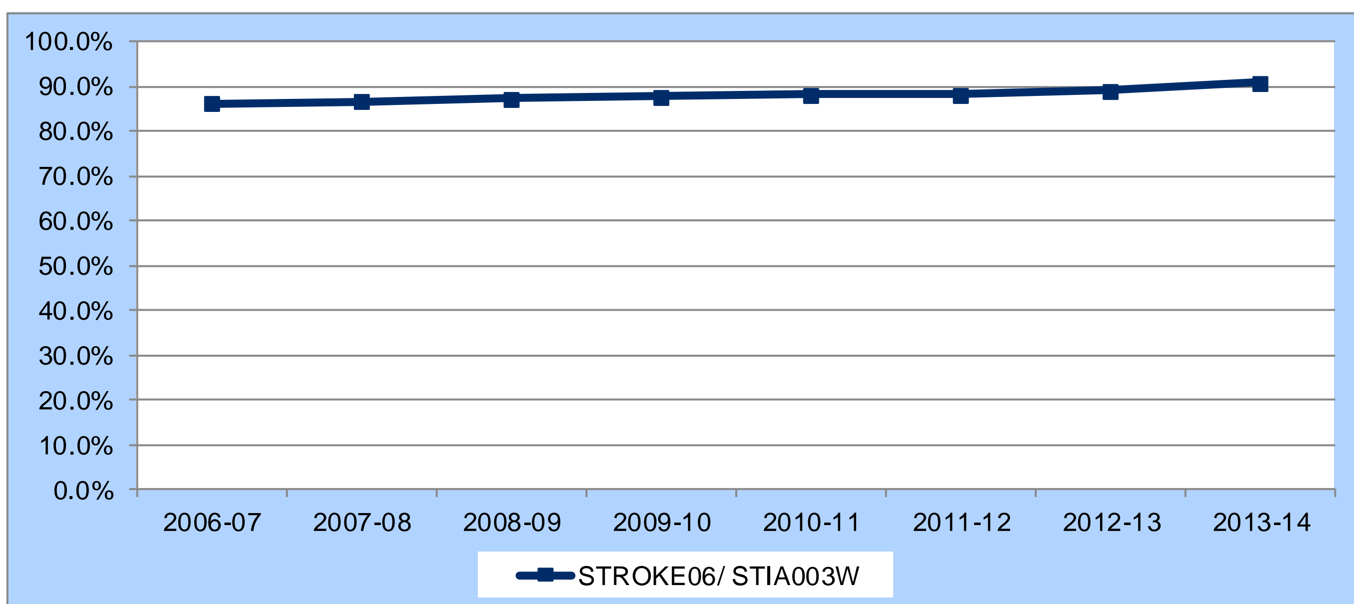
In the most recent year 88,900 patients, 84 per cent of patients on the coronary heart disease register, had a cholesterol measurement of 5 mmol/l or less.

Transient Ischemic Attacks (TIAs) and Stroke

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

Description	Indicator
Percentage of patients with a history of stroke or TIA whose last blood pressure reading (measured in the preceding 15 months) was 150/90 mmHg or less.	STIA003W

Chart 6: Percentage of patients with a history of stroke or TIA whose last blood pressure reading (in the last 15 months) was 150/ 90 mmHg or less



Source: CM Web

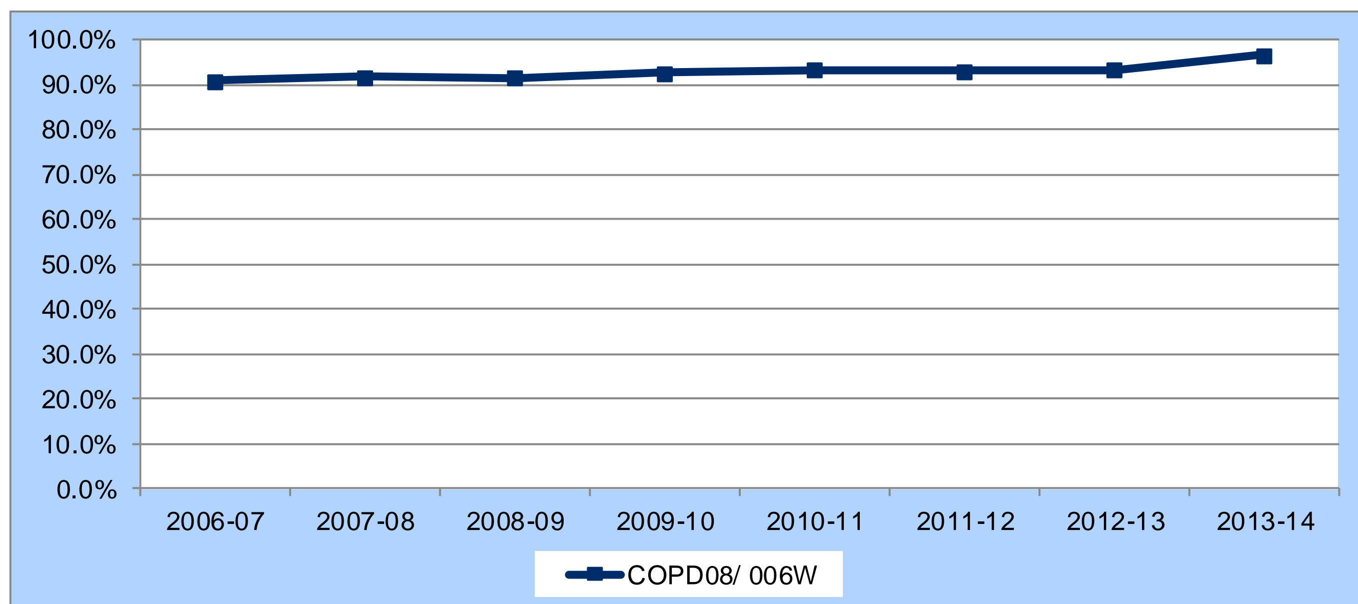
In the most recent year 55,400 patients, 91 per cent of patients on the stroke and transient ischaemic attack register, had a blood pressure measurement of 150/90 mmHG or less.

Respiratory/Health protection

Chronic Obstructive Pulmonary Disease is a common and disabling condition. Most acute exacerbations are triggered by community-acquired respiratory infections. Influenza vaccination is recommended for all persons with COPD.

Description	Indicator
Percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March.	COPD006W

Chart 7: Percentage of patients with COPD who've had an influenza immunisation in the preceding 1 September to 31 March



Source: CM Web

In the most recent year 53,800 patients, 97 per cent of patients on the chronic obstructive pulmonary disease register, had received an influenza immunisation in the preceding 6 months.

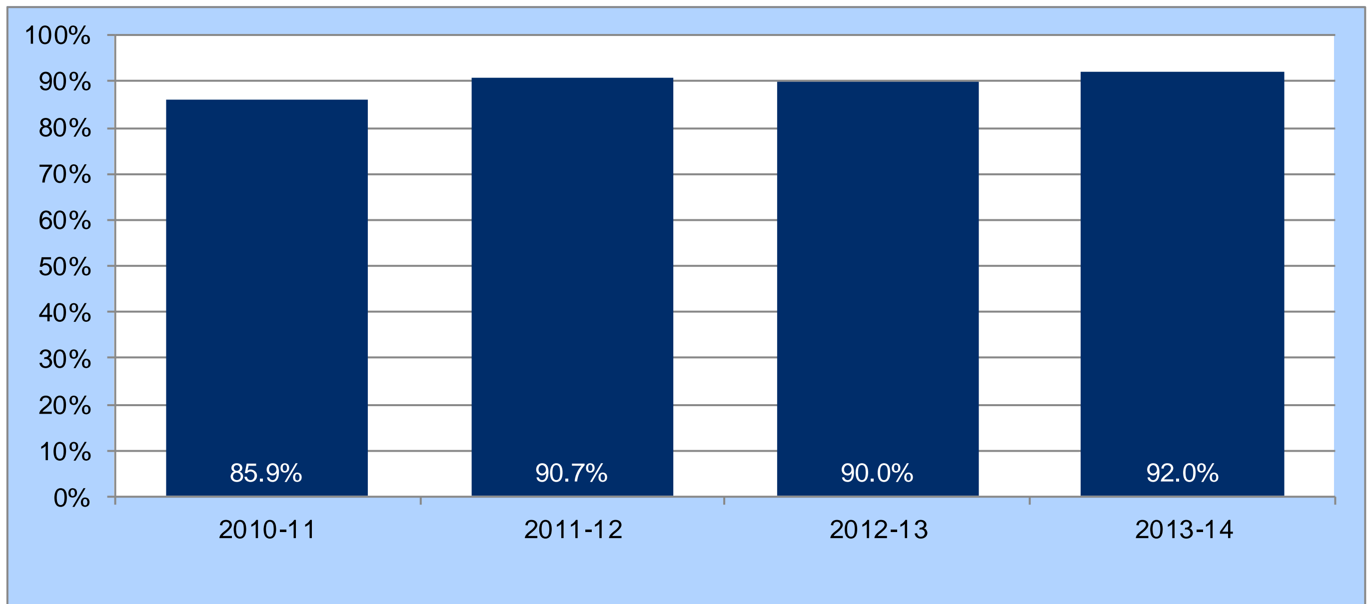
Palliative care

One of the strengths of primary care services is that they offer care across the life course. This includes continuity of care and a personalised approach as key priorities, of particular importance at the end of life.

The QOF indicators support practices to identify patients in need of palliative care and to ensure that regular reviews of care are undertaken by the multi disciplinary team.

Description	Indicator
The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.	PC002W

Chart 8: Percentage of GP practices holding review meetings, discussing their palliative care register patients, at least every 3 months



Source: CM Web

Since this indicator was introduced into QOF in 2010-11 there has been a gradual improvement in the percentage of GP practices holding regular case review meetings. 428 (92 per cent) of the practices in 2013-14 held these review meeting. This indicator (TR060) is included as a Programme for Government indicator. See Appendix 3 for further details.

7. Organisational domain

The quality and safety of clinical care is highly dependent upon the systems that support clinical practice. As prescribing levels increase, it is important that appropriate safeguards are developed to ensure regular reviews of care to minimise risk and harms.

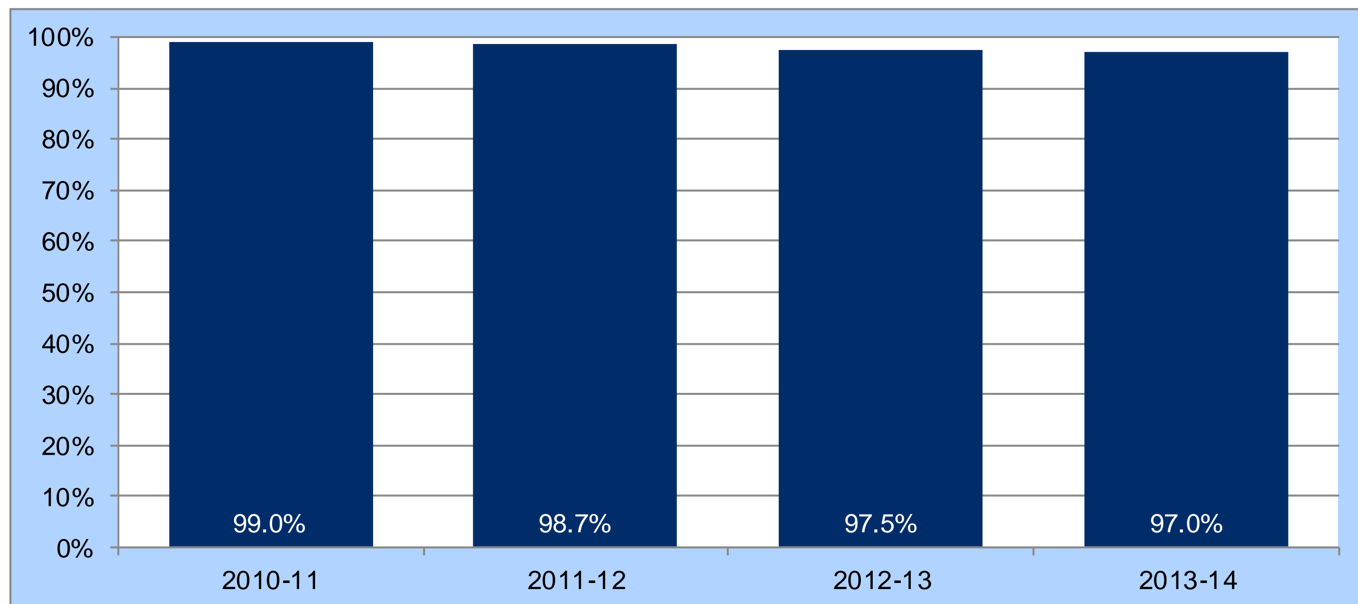
Good medical practice requires that doctors ensure that' suitable arrangements are in place for monitoring, follow up and review (of single treatment or repeat medication), taking account of patient's needs and any risks arising from the medications'.

GMC Prescribing Guidance: Reviewing medicines

QOF indicator MED007W highlights the importance of regular review for patients receiving multiple medications. Involving patients in prescribing decisions and ensuring that they receive the information and support that they need to achieve maximum benefit and minimise risk are essential actions to ensure patient safety, improved health outcomes and improved patient satisfaction

Description	Indicator
A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines.	MED007W

Chart 9: Percentage of GP practices in which a medication review takes place for all patients being prescribed four or more repeat medicines



Source: CM Web

Since this indicator was introduced into QOF in 2010-11 there has been a slight decline in the proportion of GP practices where there are medications reviews for patients prescribed four or more repeat medicines. 451 (97 per cent) practices in 2013-14 held a medication review for all patients being prescribed four or more repeat medicines. This indicator (TR062) is included as a Programme for Government indicator. See Appendix 3 for further information.

8. 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.

A small number of indicators 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:

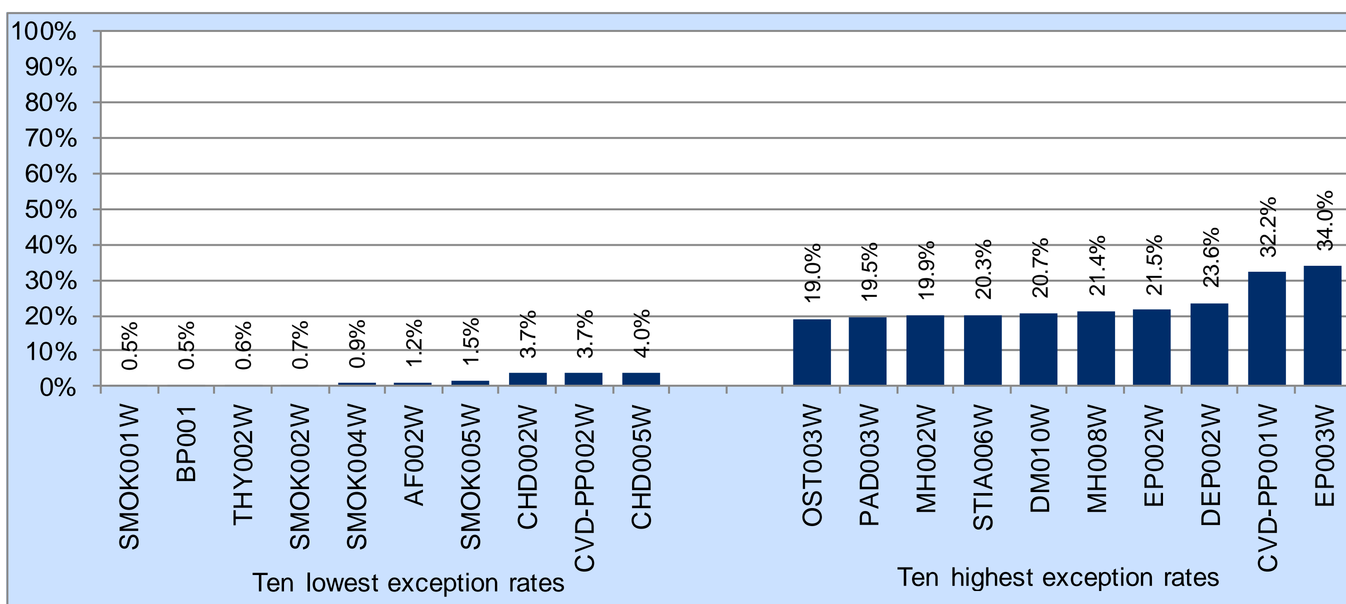
Patients who are on the disease register, but not included in the indicator denominator for definitional reasons, are referred to here as exclusions. An example of exclusion is where for heart failure only a small proportion of the patients (new diagnoses) on the heart failure register are relevant to 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 10: Exception rates - 10 indicators with highest rates and 10 with lowest rates [(a)]



Source: CM Web

(a) A full list of disease areas and indicator codes is provided in Appendix 1.

Chart 10 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 EP003W at 34.0 per cent and the lowest exception rate was for SMOK001W at 0.5 per cent. Note that for some indicators these rates may be based on small numbers.

9. Health Board variations

Prevalence – Health Boards

Table 3 shows the percentages of patients recorded on the disease registers in 2013-14 by Health Board. Variation in prevalence rates would be expected given that ill health and also age structures, and especially the proportion of elderly people, will differ between Health Boards. The location of some services such as care homes will also have an effect.

Table 3: Reported Disease Prevalence Rates, by Health Board

register (a)	Betsi Cadwaladr University	Powys Teaching	Hywel Dda University	Abertawe Bro Morgannwg University	Cwm Taf University	Cardiff & Vale University	Aneurin Bevan University
Asthma	7.1	6.8	6.9	7.4	6.5	6.6	6.9
Atrial Fibrillation	2.1	2.1	2.3	2.0	1.7	1.5	1.8
Cancer	2.5	2.7	2.5	2.2	1.9	1.8	2.2
Cardiovascular Disease (PP)	3.2	3.1	2.6	2.5	2.7	2.1	2.8
Chronic Kidney Disease (b)	4.4	4.7	3.6	3.9	3.5	2.2	3.5
Chronic Obstructive Pulmonary Disease	2.5	2.2	2.1	2.1	2.7	1.5	2.1
Coronary Heart Disease	4.1	4.1	4.2	4.0	3.9	2.9	3.9
Dementia	0.6	0.7	0.6	0.6	0.5	0.5	0.6
Depression (new cases of depression) (c)	5.2	5.2	3.5	4.8	4.4	5.7	5.6
Diabetes Mellitus (d)	5.4	5.7	5.8	6.0	5.7	4.5	6.2
Epilepsy (e)	0.7	0.7	0.8	0.8	0.9	0.6	0.8
Heart Failure	1.0	1.1	1.0	1.0	0.8	0.7	1.0
Heart Failure (due to Left Ventricular Dysfunction) (f)	0.3	0.2	0.2	0.3	0.2	0.2	0.2
Hypertension	16.3	17.3	16.3	15.2	16.8	12.5	16.2
Hypothyroidism	4.3	3.9	4.0	3.7	4.0	2.9	4.1
Learning Disabilities (g)	0.4	0.4	0.4	0.4	0.4	0.3	0.4
Mental Health	0.8	0.9	0.9	1.0	0.9	0.8	0.8
Obesity (h)	10.2	10.8	10.1	9.9	12.0	7.9	11.8
Osteoporosis (i)	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Palliative Care	0.3	0.4	0.3	0.2	0.2	0.1	0.4
Peripheral Arterial Disease	0.8	1.0	0.7	0.7	0.7	0.5	0.7
Rheumatoid arthritis (j)	0.7	0.8	0.9	0.7	0.7	0.5	0.7
Smoking register (patients with chronic conditions) (r)	27.5	28.3	27.6	27.0	27.1	22.1	27.0
Smoking status register (patients aged 15 or over with recorded smoking status) (r)	83.8	85.0	84.8	83.9	83.0	83.1	83.1
Stroke and Ischaemic Attacks	2.0	2.4	2.2	2.2	2.0	1.6	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 Depression register includes patients aged 18 and over diagnosed with depression in the preceding 1 April to 31 March.
(d) Diabetes register only includes patients aged 17 and over.
(e) Epilepsy register only includes patients aged 18 years and over.
(f) HF LVD: Note that the rules for patients being recorded on this register changed substantially between 2012-13 and 2013-14.
(g) Learning Disability register only includes patients aged 18 years and over.
(h) Obesity register only includes patients aged 16 and over.
(i) Osteoporosis register only includes patients aged 50 and over.
(j) New disease register for 2013-14; only includes patients aged 16 and over.
(r) Revised 4 November 2014.

The highest prevalence in relation to the hypertension register was recorded for Powys Teaching Health Board (17.3 per cent), Abertawe Bro Morgannwg (7.4 per cent) for the Asthma register, and Cwm Taf University (12.0 per cent) for obesity.

For further information, refer to the 'Data summary for Wales and local health boards, 2013-14' spreadsheet on the website: http://wales.gov.uk/statistics-and-research/general-medical-services-contract/?lang=en#/statistics-and-research/general-medical-services-contract/?lang=en

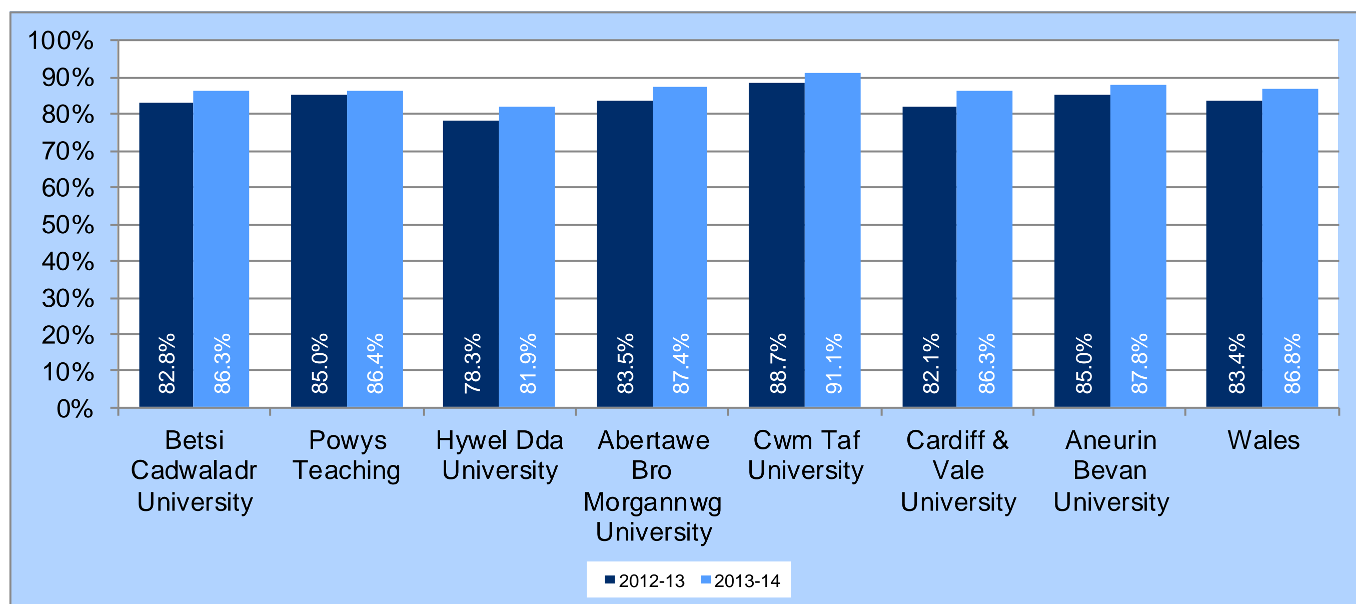
Public health domain – Health Boards

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.

Description	Indicator
The percentage of patients aged 15 or over who are recorded as current smokers and have a record of an offer of support and treatment within the preceding 27 months.	SMOK004W

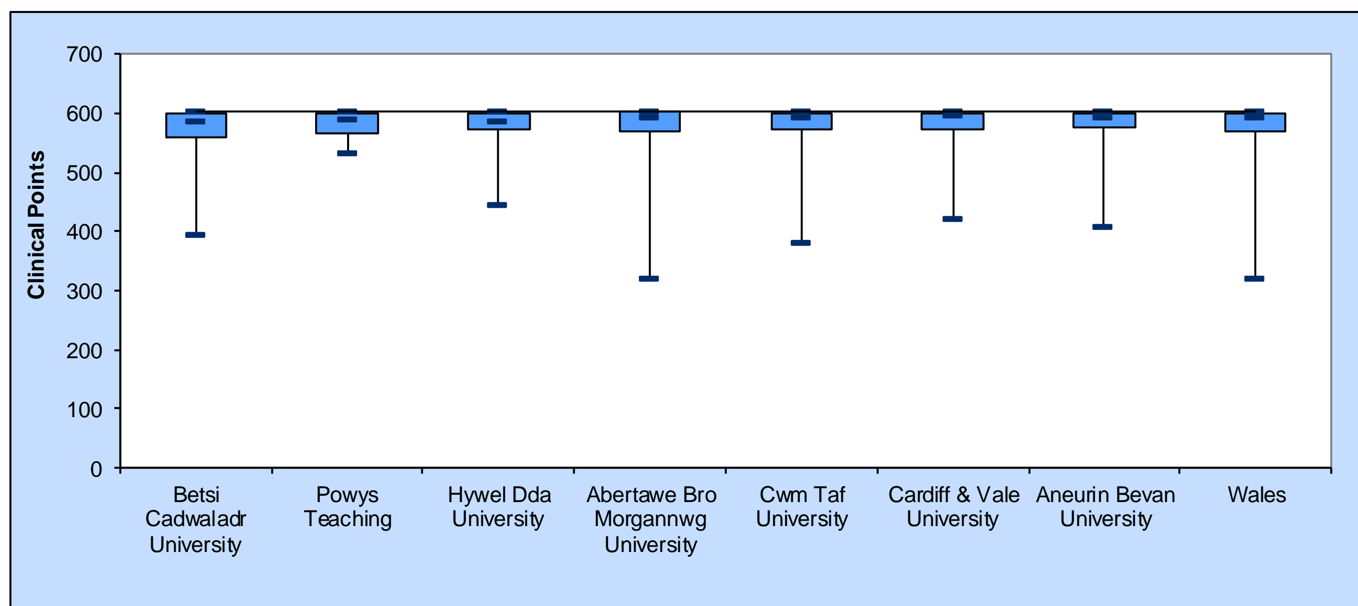
Chart 11: Percentage of patients aged 15 or over who are current smokers and have had an offer of support and treatment within the preceding 27 months, in 2012-13 and 2013-14



In every Health Board there was a small increase in the proportion of patients offered support and treatment in relation to smoking between 2012-13 and 2013-14.

Clinical domain by Local Health Boards

Chart 12: Distribution of clinical points achieved by practices



Source: CM Web

The maximum points available for the clinical domain, in 2013-14, were 604 points. 49 (10.5 per cent) practices achieved the maximum 604 points. The line in chart 12 represents the maximum 604 points. Within Health Boards the median (middle value) clinical points were all between 594.4 (Cardiff and Vale University) and 585.5 (Betsi Cadwaladr University).

Refer to the 'Clinical data by practice, 2013-14' spreadsheet for further information, which is found at:

http://wales.gov.uk/statistics-and-research/general-medical-services-contract/?lang=en#/statistics-and-research/general-medical-services-contract/?lang=en

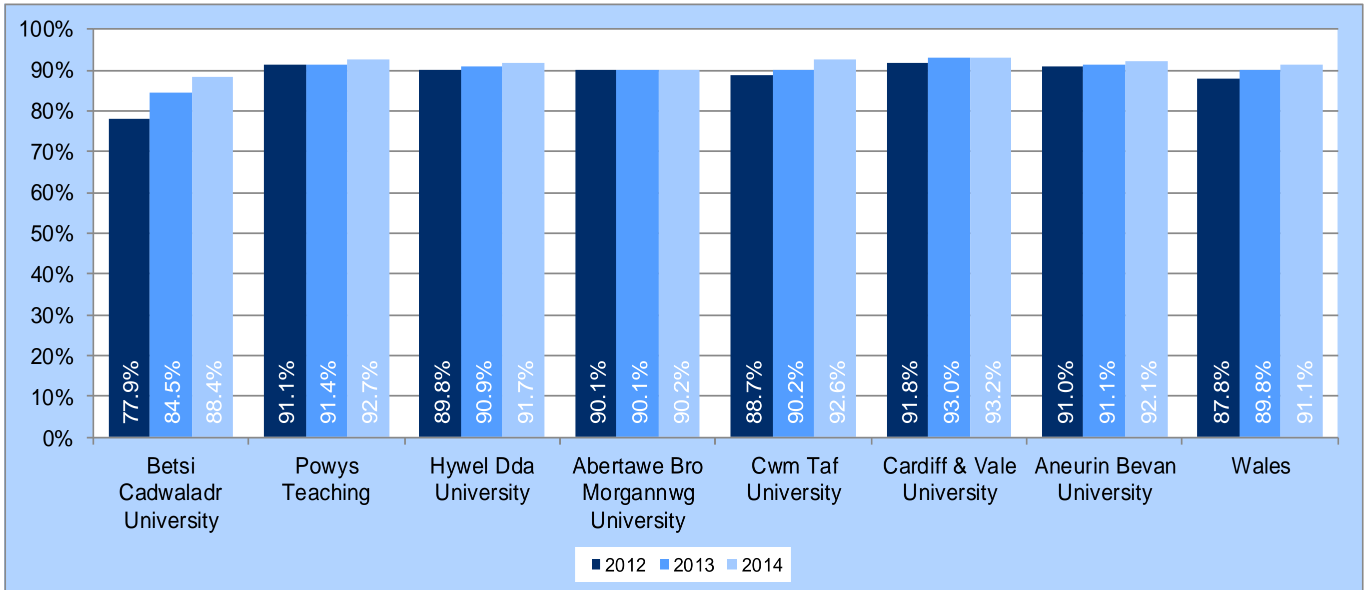
Diabetes

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.

Description	Indicator
The percentage of patients with diabetes with a record of foot examination and risk classification.	DM012W

Chart 13 below shows a year on year improvement in the proportions of patients with diabetes who have a record of foot examination. In 2013-14 Cardiff and Vale University Health Board recorded the highest proportion, accounting for 93.2 per cent.

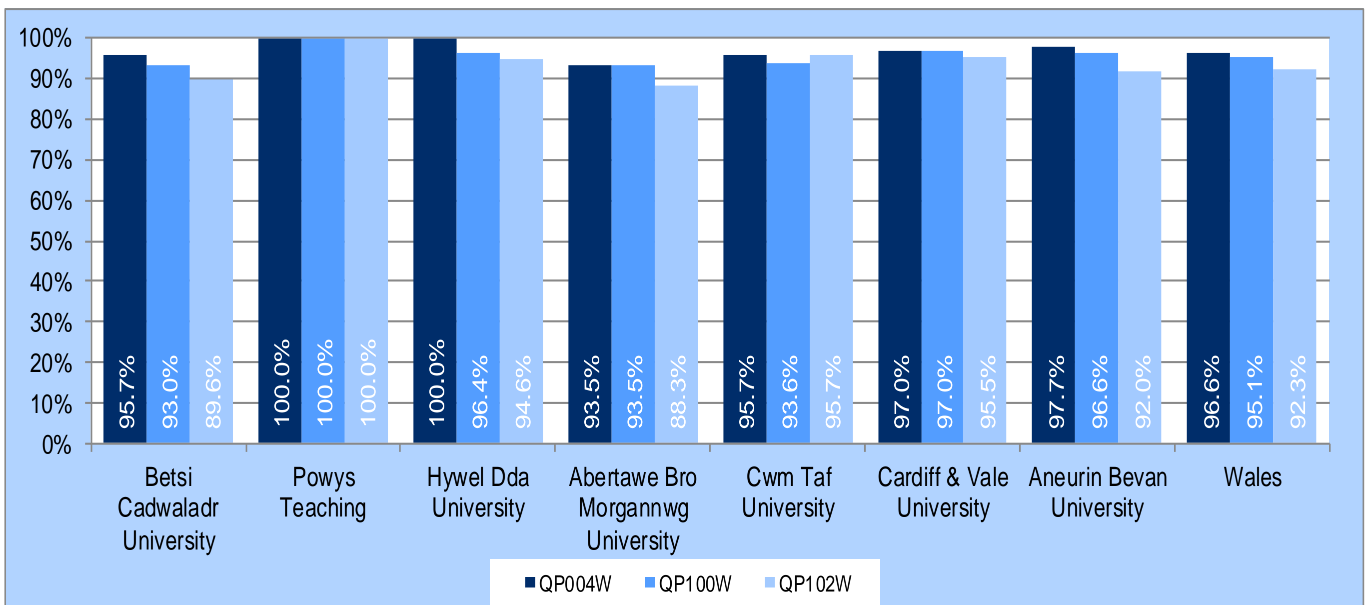
Chart 13: Percentage of patients with diabetes with a record of a foot examination by LHB



Quality and Productivity domain

The Quality and Productivity indicators were introduced to encourage and support professional networks to review and address issues such as rising emergency care pressures and the care of frail elderly patients with complex care needs. Through analysis of local data and closer working with community nursing teams and others, GP teams were encouraged to identify and address actions relevant to their communities. This approach supported the delivery of Setting the Direction the plan for primary and community services development, establishing 64 GP Clusters as collaborative professional networks serving local communities. A summary of the following three key indicators in this area are shown below by Health Board in Chart 14.

Chart 14: Percentage of GP practices which meet the requirements for the indicators QP004W, QP100W and QP102W by LHB



Description	Indicator
The contractor meets internally to review data on emergency admissions provided by the LHB.	QP004W

Description	Indicator
The practice produces a list of 5% of patients in the practice who are predicted to be a significant risk of unscheduled care admission or community based alternatives.	QP100W

Description	Indicator
The practice has at least four meetings during the year to review the needs of patients identified as a result of developing the active management plans, to identify opportunities for more effective systems of care and related changes in patient management. These meetings should be open o multi-disciplinary professionals who support the practices patients.	QP102W

In Wales as a whole 97 per cent of practices reviewed emergency admission data, 95 per cent produced a list of patients at risk of unscheduled care admission and 92 per cent held at least four active management plan meetings. This local analysis provided a detailed resource for Local Health Board Unscheduled Care plans.

Notes

Disease areas

Descriptions of the 2013-14 disease areas are listed below:

Disease Area	Register description	QOF indicators
Coronary Heart Disease (CHD)	Patients diagnosed with CHD ever.	CHD001, 002W-006W
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.	CVD-PP001W, 002W
Heart Failure	Patients diagnosed with Heart Failure ever.	HF001, 002W, 003W, 004W, 100W
Heart Failure (Due to Left Ventricular Dysfunction)	Patients diagnosed with Heart failure ever AND Left Ventricular Dysfunction ever (Note that the rules for patients being recorded on this register changed substantially between 2012-13 and 2013-14).	HF03-04
Blood Pressure	Patients aged 40 or over who have a record of high blood pressure in the last 5 years.	BP001
Stroke and Transient Ischaemic Attack (TIA)	Patients diagnosed with stroke and/or TIA ever.	STIA001, 002W-007W
Hypertension	Patients diagnosed with hypertension ever where "Hypertension Resolved" has not been recorded following latest diagnosis.	HYP001, 002W, 003W
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	DM001, 002W-016W
Chronic Obstructive Pulmonary Disease	Patients diagnosed with COPD ever.	COPD001, 002W-006W, 100W
Epilepsy	Patients aged 18 and over diagnosed with Epilepsy ever receiving Epilepsy medication within 6 months of QOF reference date.	EP001W, 002W, 003W
Hypothyroidism	Patients diagnosed with Hypothyroidism ever receiving Hypothyroidism medication within 6 months of QOF reference date (31st March)	THY001W, 002W
Cancer	Patients diagnosed with cancer since April 2003 excluding non-melanotic skin cancers.	CAN001W, 002W
Palliative care	Patients recorded as receiving Palliative Care since 1st April 2008.	PC001, 002W
Mental Health	Patients diagnosed with schizophrenia, bipolar disorders or other psychoses; or patients currently being treated with lithium.	MH001, 002W-010W
Asthma	Patients diagnosed with Asthma currently being treated with an Asthma related drug.	AST001, 002W, 003W, 004W
Dementia (DEM)	Patients diagnosed with Dementia ever.	DEM001, 002W, 003W

Depression	Patients on the Depression register aged 18 and over with a new diagnosis of depression.	DEP001W, 002W
Chronic kidney disease (CKD)	Patients aged 18 and over diagnosed with stage 3 to 5 CKD.	CKD001, 002W, 003W, 004W
Atrial fibrillation (AF)	Patients diagnosed with Atrial Fibrillation.	AF001,002W, 093W, 004W
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.	OB001W
Learning disability (LD)	Patients aged 18 and over diagnosed with a Learning Disability ever.	LD001, 002W
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.	SMOK001W, 003W, 005W
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.	SMOK002W, 004W
Peripheral arterial disease (PAD)	Patients diagnosed with Peripheral arterial disease.	PAD001, 002W, 003W, 004W
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.	OST001, 002W, 003W
Rheumatoid arthritis	Patients diagnosed with Rheumatoid arthritis	RA001, 002W, 003W, 004W

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

[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

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
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

In past editions of this release prevalence rates by age and sex have been presented using data from the Audit+ system. However due to a re-procurement of the software that took place earlier in the year, the registers have yet to be updated for the 2013-14 business rules.

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 2013-14 is presented for 465 general practices in Wales. This includes practices that had data automatically extracted by the CM Web system in June 2014, and data adjustments for the year 2013-14 submitted between April and June 2014. The 2013-14 disease prevalence tables are based on prevalence recorded on CM Web at 30 June 2014. The data presented is raw (unadjusted) disease prevalence as recorded by the practices.

Level of detail

There are no patient-specific data within CM Web.

Practice list sizes

The 2013-14 QOF data use practice list sizes that have been derived from the practice clinical system as at 31 March 2014. 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 2013-14 financial year, and are correct as at 1 July 2014.

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 2013-14 from 2012-13. These changes included the introduction of the Public Health domain, retirement of previous indicators, introduction of new indictors, including a new clinical area (Rheumatoid Arthritis), 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 2013-14 were:

- The introduction of a new public health domain;
- The introduction of a new clinical area for rheumatoid arthritis;
- The removal of the organisational domain indicators not retained in the quality and productivity domain or moved into the public health domain;
- Amendments to indicator wording for a number of indicators;
- Updating the Contractor Population Index (CPI) in order to reform the list size weighting.

In addition to above, a number of other changes were agreed. These further miscellaneous changes can be found at: http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/qof-guidance/qof-guidance-previous-revisions

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.hscic.gov.uk/searchcatalogue?topics=1%2fPrimary+care+services%2fQuality+Outcomes+Framework&sort=Relevance&size=10&page=1#top

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 2013-14 QOF indicators

Clinical Domain

Atrial Fibrillation (AF)

AF001: The contractor establishes and maintains a register of patients with atrial fibrillation.
AF002W: 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).
AF003W: 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.
AF004W: 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.

Secondary Prevention of Coronary Heart Disease (CHD)

CHD001: The contractor establishes and maintains a register of patients with coronary heart disease.
CHD002W: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.
CHD003W: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.
CHD004W: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March.
CHD005W: The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.
CHD006W: The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin.

Heart Failure (HF)

HF001: The contractor establishes and maintains a register of patients with heart failure.
HF002W: The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register.
HF003W: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.
HF004W: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.
HF100W: The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months.

Hypertension (HYP)

HYP001: The contractor establishes and maintains a register of patients with established hypertension.
HYP002W: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.
HYP003W: The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less.

Peripheral Arterial Disease (PAD)

PAD001: The contractor establishes and maintains a register of patients with peripheral arterial disease.
PAD002W: The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.
PAD003W: The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.
PAD004W: 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.

Stroke and Transient Ischaemic Attack (STIA)

STIA001: The contractor establishes and maintains a register of patients with stroke or TIA.
STIA002W: The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2008) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or TIA.
STIA003W: The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.
STIA004W: The percentage of patients with a history of a stroke or TIA who have a record of total cholesterol in the preceding 15 months.
STIA005W: The percentage of patients with a history of a stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.
STIA006W: The percentage of patients with a history of a stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March.
STIA007W: The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.

Diabetes mellitus (DM)

DM001: The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.
DM002W: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.
DM003W: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less.
DM004W: The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less.
DM005W: The percentage of patients with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 15 months.
DM006W: The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I.
DM007W. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.
DM008W: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months.
DM009W: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.
DM010W: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March.
DM011W: The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 15 months.

DM012W: The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.
DM013W: The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 15 months.
DM014W: The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.
DM015W: The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 15 months.
DM016W: The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 15 months.

Hypothyroidism (THY)

THY001: The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine.
THY002W: The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 15 months.

Asthma (AST)

AST001: The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.
AST002W: The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis.
AST003W: The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions.
AST004W: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.

Chronic Obstructive Pulmonary Disease (COPD)

COPD001: The contractor establishes and maintains a register of patients with COPD.
COPD002W: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.
COPD003W: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.
COPD004W: The percentage of patients with COPD with a record of FEV1 in the preceding 15 months.
COPD005W: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months.
COPD006W: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March.
COPD100W: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months.

Dementia (DEM)

DEM001: The contractor establishes and maintains a register of patients diagnosed with dementia.
DEM002W: The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months.
DEM003W: The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register.

Depression (DEP)

DEP001W: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.
DEP002W: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis.

Mental Health (MH)

MH001: The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.
MH002W: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate.
MH003W: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.
MH004W: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months.
MH005W: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months.
MH006W: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months.
MH007W: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.
MH008W: The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
MH009W: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.
MH010W: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.

Cancer (CAN)

CAN001: The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'.
CAN002W: The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 3 months of the contractor receiving confirmation of the diagnosis.

Chronic kidney disease (CKD)

CKD001: The contractor establishes and maintains a register of patients aged 18 or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).
CKD002W: The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 15 months) is 140/85 mmHg or less.
CKD003W: The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB.
CKD004W. 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 preceding 15 months

Epilepsy (EP)

EP001: The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.
EP002W: The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months.
EP003W: The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months.

Learning disability (LD)

LD001: The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities.
LD002W: The percentage of patients on the learning disability register with Down's Syndrome aged 18 or over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register).

Osteoporosis: secondary prevention of fragility fractures (OST)

OST001: The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012.
OST002W: The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.
OST003W: The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent.

Rheumatoid Arthritis (RA)

RA001: The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis.
RA002W: The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months.
RA003W: The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months.
RA004W: The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool

adjusted for RA in the preceding 27 months.

Palliative care (PC)

PC001: The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.
PC002W: The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.

Public health domain

Cardiovascular disease – primary prevention (PP)

CVD-PP001W: In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the LHB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins.
CVD-PP002W: The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Blood Pressure (BP)

BP001: The percentage of patients aged 40 or over who have a record of blood pressure in the preceding 5 years.

Obesity (OB)

OB001W: The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months.

Smoking (SMOK)

SMOK001W: The percentage of patients aged 15 or over whose notes record smoking status in the preceding 27 months.
SMOK002W: 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.
SMOK003W: The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.
SMOK004W: The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months.
SMOK005W: 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 are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months.

Cervical Screening (CS)

CS001W: The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates.

CS002W: The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.
CS003W: The contractor ensures there is a system for informing all women of the results of cervical screening tests.
CS004W: The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years.

Child Health Surveillance (CHS)

CHS001W: Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with the LHB.

Maternity Services (MAT)

MAT001W: Antenatal care and screening are offered according to current local guidelines agreed with the LHB.

Contraceptive (CON)

CON001W: The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS.
CON002W: The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 15 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 15 months.
CON003W: The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription.

Organisational Domain

Records and Information

REC001W: The contractor has a system for transferring and acting on information about patients seen by other doctors out of hours.
REC002W: There is a system to alert the out of hours service or duty doctor to patients dying at home.

Education and Training

EDU001W: The contractor conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team.
EDU002W: The contractor has undertaken a minimum of 12 significant event reviews in the preceding 3 years which could include: • Any death occurring on 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).

EDU003W: The contractor has undertaken a minimum of 3 significant event reviews within the preceding year.

Practice Management

MAN001W: Individual healthcare professionals have access to information on local procedures relating to Child Protection.
MAN002W: The contractor offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed with the LHB.
MAN003W: The contractor has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment.

Medicines Management

MED001W: The contractor possesses the equipment and in-date emergency drugs to treat anaphylaxis.
MED002W: There is a system for checking the expiry dates of emergency drugs on at least an annual basis.
MED003W: 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).
MED004W: 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).
MED005W: The contractor meets the LHB prescribing advisor at least annually and agrees up to three actions related to prescribing.
MED006W: The contractor meets the LHB prescribing advisor at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.
MED007W: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%.
MED008W: 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) domain

QP001W: The contractor meets internally to review the data on secondary care outpatient referrals provided by the LHB.
QP002W: The contractor participates in an external peer review to compare its secondary care outpatient referral data with an agreed group of contractors in the LHB area, for the purpose of working with the LHB to identify service design and delivery improvements..
QP003W: The contractor engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) for improving the management of patients in the primary care setting to avoid inappropriate outpatient referrals and produces a report of the action taken to the LHB no later than 31 March 2014.
QP004W: The contractor meets internally to review data on emergency admissions provided by the LHB.
QP005W: The contractor participates in an external peer review to compare its data on emergency admissions with an agreed group of contractors in the LHB area, for the purpose of working with the LHB to identify service design and delivery.
QP006W: The contractor 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 LHB no later than 31 March 2014.
QP100W: The practice produces a list of 5% of patients in the practice who are predicted to be at significant risk of unscheduled care admission or community based alternatives.
QP101W: The practice identifies a minimum of 10% (with a maximum of 0.5% of the practice list) of those patients from the list produced in indicator QP100W who would most benefit from review and ensures there is an active management plan (see template attached) is in place for each patient. The active management plan must include an appropriate review date. The frequency of each patient's review should be determined in light of their clinical and care needs. The practice will be responsible for ensuring that an appropriate system is in place for monitoring and review of the patients identified..
QP102W: The practice has at least four meetings during the year to review the needs of the patients identified as a result of developing the active management plans, to identify opportunities for more effective systems of care and related changes in patient management. These meetings should be open to multi-disciplinary professionals who support the practice's patients.
QP103W: The practice reports annually to the Health Board on system changes that may benefit patients.

Patient Experience Domain (PE)

PE001W (Length of consultations) The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes. If the contractor routinely admits extra patients during booked surgeries, then the average booked consultation length should allow for the average number of extra patients seen in a surgery session such that the length of booked appointments is not less than 10 minutes. If the extra patients are seen at the end of surgery, then it is not necessary to make this adjustment. For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes. Contractors that routinely operate a mixed economy of booked and open surgeries should ensure that the length of booked appointments is not less than 10 minutes and the length of open surgery appointments is not less than 8 minutes.

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
http://wales.gov.uk/about/programmeforgov/data?code=TR060&lang=en

TR061: Percentage of the population in Wales aged 65 years or over, who are registered with dementia
http://wales.gov.uk/about/programmeforgov/data?code=TR061&lang=en

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)
http://wales.gov.uk/about/programmeforgov/data?code=TR062&lang=en

Further information on the Programme for Government can be found at
http://wales.gov.uk/about/programmeforgov/?lang=en