ystadegau ar gyfer cymru statistics for wales

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General Medical Services Contract: Quality and Outcomes Framework Statistics for Wales, 2014-15

This release presents a summary of data from the national General Medical Services (GMS) Quality and Outcomes Framework (QOF) during 2014-15. 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 2014-15.

The QOF was first implemented in April 2004, and the financial year 2014-15 therefore represents the eleventh year of the QOF. The 2014-15 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, Public Health, Medicine Management and Cluster Network (CND) indicators. The data reported is derived from the national 'CM Web' software as at 30 June 2015.

Note that not all of the data is comparable to previous years since the points available have changed for some indicators. Some indicators are not included in the exception analysis because for definitional reasons as they are not comparable to other indicators. The format of the release focuses on services delivered rather than on the number of points achieved, although data based on 'points' is still published in the 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.

2014-15 Key results

- The disease register with the highest prevalence rate was hypertension (15.6 per cent).
- Amongst the 459 Welsh GP practices, the average total point achieved was 649.0 (97.0 per cent of the maximum 669 points available). 58 (12.6 per cent) practices achieved the maximum 669 points and 11 practices (2.4 per cent) achieved fewer than 550.0 points.
- Amongst Welsh GP practices the average points achieved for the clinical domain was 376.1 (96.7 per cent of the maximum 389 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-cic.org.uk/search/site/QOF%20dates%20and%20business%20rules

Guidance for the QOF in Wales can be found at:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=73976

The QOF is about resourcing and then rewarding good practice. The QOF measures achievement against 86 indicators. Practices score points on the basis of achievement against each indicator, up to a maximum of 669 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.

Since 2013 changes to the GMS contract for Wales have been negotiated annually by Welsh Government, NHS Wales, and the General Practitioners Committee Wales (GPC Wales) of the British Medical Association. This reflects an increasing divergence in GMS strategic priorities across the devolved administrations. Changes to the 2014-15 GMS contract included the removal of 300 points through the retirement of indicators and the extension of reporting indicators. The Quality and Productivity domain was replaced with a new GP Cluster Network Development (CND) domain, and the Organisation domain has been replaced with a new Medicine Management domain. The Patient Experience domain was retired. Further information can be found in the Key Quality Information section.

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 four main components, known as domains. The four domains in 2014-15 are: Clinical Domain, Public Health Domain, Medicine Management Domain, and Cluster Network Development 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**: 67 indicators in 17 areas (Atrial Fibrillation, Coronary Heart Disease, Heart Failure, Hypertension, Stroke and Transient Ischaemic Attack, Diabetes Mellitus, Asthma, Chronic Obstructive Pulmonary Disease, Dementia, Depression, Mental Health, Cancer, Epilepsy, Learning Difficulties, Osteoporosis, Rheumatoid Arthritis, Palliative Care. Indicators in the clinical domain are worth up to a maximum of 389 points (58.1 per cent of the total).

- **Public Health domain**: 8 indicators in 5 areas (Cardiovascular disease, Blood pressure, Obesity, Smoking, Cervical Screening). Indicators in the Public Health domain are worth a maximum of 102 points (15.2 per cent).

- **Cluster Network Development**: 8 indicators in 1 area, worth up to 160 points (23.9 per cent of the total).

- **Medicine Management**: 3 indicators in 1 area. Indicators in the Medicine Management domain are worth up to 18 points (2.7 per cent of the total).

Data is presented in the following order:

- Recorded prevalence (patients on disease registers)
- Total and domain level achievement
- Public health indicators
- Clinical indicators
- Medicine management indicators
- QOF Exceptions
- Local Health Board variations
- Cluster Network Development 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 are presented throughout the release to illustrate some of the key statistics.

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.

Prevalence rates in Table 1 have been defined as a percentage of patients on a practice list:

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

Prevalence rates for the seven age specific disease registers are underestimated when applied to the whole population as what has been done in previous years. Therefore an alternative calculation, based on an estimated age-specific list size, has been used to derive more precise prevalence rates this year:

$$100 \times \frac{\text{Number of patients on disease register}}{\text{Estimated number of patients registered with a practice in Wales, of a specific age}}$$

Table 1: Reported Disease Prevalence Rates

Percentage (%)

Register	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Prevalence rate of all patients (a)									
Asthma	6.5	6.4	6.6	6.7	6.7	6.9	7.0	6.9	7.1
Atrial Fibrillation	1.6	1.6	1.7	1.7	1.7	1.8	1.8	1.9	2.0
Cancer	0.9	1.1	1.3	1.5	1.7	1.9	2.1	2.2	2.4
Cardiovascular Disease (PP)	-	-	-	0.6	1.2	1.6	2.2	2.7	3.6
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	2.2
Coronary Heart Disease	4.3	4.2	4.2	4.1	4.0	4.0	3.9	3.9	3.8
Dementia	0.4	0.4	0.5	0.5	0.5	0.5	0.6	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)	-	-	-	-	-	-	0.0	5.0	5.8
Diabetes Mellitus (e)	4.2	4.4	4.6	4.9	5.1	5.3	5.4	5.6	5.7
Epilepsy (f)	0.7	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	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	0.3
Hypertension	14.3	14.6	14.9	15.1	15.4	15.5	15.5	15.6	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	0.4
Mental Health	0.7	0.7	0.8	0.8	0.8	0.8	0.9	0.9	0.9
Obesity (i)	9.6	9.6	9.7	10.1	10.4	10.4	10.3	10.3	9.5
Osteoporosis (j)	-	-	-	-	-	-	0.1	0.2	0.2
Palliative Care	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3
Peripheral Arterial Disease	-	-	-	-	-	-	0.7	0.7	-
Rheumatoid arthritis (k)	-	-	-	-	-	-	-	0.7	0.7
Smoking register (patients with chronic conditions)	22.3	23.9	25.2	25.5	25.8	26.0	26.4	26.5	26.7
Smoking status register (patients aged 15 or over with recorded smoking status) (m)	-	-	-	-	-	-	83.7	83.7	83.7
Stroke and Ischaemic Attacks	2.0	2.0	2.0	2.0	2.1	2.1	2.0	2.0	2.0
Age –specific prevalence rates for specific disease registers (l)									
Chronic Kidney Disease (b)	2.9	3.6	3.9	4.2	4.3	4.3	4.5	4.6	-
Diabetes Mellitus (e)	5.3	5.5	5.7	6.0	6.3	6.5	6.7	6.9	7.1
Epilepsy (f)	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Learning Disabilities (h)	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	-
Obesity (i)	11.9	11.7	11.8	12.4	12.7	12.7	12.6	12.5	11.6
Osteoporosis (j)	-	-	-	-	-	-	0.2	0.4	0.5
Rheumatoid arthritis (k)	-	-	-	-	-	-	-	0.8	0.8

Source: CM Web

(a) The denominator relates to the total number of patients registered with a practice in Wales, with no restriction for age.
(b) Chronic Kidney Disease register only includes patients aged 18 years and over. This register was retired in 2014-15.
(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.

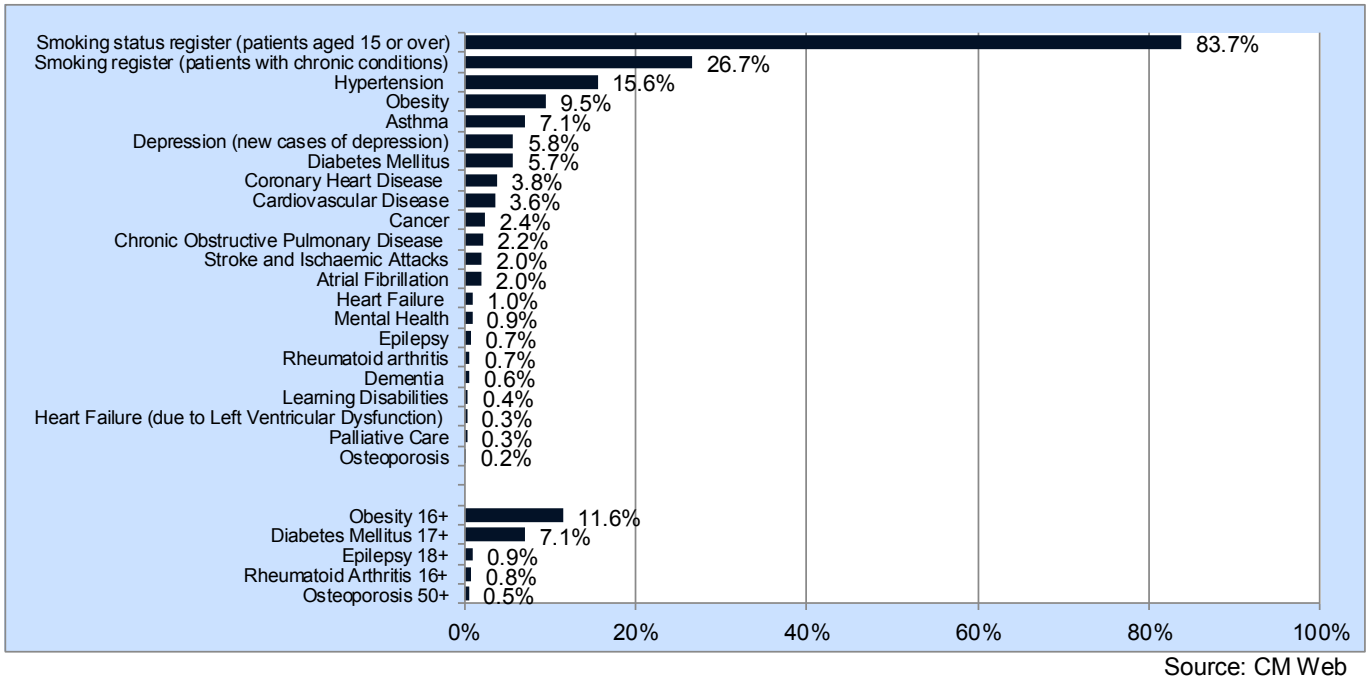
(d) The Depression register for 2013-14 includes patients aged 18 and over diagnosed with depression in the preceding 1 April to 31 March.
(e) Diabetes register only includes patients aged 17 and over.
(f) Epilepsy register only includes patients aged 18 years and over.
(g) HF LVD: Note that the rules for patients being recorded on this register changed substantially between 2012-13 and 2013-14.
(h) The Learning Disability register includes patients of all ages in 2014-15. Prior to 2014-15, the register only included 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) Rheumatoid Arthritis only includes patients aged 16 and over.
(l) These registers are age-specific. The calculation of the denominator has been derived by:
1. Dividing the population of Wales, of a specific age, by the total population of Wales, using ONS population estimates ;
2. Applying the proportion calculated in '1' to the practice list size.
'-' No data exists for this time period.

From 2006-07 the hypertension register has recorded the largest number of patients on a single disease register; in 2014-15 more than 498,500 or nearly 16 per cent of all patients were registered. Other large registers of chronic conditions include 183,300 (rounded to the nearest hundred) patients aged 17 or over with diabetes, 227,100 patients of any age with asthma, 121,400 patients of any age with Coronary Heart Disease and 69,400 with Chronic Obstructive Pulmonary Disease (COPD).

QOF also provides some key public health registers: 303,600 people aged 16 or over with a BMI of 30 or over were recorded on the Obesity disease register. Note that the Welsh Health Survey shows considerably higher rates of obesity than QOF for Wales. 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 recorded whether patients aged 50 and over had their blood pressure checked at some point during the last 5 years, and whether patients aged 15 and over were recorded as smokers or non smokers.

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://gov.wales/docs/statistics/2012/120822healthconditionsen.pdf

Chart 1: Reported disease prevalence rates of all patients, and of age-specific patients, 2014-15



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.

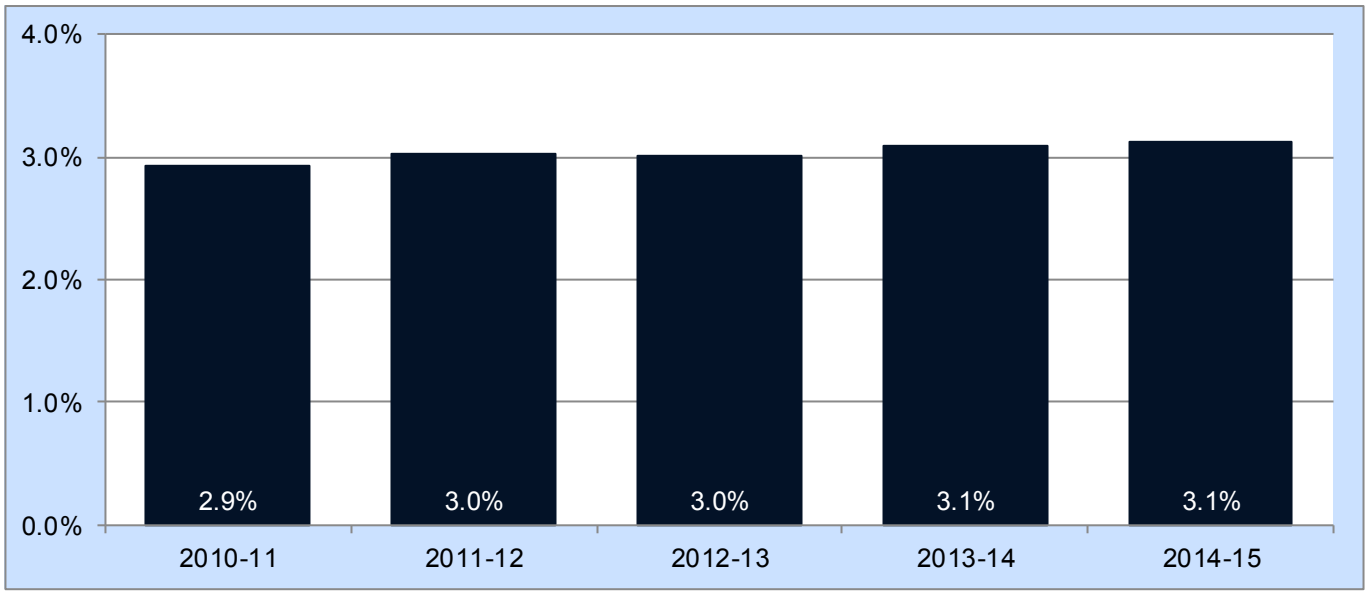
The Chronic Kidney Disease, Hypothyroidism and Peripheral Arterial Disease registers were retired in 2014-15.

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

4. Dementia Register

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

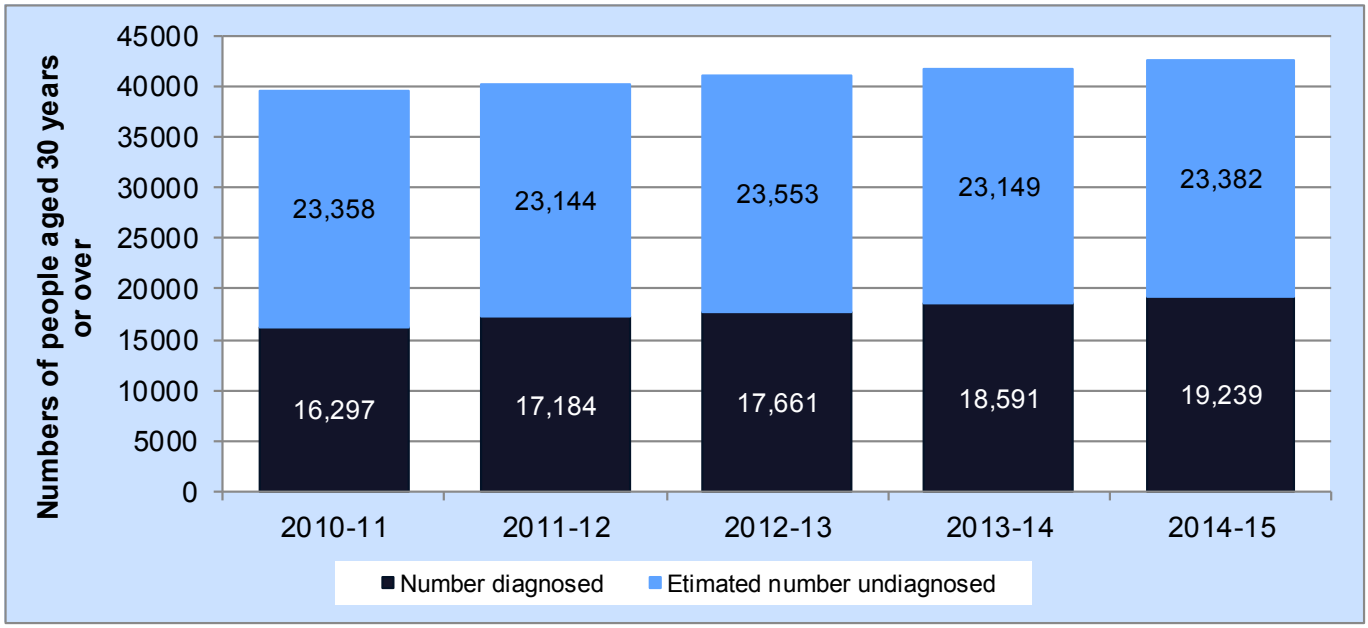


Source: CM Web

Although the Dementia disease register includes patients of all ages, in practice the majority are aged 65 or over. The Dementia UK figures imply that only 2 per cent of people with dementia in Wales were under the age of 65 years.

Chart 3 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 same as in 2013-14. 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.

Chart 3: Number of people diagnosed and estimated number undiagnosed with dementia [(a)]



Source: CM Web; Dementia UK

(a) 'Diagnosed' is the patients recorded on the QOF disease register; 'diagnosed' plus 'undiagnosed' together is estimated from prevalence rates for people aged 30 or over as calculated in Dementia UK, Alzheimer's Society (2007). For more information see Notes.

A report published by the Alzheimer's Society in 2007 presented estimated age and sex specific prevalence for dementia in people aged 30 years or over for the UK. The prevalence's, which relate to 2005, have been applied to population estimates for Wales, to calculate estimates of the numbers of people with dementia in each of the years shown in the Chart 2. The people recorded on the QOF Dementia disease register can be thought of as those who have been diagnosed, leaving the remainder as those who have the disease, but are undiagnosed.

It is estimated that in 2014-15 there were 42,600 people aged 30 or over in Wales who had dementia, an increase from 39,700 in 2010-11 and the 36,500 as estimated in the Dementia UK report for 2005. In 2014-15 just over 19,200 people were recorded on GP registers for dementia and approximately 23,400 people with dementia remained undiagnosed. In 2010-11 it is estimated that around 41 per cent of all people with dementia were diagnosed, rising gradually to 45 per cent in 2014-15.

Alternative age-specific prevalence rates for dementia are available but those published in the 2007 Dementia Report have been used as they produce a mid-range estimate.

5. Total and domain level achievement

Map 1 shows the location of each GP practice in Wales together with the 'median total points,' which is obtained by ordering all the practices of a LHB by points and then selecting the middle value. Hence the shading of the map below does not reflect the total points of the individual practices.

Within Local Health Boards the median total points were all between 657.5 (Betsi Cadwaladr) and 665.5 (Cwm Taf University). The 'median total points' achieved by practices in Wales was 661.3.

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

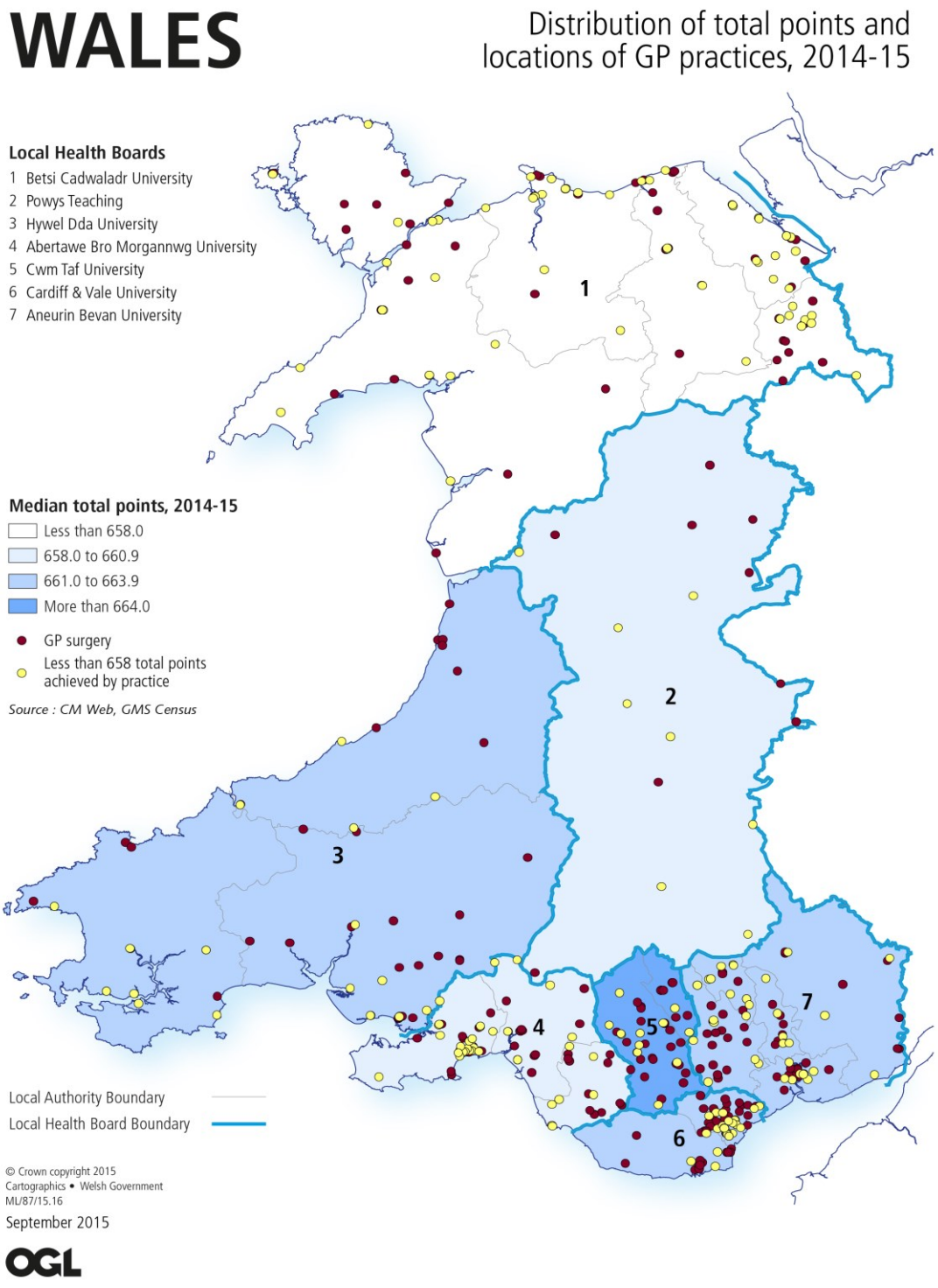
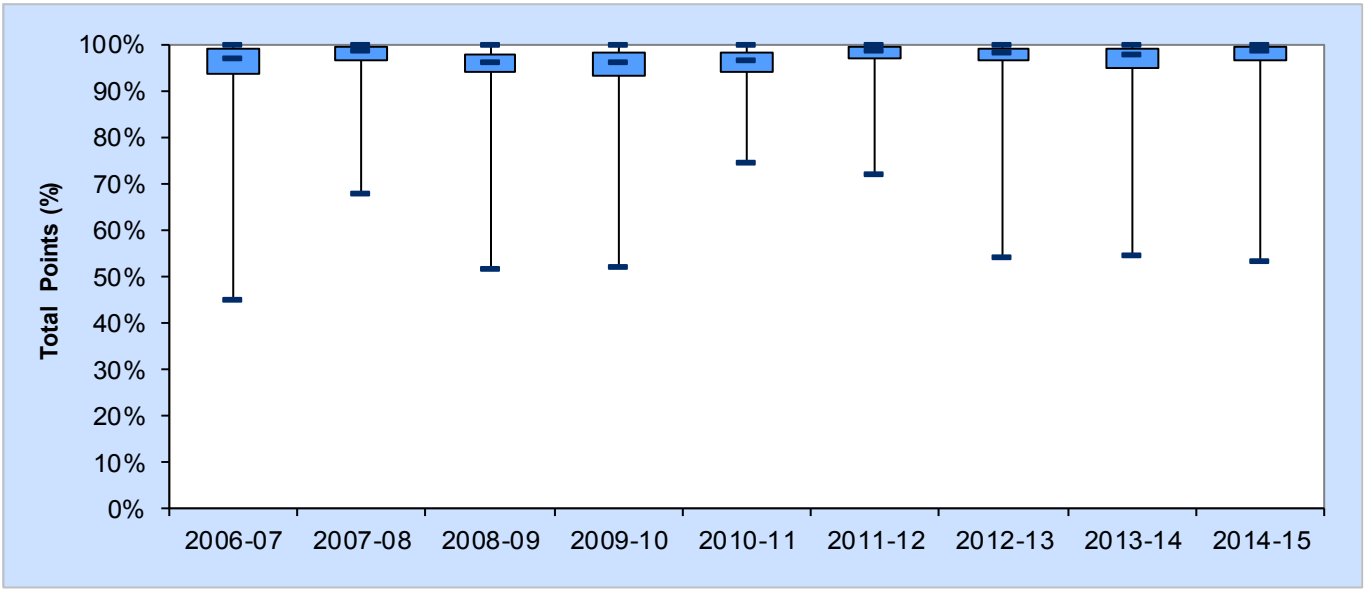


Chart 4: Historical achievement, total points



Source: CM Web

Chart 4 shows that for the last 9 years at least one practice has achieved 100 per cent achievement. 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).

5.1 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

	2012-13			2013-14			2014-15		
		Average points achieved by practices			Average points achieved by practices			Average points achieved by practices	
Domain	Points Available	Points	Proportion	Points Available	Points	Proportion	Points Available	Points	Proportion
Clinical	669.0	647.1	96.7%	604.0	577.5	95.6%	389.0	376.1	96.7%
Public Health (a)	.	.	.	157.0	151.4	96.5%	102.0	98.4	96.5%
Cluster Network Development (b)	.	.	.	.	.	.	160.0	156.8	98.0%
Medicines Management(b)	.	.	.	.	.	.	18.0	17.7	98.3%
Organisational	254.0	247.2	97.3%	59.0	57.8	97.9%	.	.	.
Patient Experience	33.0	32.8	99.4%	33.0	32.5	98.5%	.	.	.
Quality and Productivity (c)	.	.	.	116.0	109.6	94.5%	.	.	.
Additional Service (d)	44.0	42.7	97.1%	.	.	.	.	.	.
All domains	**1000.0**	**927.1**	**92.7%**	**969.0**	**928.9**	**95.9%**	**669.0**	**649.0**	**97.0%**

Source: CM Web

(a) New domain from 2013-14.
(b) New domains from 2014-15.
(c) The 'Quality and Productivity' indicators were previously included in the Organisational domain.
(d) 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 649.0 (97.0 per cent of the maximum 669 points available). 58 (12.6 per cent) practices achieved the maximum 669 points and 11 practices (2.4 per cent) achieved fewer than 550.0 points.

The average points achieved, for the clinical domain, was 376.1 (96.7 per cent of the maximum 389 points available).

As Table 2 shows, there has been a reallocation of points between domains in 2014-15. Further miscellaneous changes can be found at:
http://www.brotaflmc.org.uk/ESW/Files/GMS_contract_changes_2014-15_FAQ.doc

5.2 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

$$\text{Underlying Achievement} = 100 \times \frac{\text{Indicator Numerator}}{\text{Indicator Denominator}}$$

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

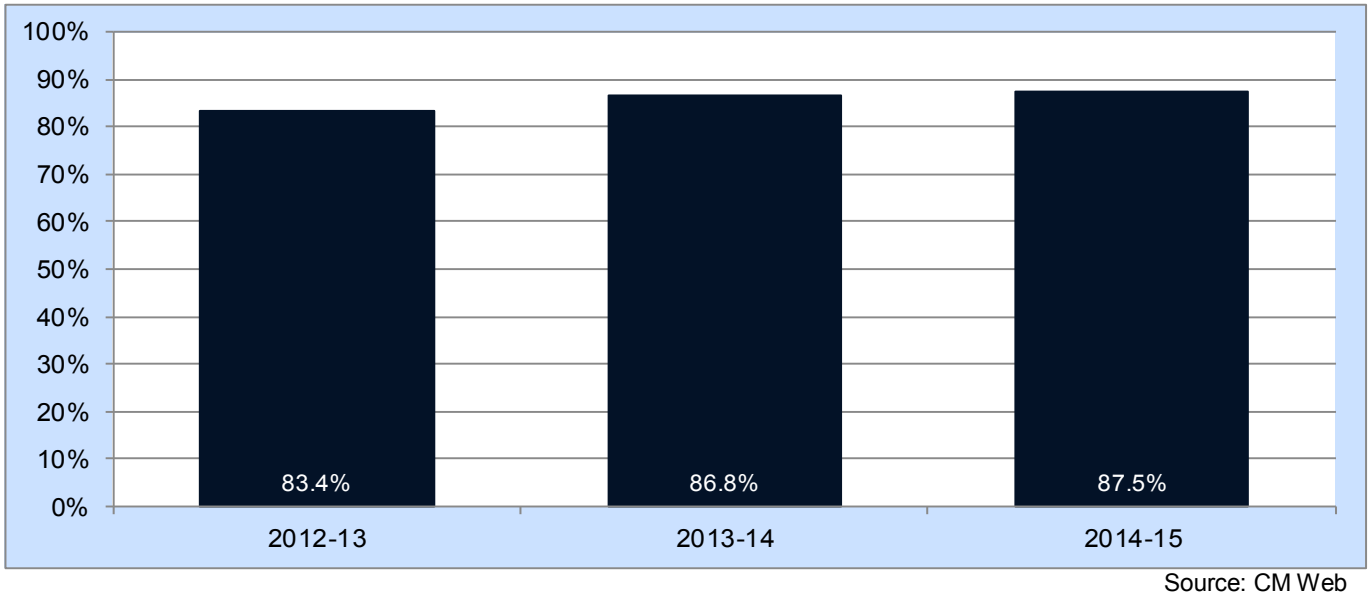
6. Public health domain

In 2013-14, a number of existing indicators were re-classified as public health indicators; as a group these are about prevention such as SMOK004.

Description	Indicator
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.	SMOK004

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 5: 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, 2012-13 to 2014-15



Source: CM Web

During 2014-15, 87.5 per cent of patients aged 15 and over who smoked in Wales were offered support and treatment, a slight increase when compared to 2013-14.

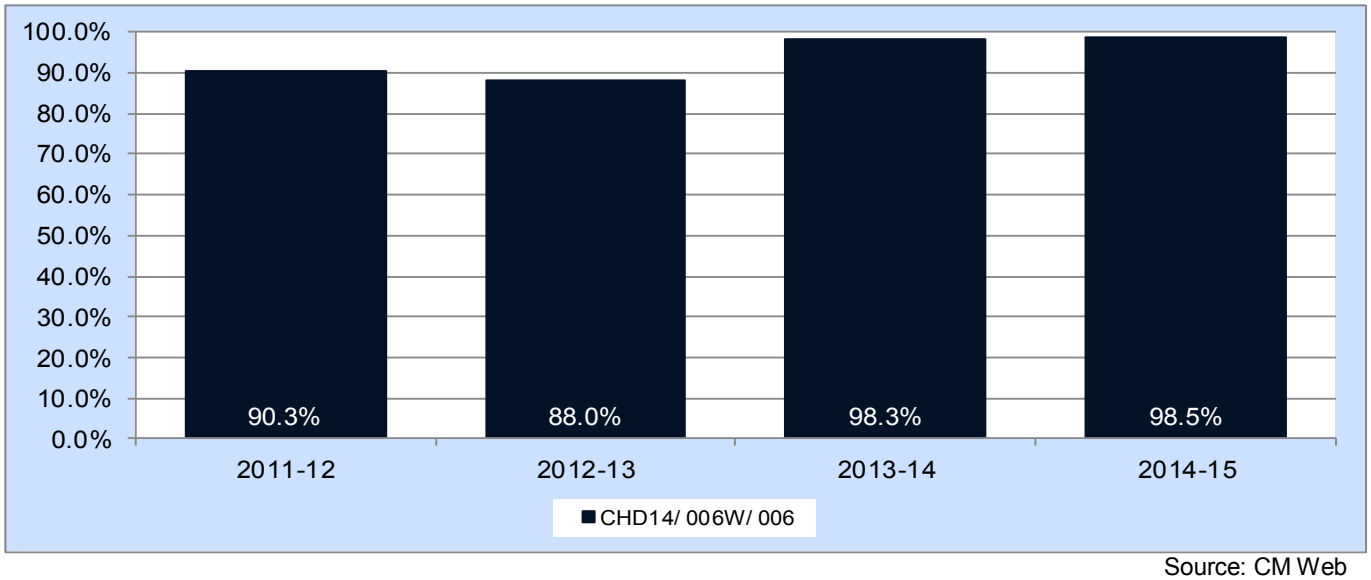
Cardiovascular disease

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, the main focus of QOF is to encourage shared decision making about lifelong treatment or behaviour change, as one illustration of the prudent approach to healthcare. Patients with a history of an acute myocardial infarction receiving treatment are monitored by the GP. This approach is termed secondary prevention and outcomes can be achieved through lifestyle advice and the use of drug therapy.

Description	Indicator
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.	CHD006

Chart 6: 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



Source: CM Web

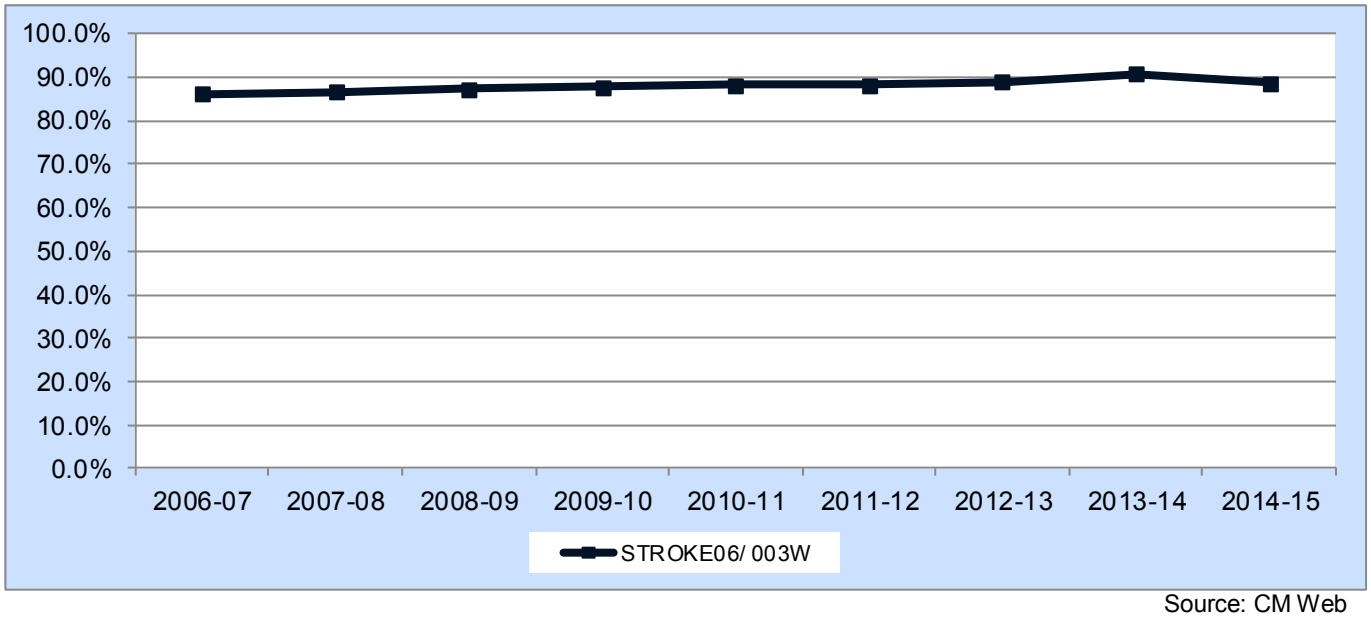
In the most recent year, 98.5 per cent of patients on the coronary heart disease register, had a history of myocardial infarction, which has been treated with an ACE-I, aspirin or an alternative anti-platelet therapy, beta-blocker or statin. This is similar to the percentage seen in 2013-14.

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 by having indicators such as STIA003W in place to reduce risk of first stroke or recurrence.

Description	Indicator
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.	STIA003W

Chart 7: 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

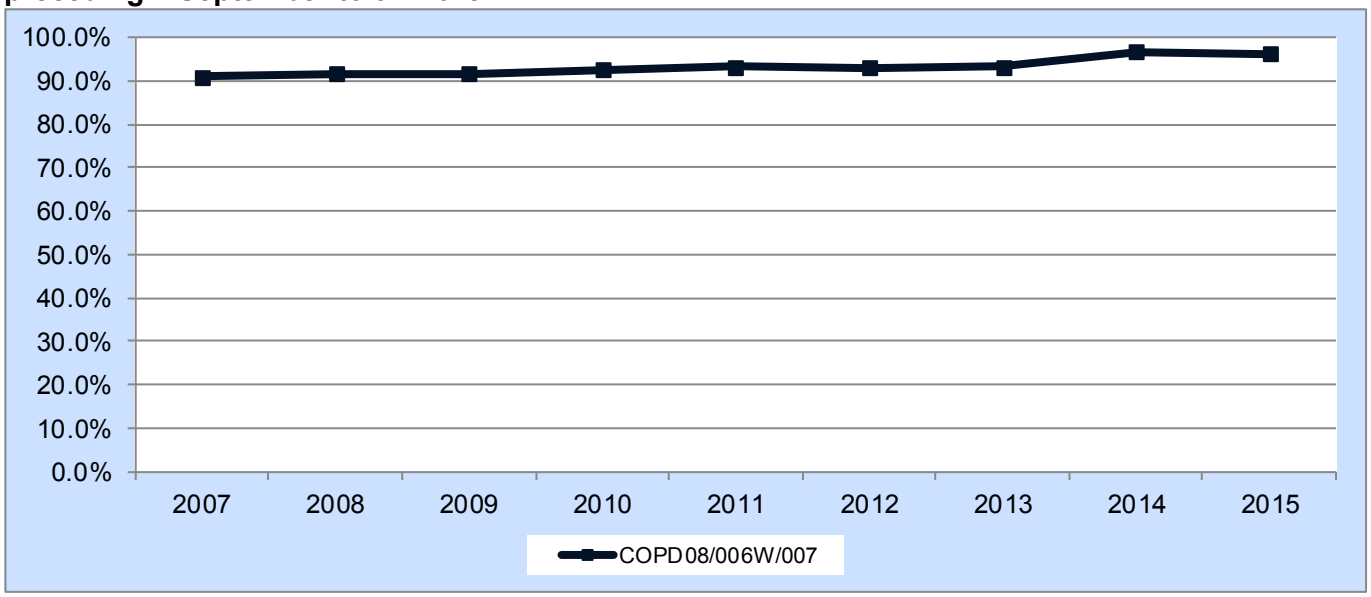
In the most recent year over 54,900 patients, 88.7 per cent of patients on the stroke and transient ischaemic attack register, had a blood pressure measurement of 150/90 mmHG or less, a decrease of 515 patients and 2.1 percentage points when compared to 2013-14.

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
The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.	COPD007

Chart 8: Percentage of patients with COPD who have had an influenza immunisation in the preceding 1 September to 31 March [(a)]



Source: CM Web

(a) Prior to 2015, the indictor was measured in the preceding 1 September to 31 March; however for 2015 it was measured from 1 August to 31 March.

In the most recent year just over 53,900 patients, 96.2 per cent of patients on the chronic obstructive pulmonary disease register, had received an influenza immunisation in the preceding 1 August to 31 March.

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.

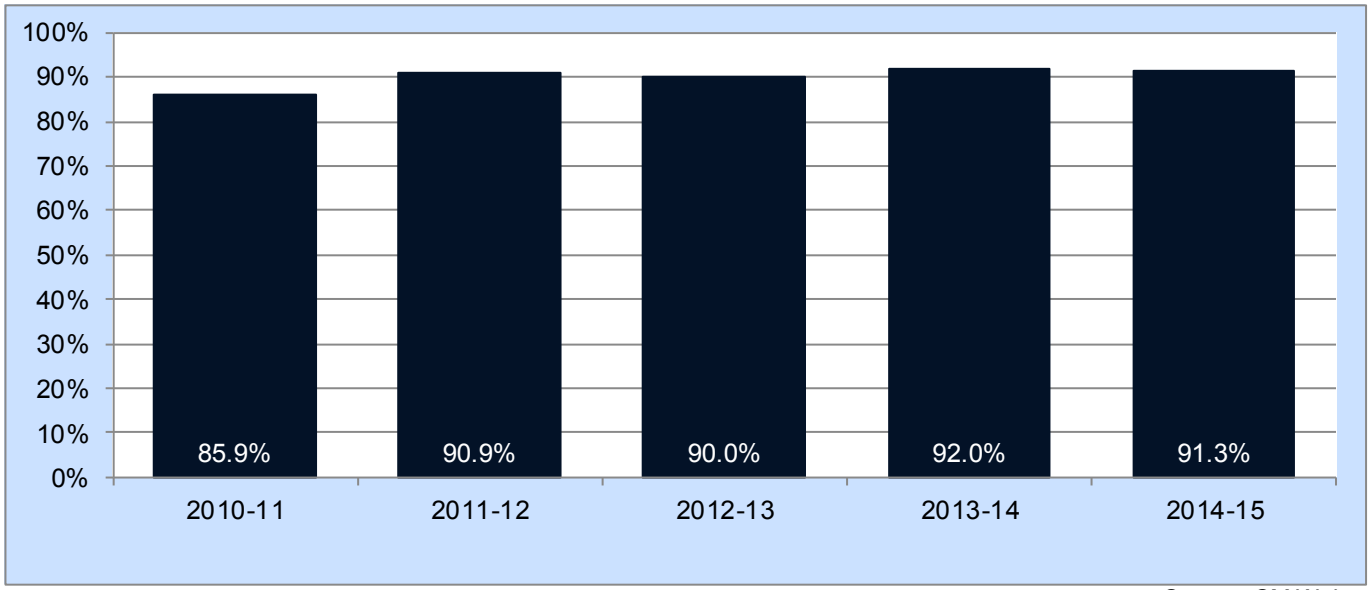
The QOF indicators, such as PC002W, support practices to identify patients in need of palliative care and to ensure that regular reviews of care are undertaken by the multi disciplinary team.

Description	Indicator
The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.	PC002W

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, as illustrated in Chart 9. 419 (91.3 per cent) of the practices in 2014-15 held these review meetings.

This indicator (TR060) is included as a Programme for Government indicator. See Appendix 3 for further details.

Chart 9: Percentage of GP practices holding review meetings, discussing their palliative care register patients, at least every 3 months[(a)]



Source: CM Web

(a) Previously to 2014-2015 multi-disciplinary case review meetings were discussed at least every 3 months, now they are discussed at least every 2 months.

7. Medicine Management

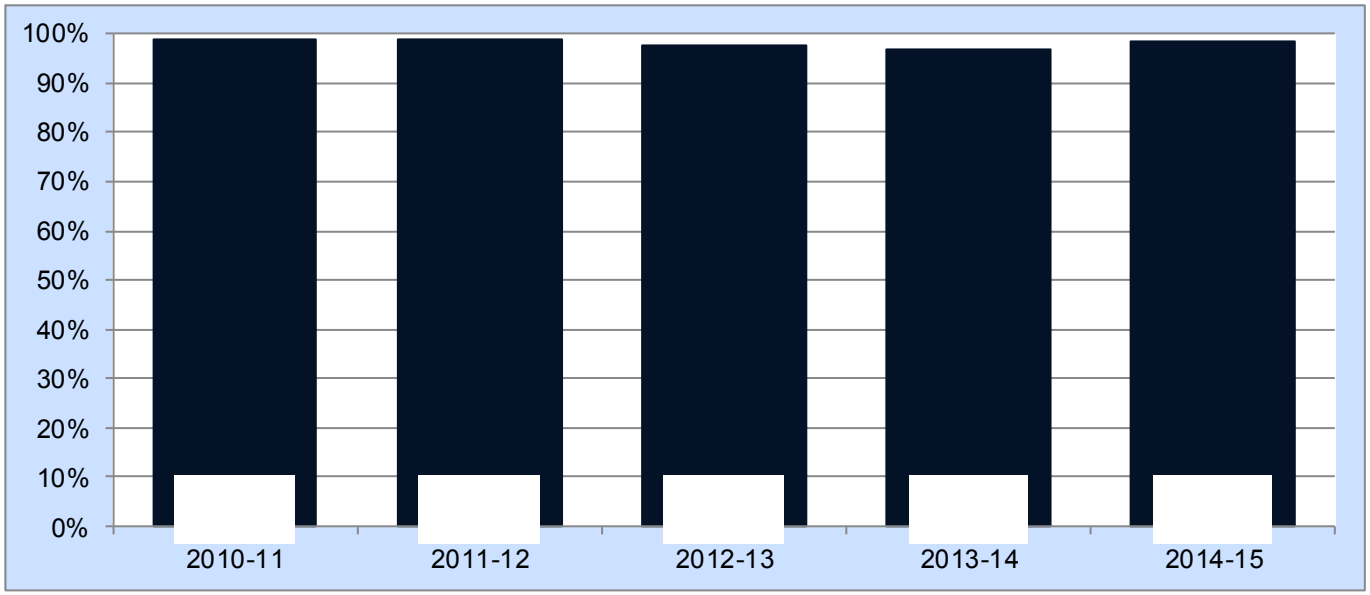
The quality and safety of clinical care is highly dependent upon the systems that support clinical practice. As prescribing levels increase, it is important that appropriate safeguards are developed to ensure regular reviews of care to minimise risk and harms.

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 to minimise risk are essential actions to ensure patient safety as well as improved health outcomes and patient satisfaction.

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

Chart 10: Percentage of GP practices in which a medication review takes place for all patients being prescribed four or more repeat medicines



Source: CM Web

After this indicator was introduced into QOF in 2010-11, there was a slight decrease in the proportion of GP practices holding medical reviews for these patients. However in 2014-15, the proportion increased for the first time in comparison to the previous year. 451 (98.3 per cent) practices in 2014-15 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 spreadsheets on the Welsh Government website. 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 and public health 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 and palliative care indicators. See the Notes section 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:

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

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:

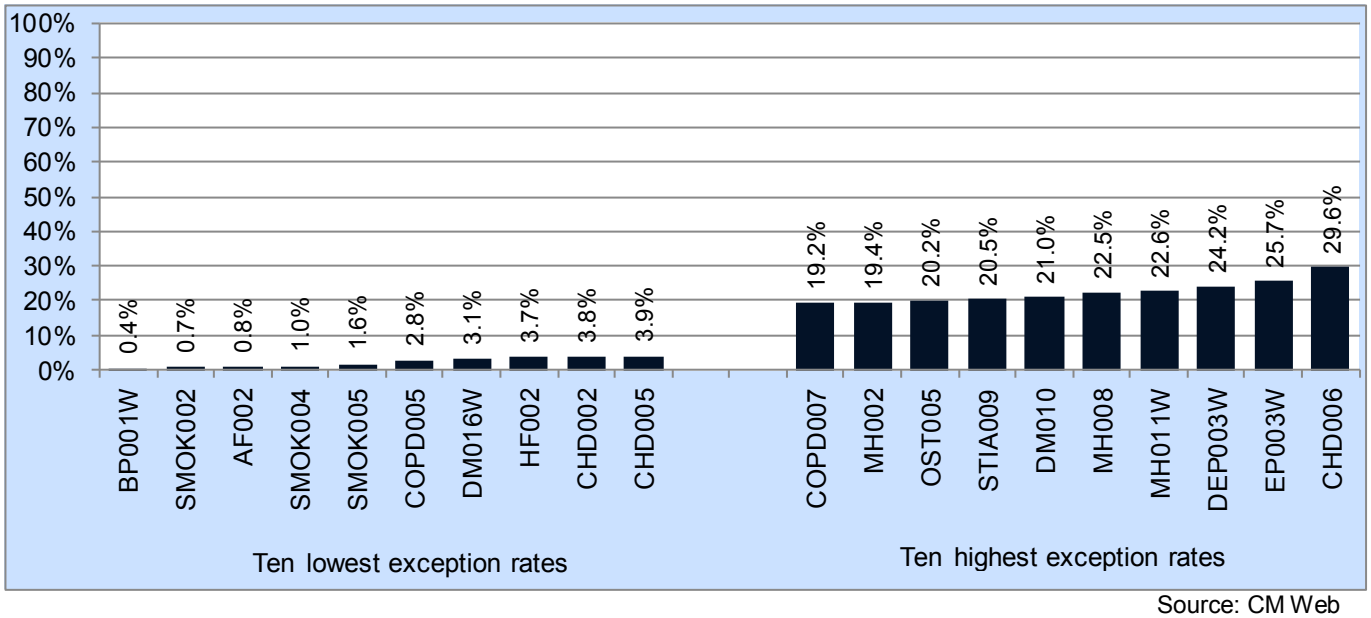
Patients who are on the disease register, but not included in the indicator denominator for definitional reasons, are referred to here as exclusions. An example of exclusion is where for heart failure only a small proportion of the patients (new diagnoses) on the heart failure register are relevant to indicator HF002.

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

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

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

Chart 11: 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 11 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 CHD006 at 29.6 per cent and the lowest exception rate was for BP001W at 0.4 per cent. Note that for some indicators these rates may be based on small numbers.

10. Health Board variations

Prevalence – Health Boards

Table 3 shows the percentages of patients recorded on the disease registers in 2014-15 by local health board. Variation in prevalence rates would be expected given that ill health, age structures, and 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 Local Health Board

Percentage (%)

Register	Betsi Cadwaladr University	Powys Teaching	Hywel Dda University	Abertawe Bro Morgannwg University	Cwm Taf University	Cardiff & Vale University	Aneurin Bevan University	Wales
Prevalence of patients on the practice list (a)								
Asthma	7.3	7.1	6.9	7.5	6.7	6.7	7.1	7.1
Atrial Fibrillation	2.1	2.2	2.4	2.0	1.8	1.5	1.8	2.0
Cancer	2.7	2.9	2.8	2.4	2.1	2.0	2.3	2.4
Cardiovascular Disease (PP)	4.1	3.8	3.4	3.3	3.5	2.9	3.8	3.6
Chronic Obstructive Pulmonary Disease	2.5	2.2	2.1	2.1	2.6	1.5	2.1	2.2
Coronary Heart Disease	4.0	4.1	4.1	3.9	3.8	2.8	3.9	3.8
Dementia	0.7	0.7	0.6	0.6	0.5	0.5	0.6	0.6
Depression (new cases of depression) (b)	6.0	5.6	4.0	5.5	5.1	6.3	6.7	5.8
Diabetes Mellitus (c)	5.5	5.9	6.0	6.0	6.0	4.6	6.3	5.7
Epilepsy (d)	0.7	0.7	0.8	0.8	0.9	0.6	0.8	0.7
Heart Failure	1.1	1.2	1.0	1.0	0.9	0.8	0.9	1.0
Heart Failure (due to Left Ventricular Dysfunction) (e	0.3	0.2	0.3	0.3	0.2	0.2	0.2	0.3
Hypertension	16.4	17.3	16.2	15.2	16.8	12.4	16.2	15.6
Learning Disabilities (f)	0.5	0.4	0.5	0.4	0.4	0.4	0.5	0.4
Mental Health	0.8	0.9	0.9	1.0	0.9	0.8	0.9	0.9
Obesity (g)	8.7	9.6	9.7	9.1	11.5	7.4	11.3	9.5
Osteoporosis (h)	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.2
Palliative Care	0.3	0.4	0.3	0.2	0.2	0.2	0.4	0.3
Rheumatoid arthritis (i)	0.7	0.8	0.9	0.6	0.7	0.5	0.7	0.7
Smoking register (patients with chronic conditions)	27.8	28.6	27.6	27.2	27.3	22.2	27.2	26.7
Smoking status register (patients aged 15 or over)	83.9	85.2	84.7	83.9	83.1	83.2	83.2	83.7
Stroke and Ischaemic Attacks	2.0	2.4	2.2	2.2	2.0	1.6	2.0	2.0
Age –specific prevalence rates for specific disease registers (j)								
Diabetes Mellitus (c)	6.8	7.1	7.3	7.4	7.4	5.7	7.9	7.1
Epilepsy (d)	0.9	0.8	1.0	1.0	1.1	0.8	1.0	0.9
Obesity (g)	10.6	11.6	11.7	11.1	14.1	9.1	13.8	11.6
Osteoporosis (h)	0.6	0.5	0.5	0.5	0.4	0.5	0.4	0.5
Rheumatoid arthritis (i)	0.8	1.0	1.0	0.8	0.8	0.6	0.8	0.8

Source: CM Web

(a) The denominator relates to the total number of patients registered with a practice in each LHB, with no restriction for age.
(b) The Depression register for 2013-14 includes patients aged 18 and over diagnosed with depression in the preceding 1 April to 31 March.
(c) Diabetes register only includes patients aged 17 and over.
(d) Epilepsy register only includes patients aged 18 years and over.
(e) HF LVD: Note that the rules for patients being recorded on this register changed substantially between 2012-13 and 2013-14.
(f) The Learning Disability register includes patients of all ages in 2014-15. Prior to 2014-15, the register only includes patients aged 18 years and over.
(g) Obesity register only includes patients aged 16 and over.
(h) Osteoporosis register only includes patients aged 50 and over.
(i) Rheumatoid Arthritis only includes patients aged 16 and over.
(j) These registers are age-specific. The calculation of the denominator has been derived by:
1. Dividing the population of each LHB, of a specific age, by the total LHB population, using ONS population estimates ;
2. Applying the proportion calculated in '1' to the LHB practice list sizes.

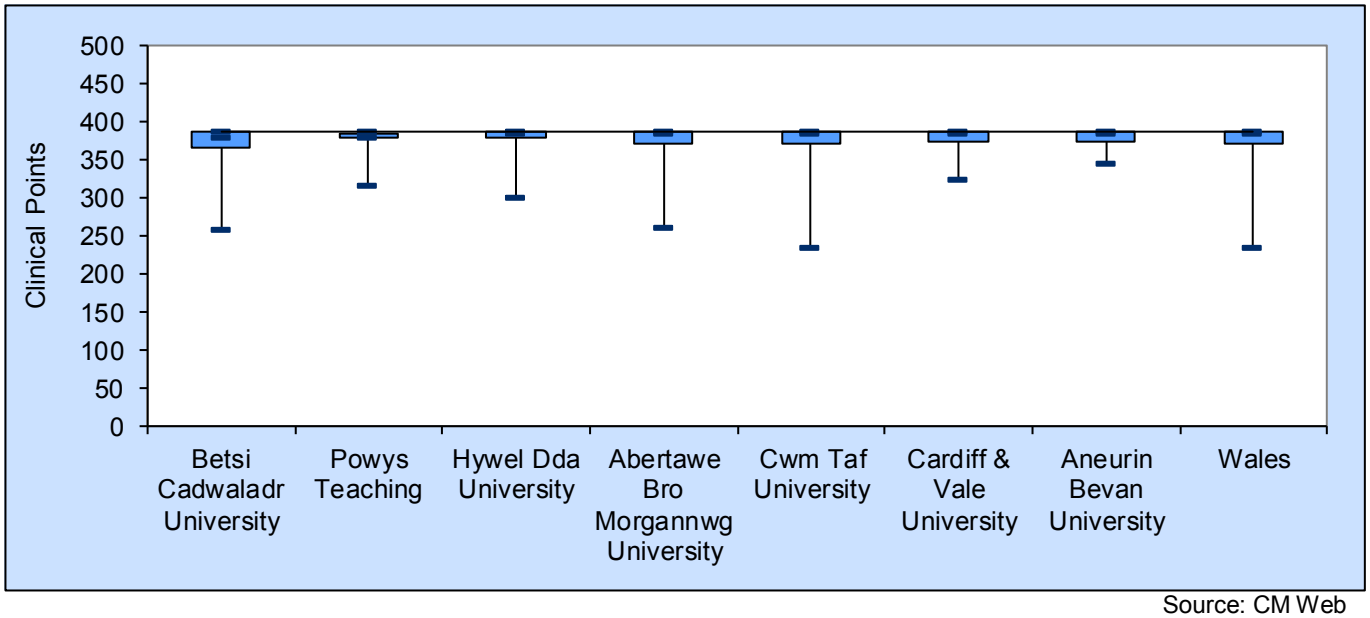
'-' No data exists for this time period.

The highest prevalence rate in relation to the hypertension register was recorded for Powys Teaching Health Board (17.3 per cent), Abertawe Bro Morgannwg (7.5 per cent) for the asthma register, and Cwm Taf University (11.5 per cent) for the obesity register.

For further information, refer to the 'Data summary for Wales and local health boards, 2014-15' spreadsheet on the website: http://gov.wales/statistics-and-research/general-medical-services-contract/?lang=en#/statistics-and-research/general-medical-services-contract/?lang=en

Clinical domain by Local Health Boards

Chart 12: Distribution of clinical points achieved by practices



Source: CM Web

The maximum point available for the clinical domain, in 2014-15, was 389 points. 81 (17.6 per cent) practices achieved the maximum 389 points. The line in chart 12 represents the maximum 389 points. Within Health Boards the median (middle value) clinical points were all between 379.5 (Powys Teaching) and 386.0 (Cwm Taf University).

Refer to the 'Clinical data by practice, 2014-15' spreadsheet for further information, which is found at:http://gov.wales/statistics-and-research/general-medical-services-contract/?lang=en#/statistics-and-research/general-medical-services-contract/?lang=en

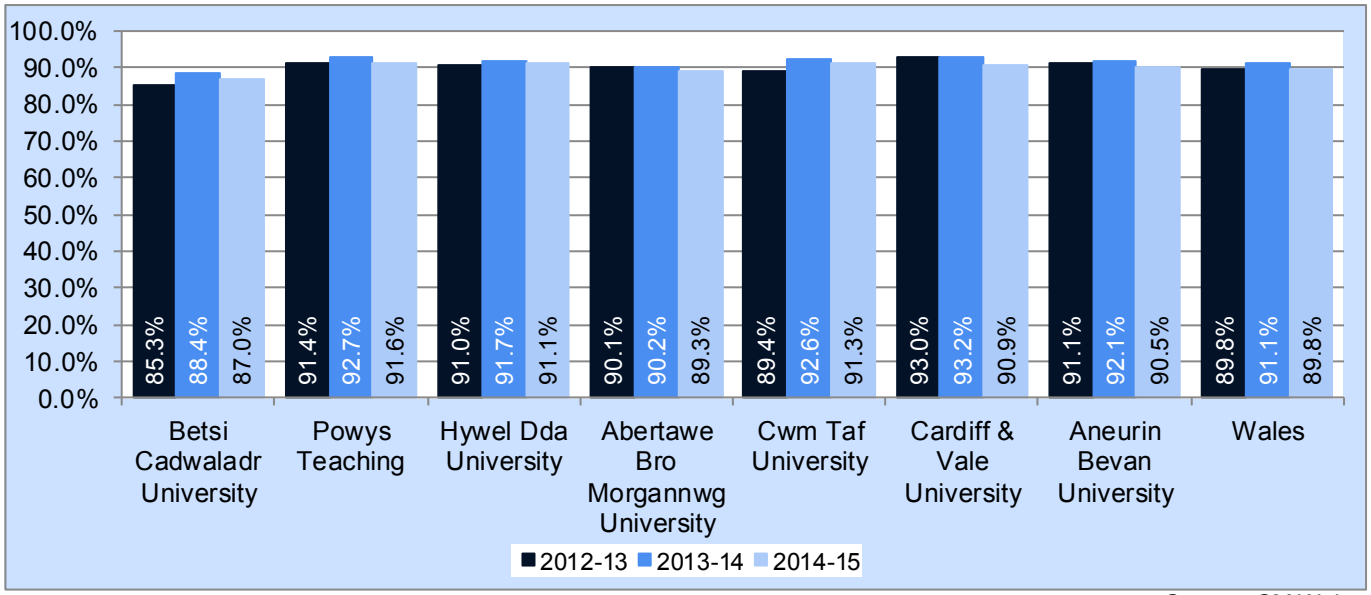
Diabetes

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 shows there was a decrease in the proportion of patients with diabetes with a record of foot examination in every health board in 2014-15, when compared to 2013-14. In 2014-15, Powys Teaching Health Board recorded the highest proportion, accounting for 91.6 per cent of patients with a record of a foot examination.

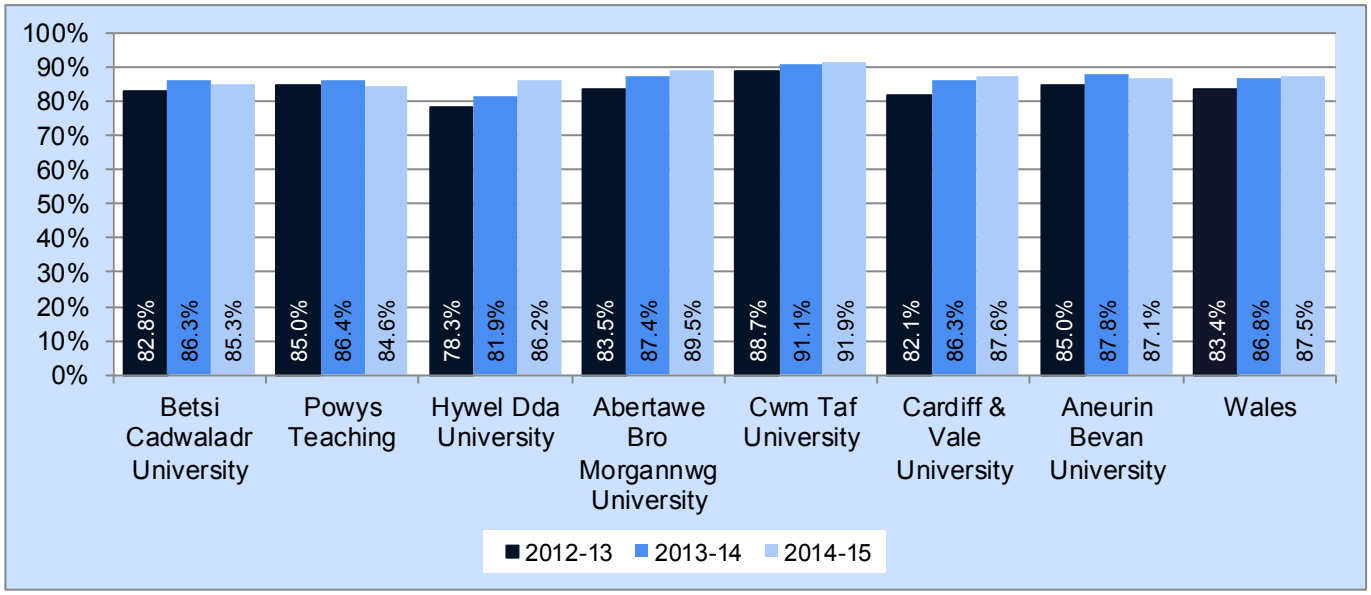
Chart 13: Percentage of patients with diabetes with a record of a foot examination by LHB



Source: CM Web

Public Health domain by Local Health Boards

Chart 14: 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, by Local Health Board



Source: CM Web

Four Health Boards saw a small increase in the proportion of patients offered support and treatment in relation to smoking in 2014-15, when compared to the previous year.

In 2014-15, 91.9 per cent of patients who were current smokers in Cwm Taf University were offered support and treatment to stop smoking, the highest in Wales. The lowest proportion was in Powys Teaching, where 84.6 per cent of current smokers were offered support.

11. Cluster Network Development Domain

A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board's area of operation.

The QOF Quality and Productivity domain has been replaced with a new GP Cluster Network Development Domain. This new QOF Domain, which attracts 160 points, forms part of a three year development programme to support practices to work collaboratively within Cluster Networks. The aim of this work is to improve the coordination of care, improve the integration of health and social care and improve collaborative working with local communities and networks to reduce inequalities in health. GP practices are required to agree Practice Development Plans and Cluster Network Action Plans, producing a Cluster Network Annual Report to summarise this work.

Practices also review patient care in three National Clinical Priority areas- covering the early detection of cancer, end of life care and prescribing for frail, elderly patients. These are complex areas of practice and the learning within practices and in Cluster networks will inform service improvement actions. As part of the new GP Cluster Network Development Domain, practices are also required to complete the Clinical Governance Practice Self Assessment tool (GGPSAT) which supports practices to reflect and assess the governance systems they have in place in order to facilitate safe and effective clinical practice.

Indicators in the GP Cluster Network Development Domain have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and where the points available are awarded in full if it is carried out or not at all if it is not carried out.

Description	Indicator
The contractor undertakes a review of local need and the provision of services within the practice, developing priorities for action to inform the production of a Practice Development Plan.	CND001W

Description	Indicator
The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the GP Cluster Network, including relevant issues identified within Practice Development Plan that can be most effectively addressed as a GP cluster network action. The contractor agrees the contents of a GP Cluster Network Action Plan to deliver against shared local objectives.	CND002W

Description	Indicator
The contractor participates in four GP cluster network meetings to review the implementation and delivery of the GP Cluster Network Action Plan.	CND003W

Description	Indicator
The contractor participates in one GP cluster network meeting to develop and agree a GP Cluster Network Annual Report.	CND004W

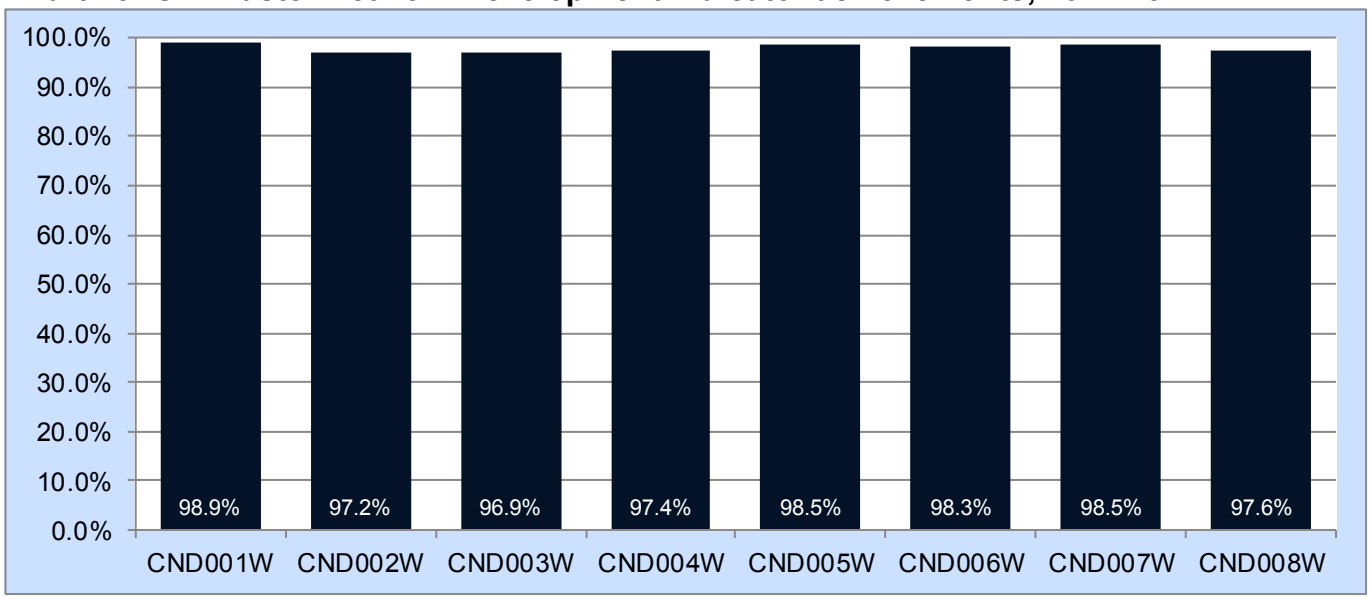
Description	Indicator
The contractor completes the Clinical Governance Practice Self Assessment Toolkit (CGPSAT).	CND005W

Description	Indicator
Understanding cancer care pathways and identifying opportunities for service improvement. The contractor will: 1. Review the care of all patients newly diagnosed between 1st January 2014 and 31st December 2014 with lung (including mesothelioma) or digestive system cancer using a Significant Event Analysis tool. 2. Summarise learning and actions to be shared with the network and the wider LHB. 3. Identify and include any relevant actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.	CND006W

Description	Indicator
Improving end of life care: identify all deaths 1 January to 31 December 2014, review to assess delivery at end of life and identify actions required. The contractor will: 1. Identify all deaths 170(up to a maximum of 5/ 1000 registered patients) occurring between 1st January 2014 and 31st December 2014. 2. Use the individual case review to assess delivery of end of life care. 3. Identify and include actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for review with the cluster network at the meetings and share information with the LHB as required.	CND007W

Description	Indicator
Minimising the harms of polypharmacy. The contractor will: 1. Identify and record number the % of patients aged 85 years or more receiving 6 or more medications. 2. Undertake face to face medication reviews, using the "No Tears" approach or similar tool as agreed within the cluster, for at least 60% of the cohort defined in 1 above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached). 3. Identify actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.	CND008W

Chart 15: GP Cluster Network Development indicator achievements, 2014-15



Source: CM Web

454 (98.9 per cent) practices produced an agreed practice development plan and shared it with their Health Board (CND001W), 446 (97.2 per cent) practices agreed to a GP cluster network action plan (CND002W) and 445 (96.9 per cent) practices participated in four GP cluster network meetings to review and implement and delivery of the GP cluster network action plan (CND003W).

447 (97.4 per cent) practices participated in a GP cluster meeting to develop and agree a GP cluster network annual report (CND004W) and 452 (98.5 per cent) practices completed the clinical governance practice self assessment toolkit (CND005W).

451 (98.3 per cent) practices reviewed the care of all patients newly diagnosed between 1 January 2014 and 31 December 2014 with lung (including mesothelioma) or digestive system cancer (CND006W), and 452 (98.5 per cent) practices identified all deaths between 1 January and 31 December 2014 and reviewed end of life care (CND007W). Also, 448 (97.6 per cent) practices identified and recorded the proportion of patients aged 85 or more receiving six or more medications (CND008W).

Chart 16: Cluster Hypertension prevalence rates, 2014-15

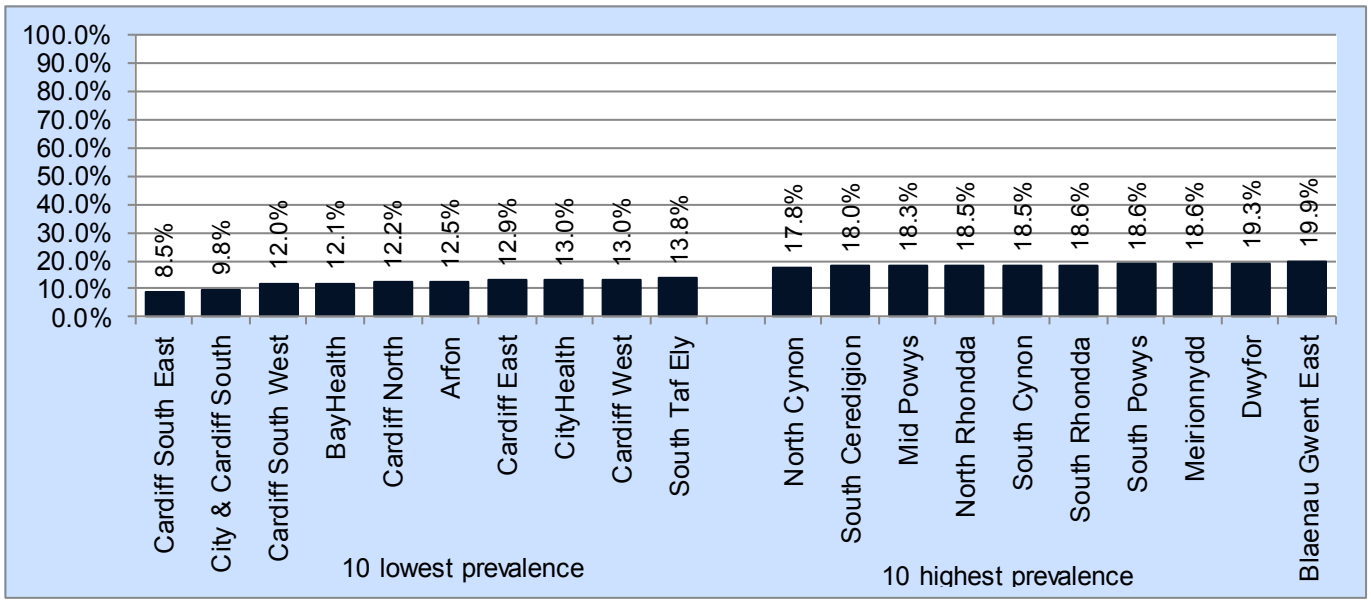


Chart 16 illustrates which clusters had the 10 highest and 10 lowest hypertension prevalence rates. The cluster with the highest prevalence rate was Blaenau Gwent East at 19.9 per cent and the cluster with the lowest prevalence rate was Cardiff South East at 8.5 per cent.

Chart 17: Cluster Chronic Obstructive Pulmonary Disease prevalence rates, 2014-15

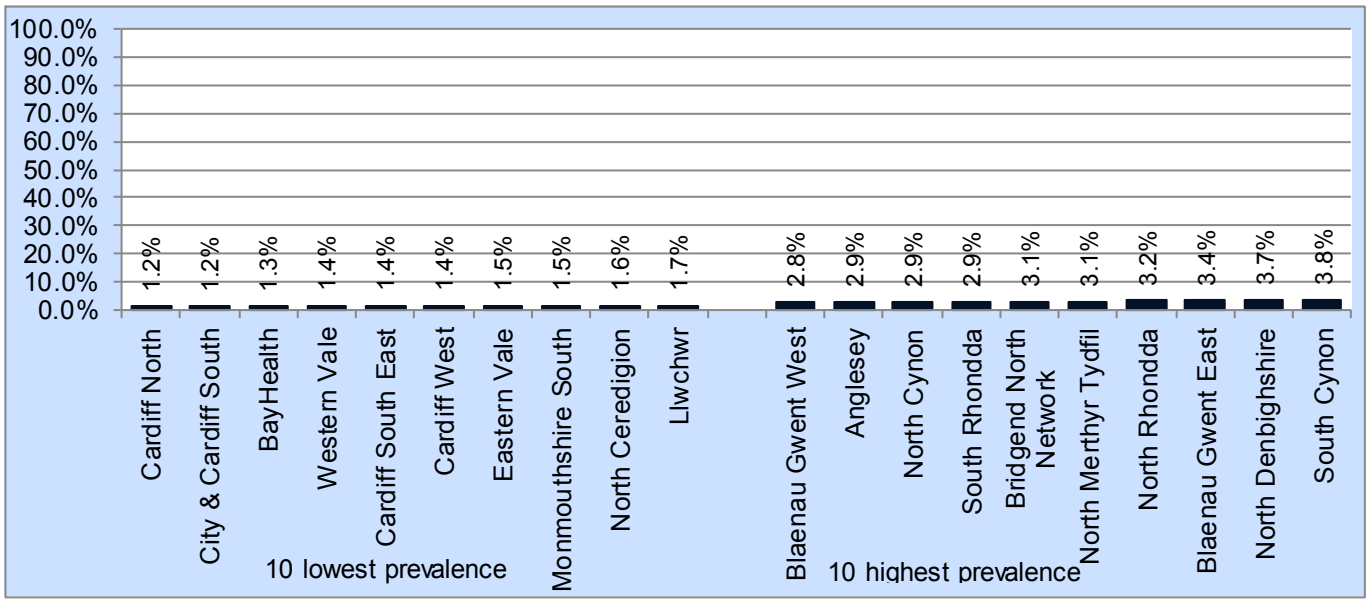
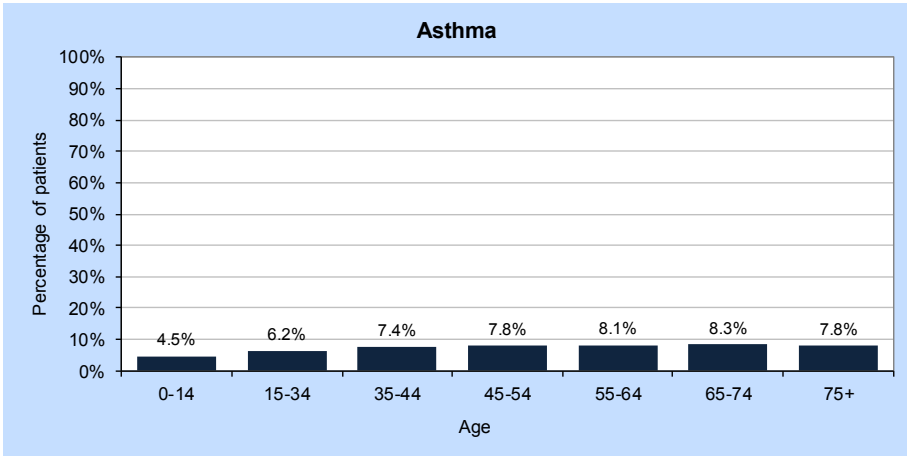


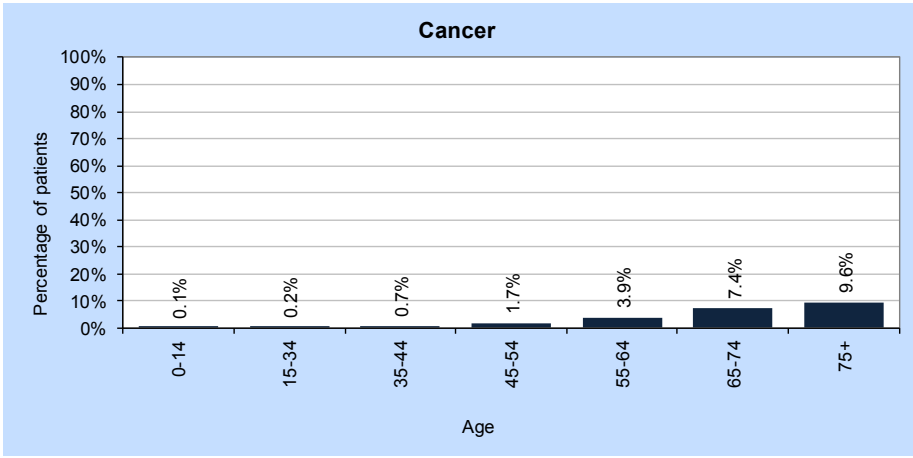
Chart 17 shows which clusters had the 10 highest and 10 lowest chronic obstructive pulmonary disease (COPD) prevalence rates. South Cynon had highest prevalence rate at 3.8 per cent and Cardiff North had the lowest prevalence rate at 1.2.

Charts 18: Disease Prevalence charts

The disease prevalence charts display the age-specific prevalence for each disease area, that is, the proportion of patients in each age group who are recorded on each disease register in Audit+. The data is at 31 March 2015 and is from 442 practices.



Source: Audit+



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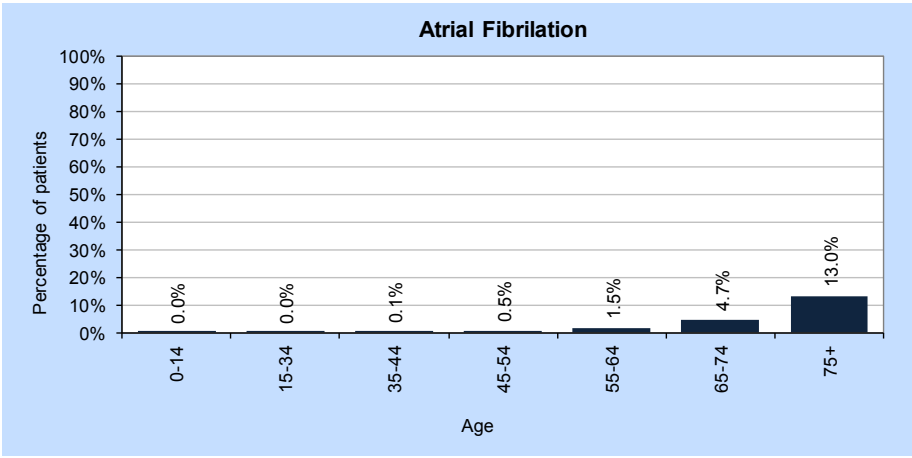

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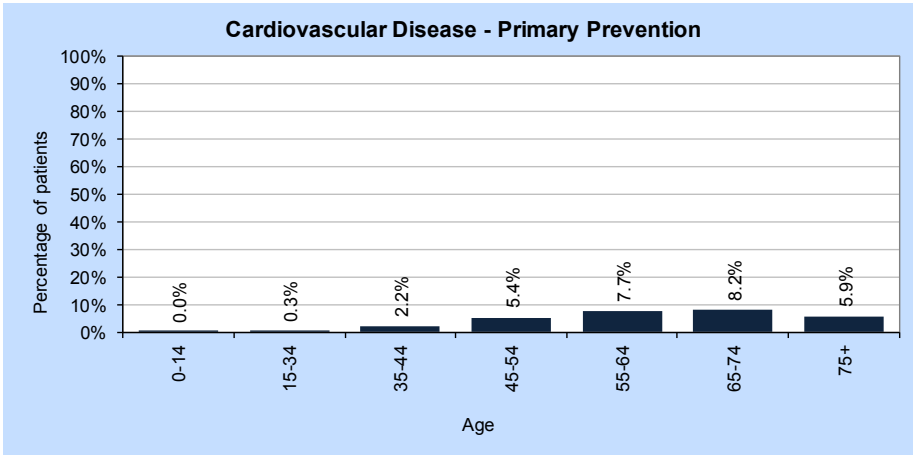

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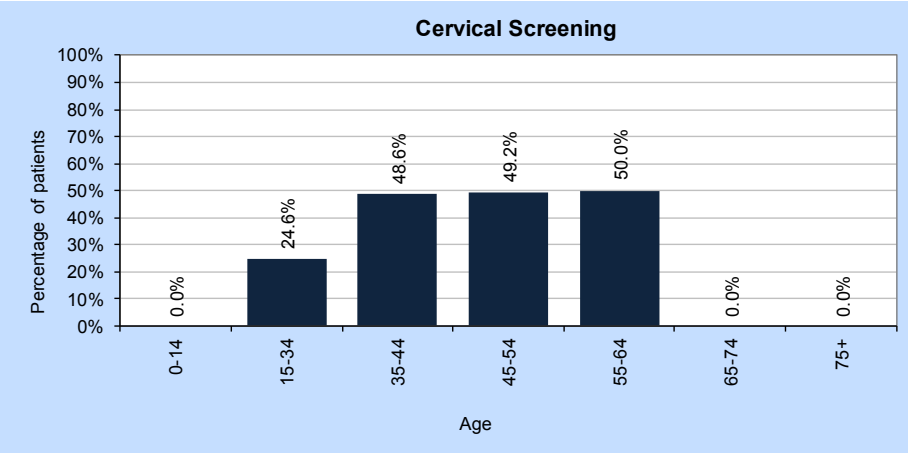

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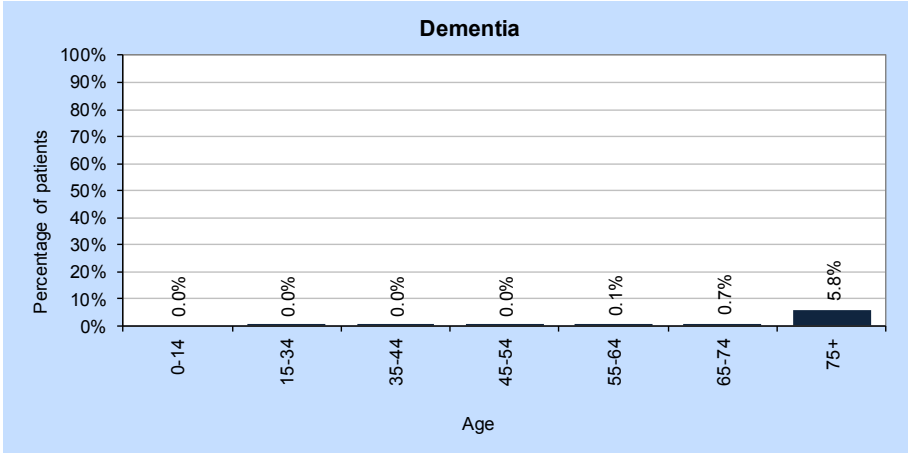

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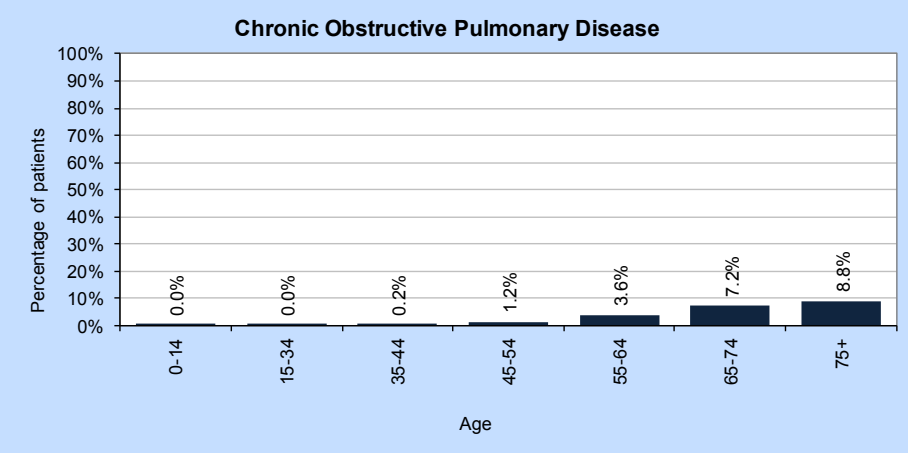

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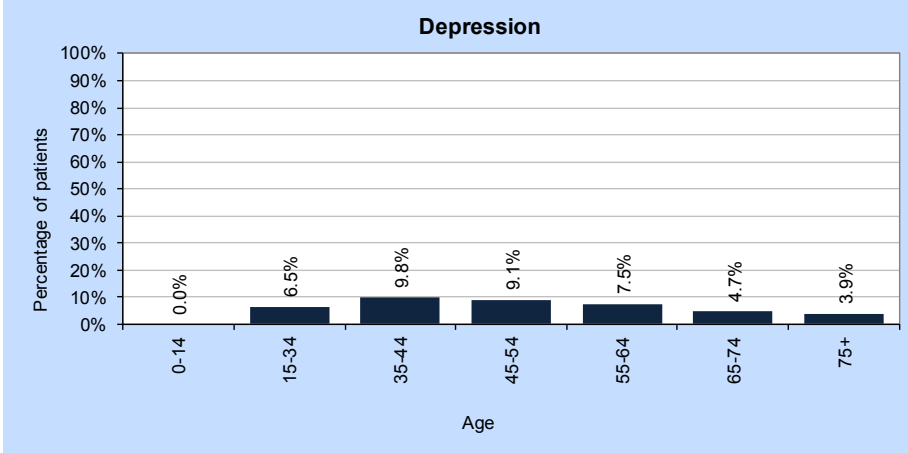

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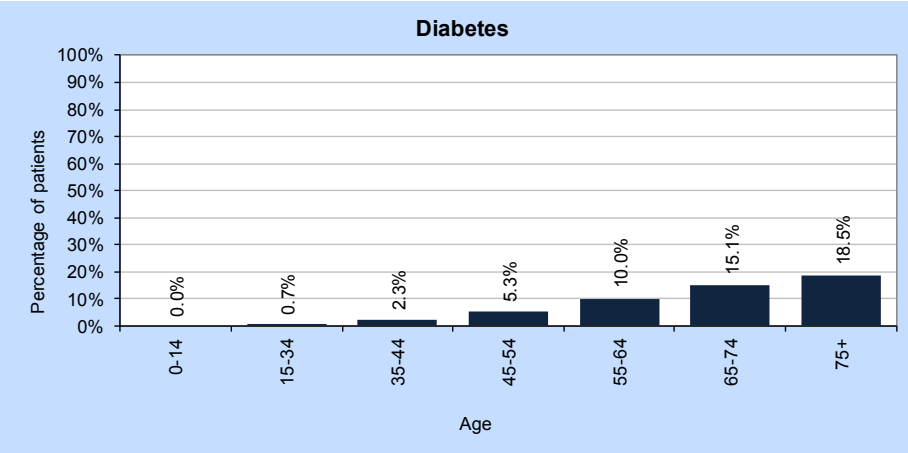

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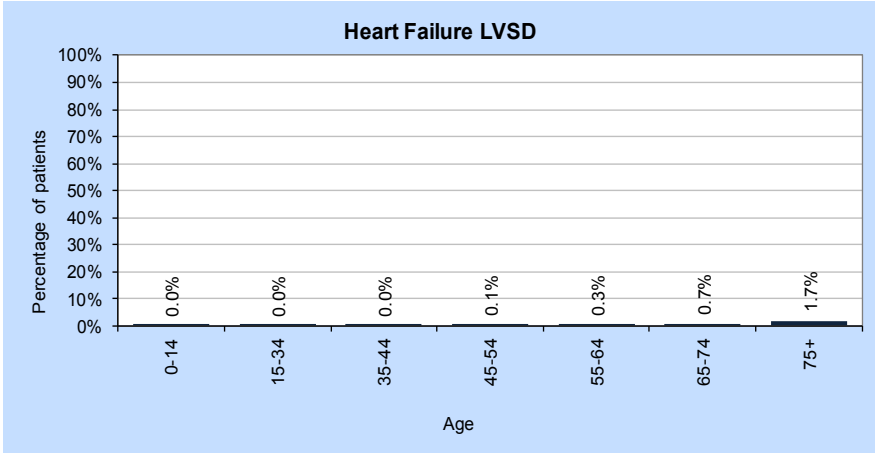

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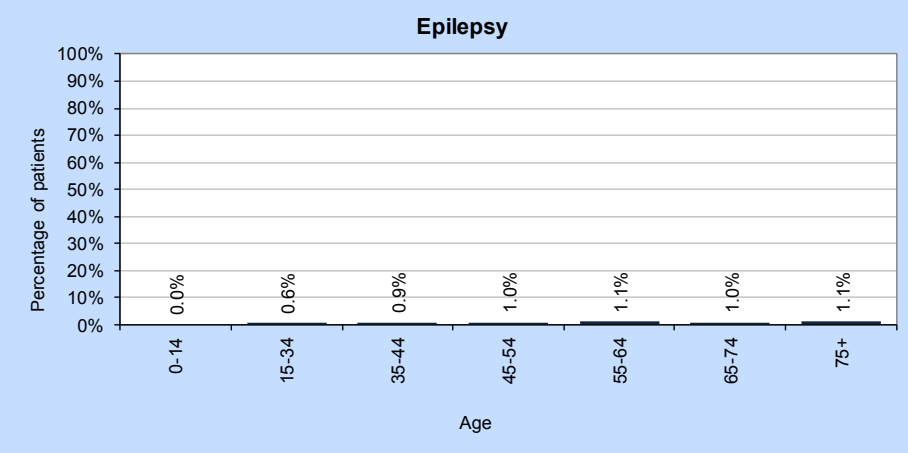

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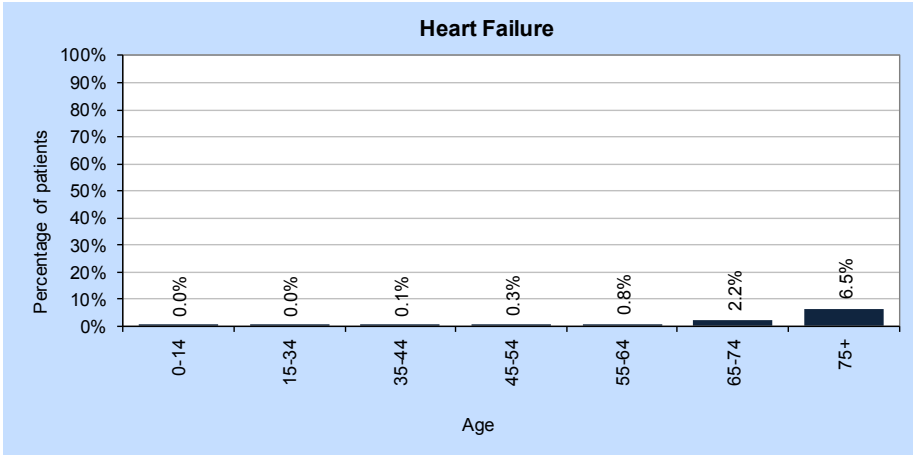
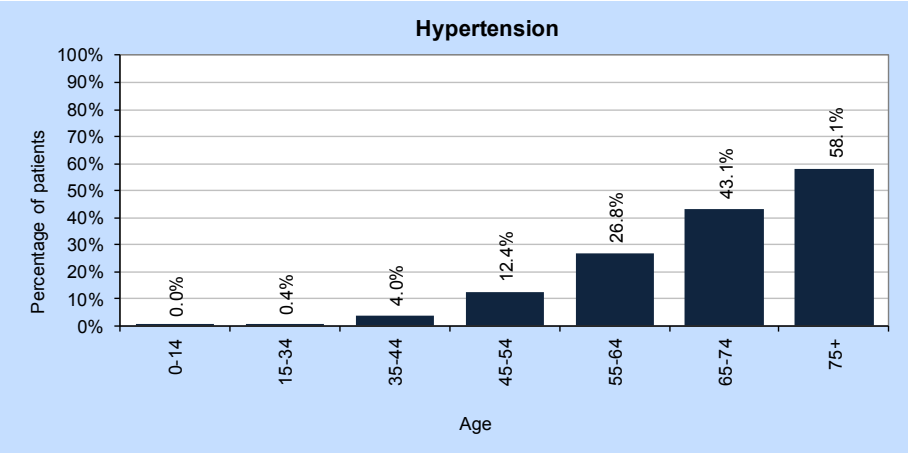


Source: Audit+



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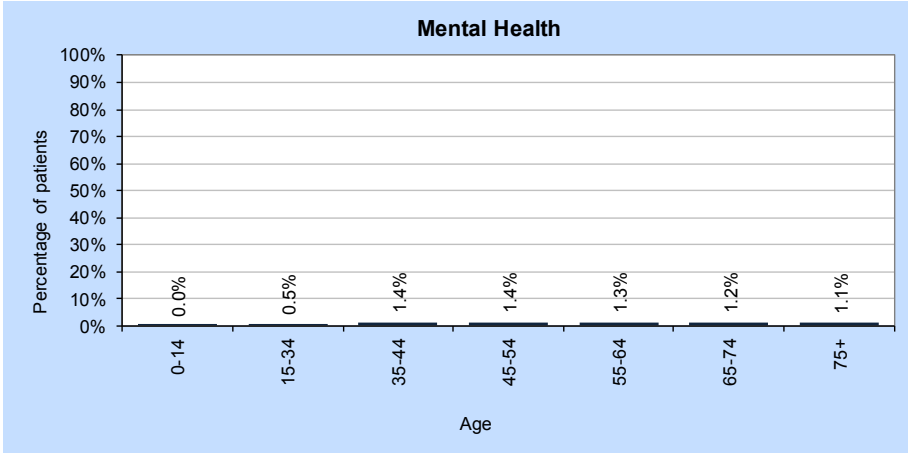

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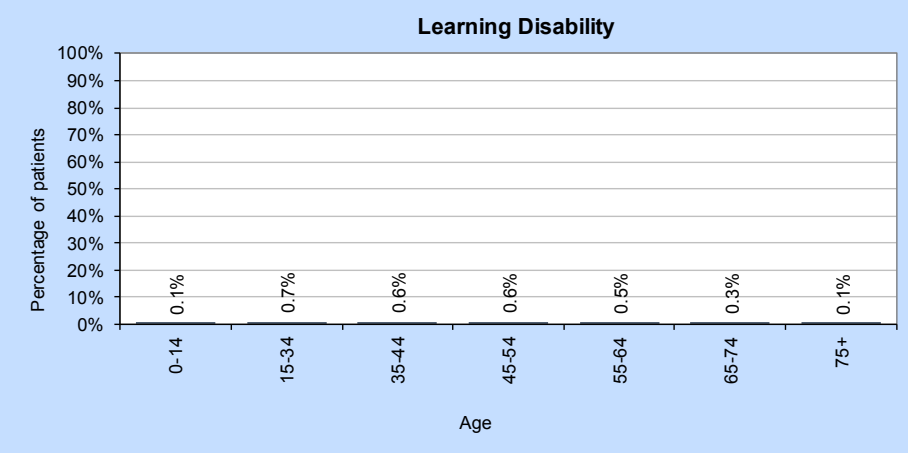

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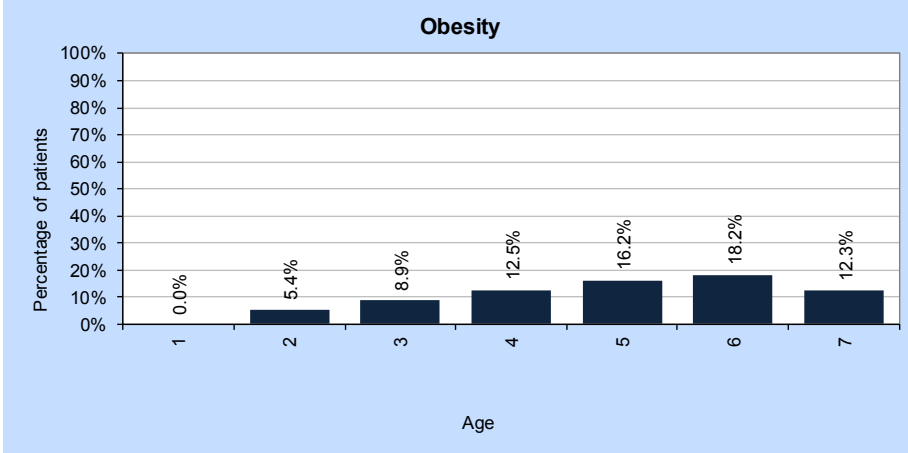

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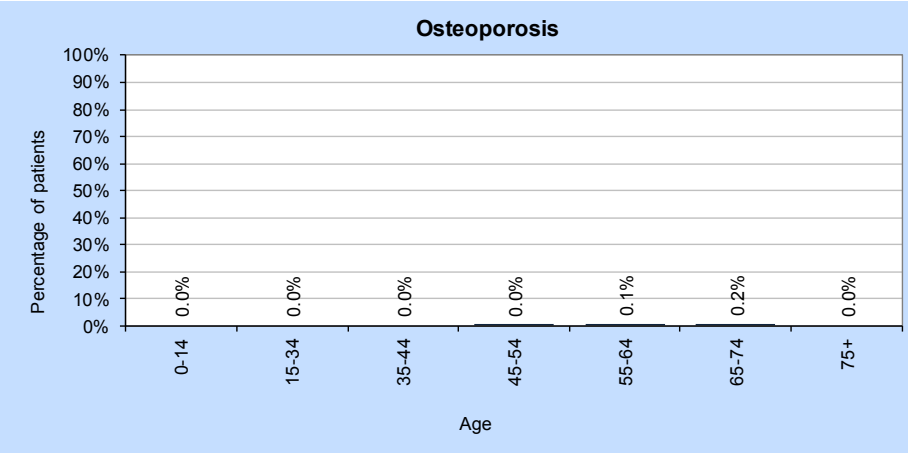

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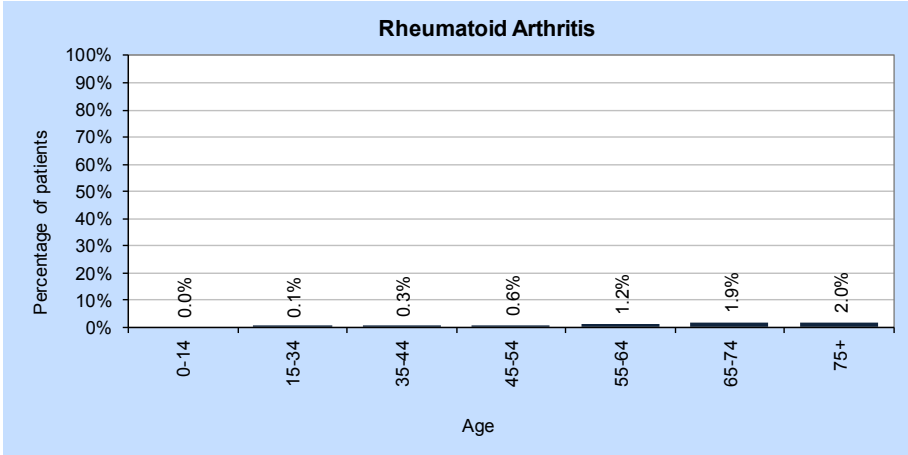

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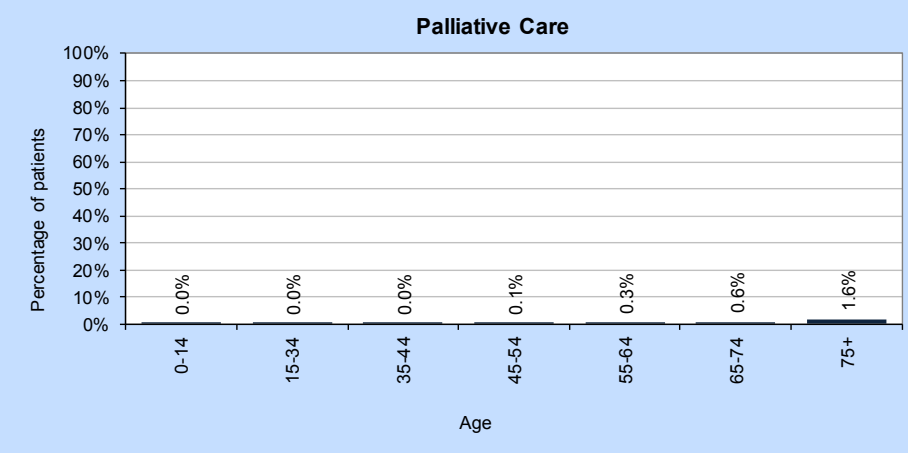

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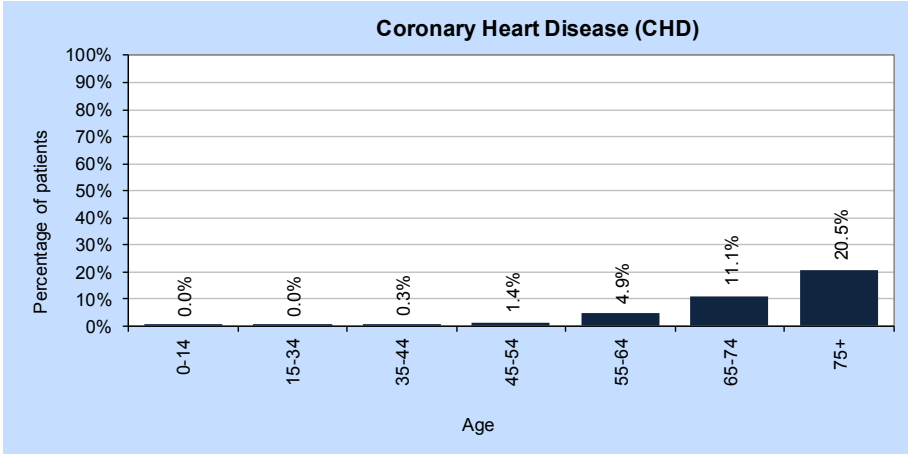

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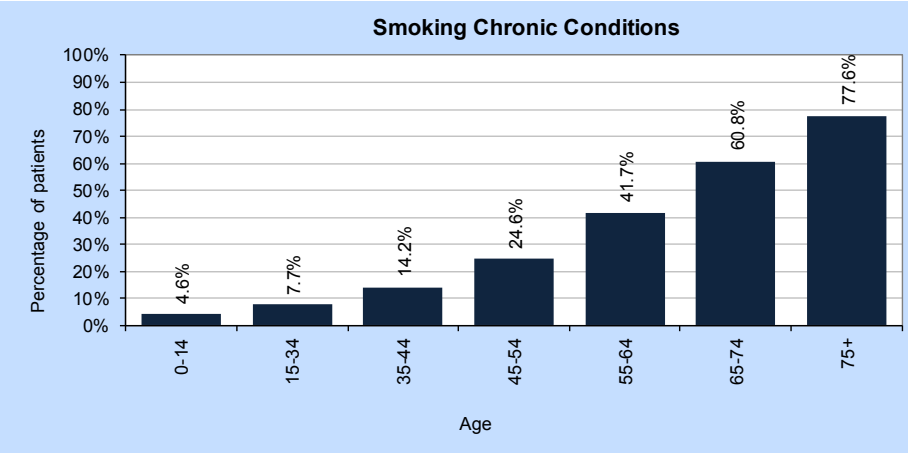

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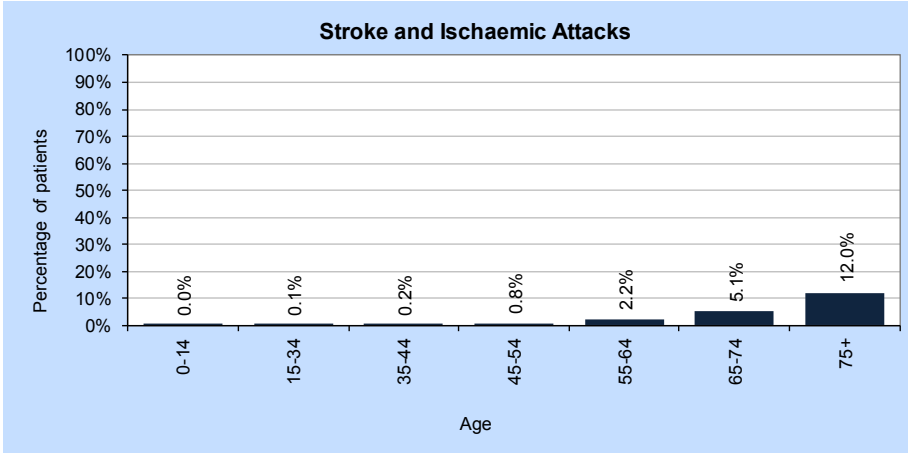

Source: Audit+

Notes

Disease areas

Descriptions of the 2014-15 disease areas are listed below:

Disease Area	Register description	QOF indicators
Coronary Heart Disease (CHD)	Patients diagnosed with CHD ever.	CHD001, 002, 005-007
Cardiovascular disease – primary prevention (PP)	Patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75 (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) who have a recorded CVD risk assessment score of 20% or more in the preceding 15 months.	CVD-PP001
Heart Failure	Patients diagnosed with Heart Failure ever.	HF001-002, 005W,
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).	HF003-004
Blood Pressure	Patients aged 50 or over who have a record of high blood pressure in the last 5 years.	BP001W
Stroke and Transient Ischaemic Attack (TIA)	Patients diagnosed with stroke and/or TIA ever.	STIA001, 003,007,008W,009
Hypertension	Patients diagnosed with established hypertension ever.	HYP001, 006
Diabetes Mellitus	Patients aged 17 and over diagnosed Diabetes.	DM001-003,007,008,010,012,014,015W,016W
Chronic Obstructive Pulmonary Disease	Patients diagnosed with COPD ever.	COPD001- 003, 004W,005,007, 008W
Epilepsy	Patients aged 18 and over diagnosed with Epilepsy receiving Epilepsy medication.	EP001, 003W
Cancer	Patients diagnosed with cancer since April 2003 excluding non-melanotic skin cancers.	CAN001, 003W
Palliative care	Patients recorded as receiving Palliative Care.	PC001, 002W
Mental Health	Patients diagnosed with schizophrenia, bipolar affective disorder or other psychoses and other patients on lithium therapy.	MH001, 002,007-010,011W
Asthma	Patients diagnosed with Asthma who have been prescribed asthma-related drugs in the preceding 12 months.	AST001-004
Dementia (DEM)	Patients diagnosed with Dementia ever.	DEM001, 002
Depression	Patients on the Depression register aged 18 and over with a new diagnosis of depression.	DEP003W
Atrial fibrillation (AF)	Patients diagnosed with Atrial Fibrillation.	AF001,002, 004, 005W
Obesity (OB)	Patients aged 16 and over with an obesity diagnosis recorded (a BMI of 30 or greater) within 15 months of the QOF reference date.	OB001
Learning Disability (LD)	Patients diagnosed with a Learning Disability ever.	LD001, 002W

Smoking (patients with chronic conditions)	Patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, and/or learning difficulties whose notes record smoking status in the preceding 15 months	SMOK002, 005
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.	SMOK004
Osteoporosis: secondary prevention of fragility fractures (OST)	Patients aged 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, 002, 005 RA001-004
Rheumatoid Arthritis	Patients aged 16 or over with Rheumatoid arthritis	

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 financial year to which the achievement payments relate (except in the case of indicator CS002, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (e.g. the preceding five years ending on 31 March in the financial year to which achievement payments relate).

b) Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.

c) Patients newly diagnosed or who have recently registered with the contractor 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, contra-indication or have experienced an adverse reaction.

f) Where a patient has not tolerated medication.

[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

g) Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

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 these patients are removed from the denominator for all indicators in that disease area where the care had not been delivered. For example, a contractor with 100 patients on the coronary heart disease (CHD) disease register, of which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95. However, all 100 patients with CHD would be included in the Quality and Outcomes Framework guidance for GMS contract Wales 2014/15 calculation of APDF (practice prevalence). This would apply to all relevant indicators in the CHD set.

In addition, contractors may exception report patients from single indicators if they meet criteria in C to I, for example a patient who has heart failure (HF) due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin converting enzyme inhibitors (ACE-inhibitors/ACE-I) and angiotensin receptor blocker (ARB) could be exception reported from HF003. This would result in the patient being removed from the denominator for that indicator only.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have 'excepted' patients from an indicator and this can be identifiable in the patient record.

A small number of indicators were introduced in 2013/14 that required referral to a service that may not have been available in all areas of Wales, an example is HF005W (previously HF100W). Unfortunately no 'service unavailable' exception Read codes were available for these indicators at that point in time and advice agreed by WG and GPCW was circulated to LHBs and GPs on how to deal with these indicators in such circumstances. Such 'service unavailable' exception Read codes have subsequently been released and are available for use in General Practice.

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 age groups have been obtained from the aggregated Audit Web system derived from Audit+.

Estimated diagnosis rate for people with dementia

The dementia estimates in section 4 of the release measure the number of people that have been diagnosed with dementia as a proportion of the number who are estimated to have the condition. They are calculated as follows:

- The estimated UK dementia prevalence rates by age (for people aged 30 or over) and sex is sourced from Dementia UK, 2007.
- The UK age/sex prevalence rates are applied to mid year estimates for Wales for subsequent years to produce estimated counts of people with dementia. An estimate for the numbers of 90-94 year olds and 95+ year olds (using ONS's 'Population Estimates of the very elderly' publication) is made and a small amendment is then made to account for early onset dementia.
- Patients recorded on the QOF dementia register are counted as 'diagnosed' and the remainder as 'undiagnosed'.

Alternative age-specific prevalence rates for dementia are available, including rates published in an update of the Dementia UK report and also by the Cognitive Function and Ageing Study: CFAS II study but those published in the 2007 Dementia Report have been used as they produce a mid-range estimate. The use of alternative rates will be kept under review in future editions. The Health and Social Care Information Centre also publishes an estimated diagnosis rate for dementia for England, as one of the indicators of the NHS Outcomes Framework at: http://www.hscic.gov.uk/nhsof.

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 2014-15 is presented for 459 general practices in Wales. This includes practices that had data automatically extracted by the CM Web system in June 2015, and data adjustments for the year 2014-15 submitted between April and June 2015. The 2014-15 disease prevalence tables are based on prevalence recorded on CM Web at 30 June 2015. 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 2014-15 QOF data use practice list sizes that have been derived from the practice clinical system as at 31 March 2015. 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 2014-15 financial year, and are correct as at 1 July 2015.

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. Below is a link to the tables previously mentioned.

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

Comparability

There were changes to the QOF indicators in 2014-15. These changes included the introduction of the Medicine Management and Cluster Network Development domain, retirement of previous indicators, introduction of new indictors, 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 2014-15 were:

- Reduction in the maximum number of QOF points available to 669 (969 in the previous year);
- 270 points releases from the clinical and public heath domains through the retirement of indicators or the extension of reporting indicator timescales in relation to those indicators which have been considered to be either overly prescriptive, or duplicated elsewhere within QOF, or have been considered to be sufficiently embedded in clinical practice, or which will be addressed through a more holistic approach to certain health conditions. The following extension of reporting indicator timescales are proposed:
  - AF002; DM015; DM016; EP003; RA003: assessment period to be extended from 15 months to three years.
  - RA004: assessment period to be extended from 24 months to three years.
  - AF003: assessment period to be extended from 12 months to three years.
  - HYP002: assessment period to be extended from 9 months to 12 months.
  - BP001: age range to be extended from 45 years to 50 years.
  - CHD004; COPD006; DM010; STIA 006: timeframe to be amended to allow (seasonal flu) vaccinating from 1 August each year. No points change.
  - CAN002: timeframe to be amended from three months to six months, but where clinically appropriate, review delivery within three months. Amend also to include telephone consultation with offer of face to face appointment. No points change.
  - DEP 002: assessment period to be amended from two to eight weeks. No points change.

- STIA002 referral after stroke to be reset from April 2014. Amend to require a referral after each stroke and only after first TIA.

- The introduction of a new Medicine Management and a new Cluster Network Development domain;
- Retirement of the Chronic Kidney Disease, Hypothyroidism and Peripheral Atrial Disease indicators;
- 33 points were released through the retirement of the Patient Experience domain. This enabled GPs to adopt flexibility in appointment setting based on clinical need and practice population.
- 41 points were released from the Organisational domain through the retirement of indicators considered to be sufficiently embedded as good practice.
- 44 points (from the 344 points identified to be released as outlined above) were transferred to a new Cluster Network Development domain to replace the existing Quality and Productivity domain. This provides a much stronger focus on Practice development and sustainability with population needs assessment increasingly used to inform service planning.

These miscellaneous changes can be found in the links below:

http://www.wales.nhs.uk/sites3/documents/480/GMS%20Contract%202014%2015%20QOF%20Changes%2010%20January%202014.pdf

http://www.brotaflmc.org.uk/ESW/Files/GMS_contract_changes_2014-15_FAQ.doc

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/quality_and_outcomes_framework.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 2014-15 QOF indicators

Clinical Domain

Atrial Fibrillation (AF)

AF001: The contractor establishes and maintains a register of patients with atrial fibrillation.
AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 3 years (excluding those whose previous CHADS2 score is greater than 1).
AF004: 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.
AF005W: In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1, in the preceding 3 years, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy.

Secondary Prevention of Coronary Heart Disease (CHD)

CHD001: The contractor establishes and maintains a register of patients with coronary heart disease.
CHD002: 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.
CHD005: 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.
CHD006: 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.
CHD007: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.

Heart Failure (HF)

HF001: The contractor establishes and maintains a register of patients with heart failure.
HF002: 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.
HF003: 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.
HF004: 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.
HF005W: 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.
HYP006: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.

Stroke and Transient Ischaemic Attack (STIA)

STIA001: The contractor establishes and maintains a register of patients with stroke or TIA.
STIA003: 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.
STIA007: 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.
STIA008W: The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the first TIA only and after each latest recorded stroke.
STIA009: The percentage of patients with a history of a stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.

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.
DM002: 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.
DM003: 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.
DM007. 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.
DM008: 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.
DM010: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March.
DM012: 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.
DM014: 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 3 years.
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 3 years.

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.
AST002: 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.
AST003: 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.
AST004: 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.
COPD002: 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.
COPD003: 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 and a MRC dyspnoea score greater than or equal to 3 in the preceding 15 months who also have a record of FEV1 in the preceding 15 months. Patients with MRC dyspnoea scoring less than 3 will be monitored according to an agreed management plan.
COPD005: 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.
COPD007: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.
COPD008W: 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.

Depression (DEP)

DEP003W: 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 2 weeks after and not later than 8 weeks 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.
MH002: 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.
MH007: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.
MH008: 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.
MH009: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.
MH010: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.
MH011W:The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure and BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 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'.
CAN003W: The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.

Epilepsy (EP)

EP001: The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.
EP003W: The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of being given information and advice about pregnancy or conception, or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years.

Learning disability (LD)

LD001: The contractor establishes and maintains a register of patients 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.
OST002: 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.
OST005: 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.
RA002: The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months.
RA003: 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 3 years.
RA004: 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 3 years.

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 2 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-PP001: 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.

Blood Pressure (BP)

BP001W: The percentage of patients aged 50 or over who have a record of blood pressure in the preceding 5 years.

Obesity (OB)

OB001: The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months.

Smoking (SMOK)

SMOK002: 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.
SMOK004: 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.
SMOK005: 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)

CS001: 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.
CS002: 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.

Medicines Management domain

Medicines Management

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%.

Cluster Network Development domain

Cluster Network Development

CND 001W: The contractor undertakes a review of local need and the provision of services within the practice, developing priorities for action to inform the production of a Practice Development Plan.
CND 002W: The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the GP Cluster Network, including relevant issues identified within Practice Development Plan that can be most effectively addressed as a GP cluster network action. The contractor agrees the contents of a GP Cluster Network Action Plan to deliver against shared local objectives.
CND 003W: The contractor participates in four GP cluster network meetings to review the implementation and delivery of the GP Cluster Network Action Plan.
CND 004W: The contractor participates in one GP cluster network meeting to develop and agree a GP Cluster Network Annual Report and submits to the LHB by 31 March 2015.
CND 005W: The contractor completes the Clinical Governance Practice Self Assessment Toolkit (CGPSAT) and confirms completion to the LHB by 31 March 2015.
CND 006W: Understanding cancer care pathways and identifying opportunities for service improvement. The contractor will: 1. Review the care of all patients newly diagnosed between 1st January 2014 and 31st December 2014 with lung (including mesothelioma) or digestive system cancer using a Significant Event Analysis tool. 2. Summarise learning and actions to be shared with the network and the wider LHB. 3. Identify and include any relevant actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.
CND 007W: Improving end of life care: identify all deaths 1 January to 31 December 2014, review to assess delivery at end of life and identify actions required. The contractor will: 1. Identify all deaths 170(up to a maximum of 5/ 1000 registered patients) occurring between 1st January 2014 and 31st December 2014. 2. Use the individual case review to assess delivery of end of life care. 3. Identify and include actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for review with the cluster network at the meetings and share information with the LHB as required.
CND 008W: Minimising the harms of polypharmacy. The contractor will: 1. Identify and record number the % of patients aged 85 years or more receiving 6 or more medications. 2. Undertake face to face medication reviews, using the "No Tears" approach or similar tool as agreed within the cluster, for at least 60% of the cohort defined in 1 above (for a minimum number

equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached).
3. Identify actions to be addressed in the Practice Development Plan.
4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.

Appendix 2 - StatsWales tables views

QOF points by 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://gov.wales/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://gov.wales/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://gov.wales/about/programmeforgov/data?code=TR062&lang=en

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