ystadegau ar gyfer cymru statistics for wales

Statistical First Release

Llywodraeth Cymru Welsh Government

General Medical Services contract: Quality and Outcomes Framework statistics for Wales, 2015-16

19 October 2016
SFR 141/2016

The Quality and Outcomes Framework (QOF) was first implemented in April 2004. This year's 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 2016. Note that not all of the data is comparable to previous years since the points available have changed for some indicators. For more information see Key Quality Information

Of patients were recorded on the hypertension disease register. The largest number of patients on a single register in 2015-16

2015-16 Key results

- Amongst the 449 Welsh GP practices, the average total point achieved was 547.5 (96.6 per cent of the maximum 567 points available). 76 (16.9 per cent) practices achieved the maximum 567 points and 13 practices (2.9 per cent) achieved fewer than 450.0 points.
- Amongst Welsh GP practices the average points achieved for the clinical domain was 263.6 (96.9 per cent of the maximum 272 points available).

About this release

This release presents a summary of data from the national General Medical Services (GMS) Quality and Outcomes Framework (QOF) during 2015-16. 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 2015-16.

More detailed tables are provided in StatsWales and in the associated spreadsheets, which includes local health board, cluster, and practice level data

In this release

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Tables and charts

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'.

Guidance for the QOF in Wales.

The QOF is about resourcing and then rewarding good practice. The QOF measures achievement against 62 indicators. Practices score points on the basis of achievement against each indicator, up to a maximum of 567 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 2015-16 GMS contract included the removal of 102 points through the retirement of indicators and the extension of reporting indicators. 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**: 42 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 272 points (48.0 per cent of the total).
- **Public Health domain**: 10 indicators in 6 areas (Cardiovascular disease, Blood pressure, Obesity, Smoking, Cervical Screening, Influenza). Indicators in the Public Health domain are worth a maximum of 117 points (20.6 per cent).
- **Cluster Network Development**: 8 indicators in 1 area, worth up to 160 points (28.2 per cent of the total).
- **Medicine Management**: 3 indicators in 1 area. Indicators in the Medicine Management domain are worth up to 18 points (3.2 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	2015-16
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	6.9
Atrial Fibrillation	1.6	1.6	1.7	1.7	1.7	1.8	1.8	1.9	2.0	2.0
Cancer	0.9	1.1	1.3	1.5	1.7	1.9	2.1	2.2	2.4	2.6
Cardiovascular Disease (PP)	-	-	-	0.6	1.2	1.6	2.2	2.7	3.6	3.4
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	2.2
Coronary Heart Disease	4.3	4.2	4.2	4.1	4.0	4.0	3.9	3.9	3.8	3.8
Dementia	0.4	0.4	0.5	0.5	0.5	0.5	0.6	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)	-	-	-	-	-	-	-	5.0	5.8	6.6
Diabetes Mellitus (e)	4.2	4.4	4.6	4.9	5.1	5.3	5.4	5.6	5.7	5.9
Epilepsy (f)	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.8
Heart Failure	1.0	0.9	0.9	0.9	0.9	0.9	0.9	1.0	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	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	0.5
Mental Health	0.7	0.7	0.8	0.8	0.8	0.8	0.9	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	9.3
Osteoporosis (j)	-	-	-	-	-	-	0.1	0.2	0.2	0.2
Palliative Care	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Peripheral Arterial Disease	-	-	-	-	-	-	0.7	0.7	-	-
Rheumatoid arthritis (k)	-	-	-	-	-	-	-	0.7	0.7	0.7
Stroke and Ischaemic Attacks	2.0	2.0	2.0	2.0	2.1	2.1	2.0	2.0	2.0	2.0
Smoking register (patients with chronic conditions)	22.3	23.9	25.2	25.5	25.8	26.0	26.4	26.5	26.7	26.2
Smoking status register (patients aged 15 or over with recorded smoking status) (m)	-	-	-	-	-	-	83.7	83.7	83.7	83.7
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	7.3
Epilepsy (f)	0.9	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	11.4
Osteoporosis (j)	-	-	-	-	-	-	0.2	0.4	0.5	0.6
Rheumatoid arthritis (k)	-	-	-	-	-	-	-	0.8	0.8	0.8

(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.

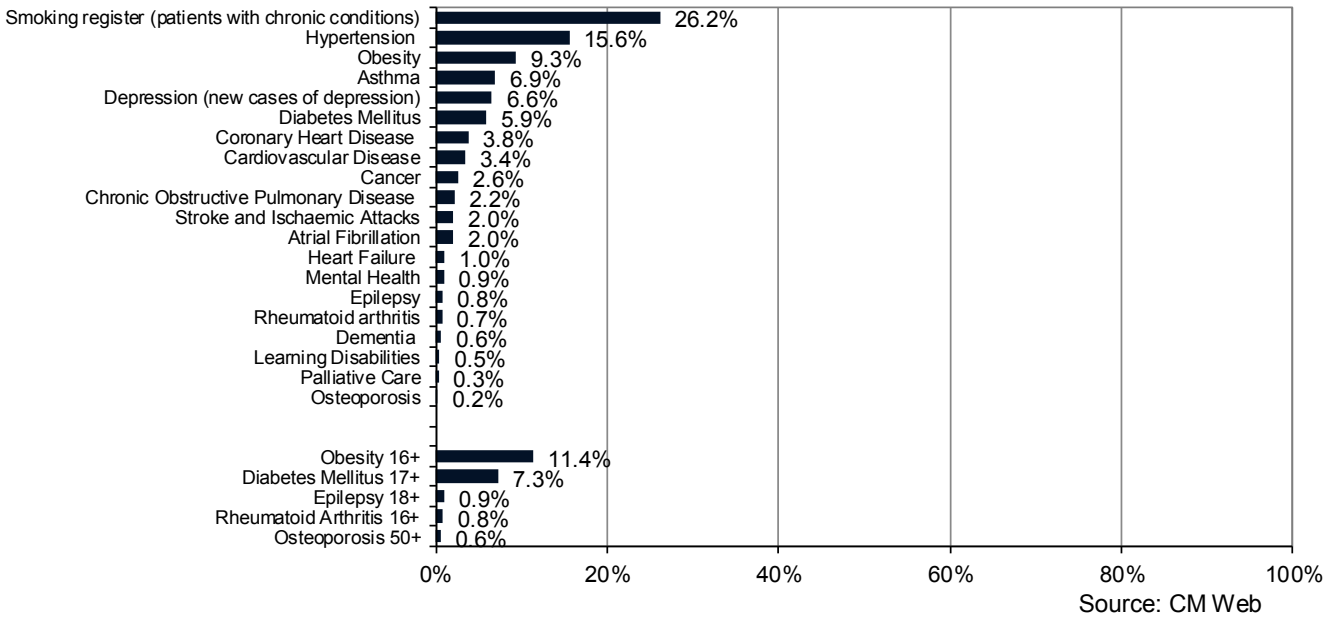
'-' No data exists for this time period.

From 2006-07 the hypertension register has recorded the largest number of patients on a single disease register; in 2015-16 more than 500,500 or nearly 16 per cent of all patients were registered. Other large registers of chronic conditions include over 188,600 (rounded to the nearest hundred) patients aged 17 or over with diabetes, nearly 222,600 patients of any age with asthma, over 120,600 patients of any age with Coronary Heart Disease and 71,200 with Chronic Obstructive Pulmonary Disease (COPD).

QOF also provides some key public health registers: nearly 300,100 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.

Chart 1: Reported disease prevalence rates of all patients, and of age-specific patients, 2015-16 (a)



(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. An Influenza domain (FLU) was been introduced in 2015-16.

The Chronic Kidney Disease, Hypothyroidism and Peripheral Arterial Disease registers were retired in 2014-15. The Heart Failure (due to left Ventricular Dysfunction) register was retired in 2015-16

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.

4. Dementia register

Table 2: Number of people diagnosed and estimated number undiagnosed with dementia, 2015-16 [(a)]

Local Health Board	Number diagnosed	Males: with dementia	Females: with dementia	Persons: with dementia	Number undiagnosed	% diagnosed
Betsi Cadwaladr University Health Board	4,705	3,447	6,153	9,600	4,894	49.0%
Powys Teaching Health Board	979	795	1,365	2,160	1,181	45.3%
Hywel Dda University Health Board	2,424	2,045	3,543	5,588	3,164	43.4%
Abertawe Bro Morgannwg University Health I	3,581	2,256	4,156	6,412	2,831	55.8%
Cwm Taf University Health Board	1,573	1,169	2,117	3,287	1,713	47.9%
Aneurin Bevan University Health Board	3,685	2,453	4,388	6,841	3,156	53.9%
Cardiff and Vale University Health Board	2,859	1,646	3,301	4,947	2,088	57.8%
Wales	**19,806**	**13,811**	**25,024**	**38,835**	**19,028**	**51.0%**

Source: QOF data, CFAS II study prevalences, ONS mid year estimates

(a) People aged 65 or over (dementia register reduced by 3% to exclude under 65 year olds)

Estimates of the numbers of people with dementia in Wales have been made using prevalence rates published in a Lancet paper from the CFAS (Cognitive Function and Ageing Study) II study. 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. Using the CFAS II rates is a change of methodology since the 2014-15 release when the estimates were made for a different age group (adults aged 30 or over), and utilised prevalence rates from the Dementia UK report published by the Alzheimer's Society in 2007. NHS England has also changed its methodology to use the CFAS II rates. For more information see Notes.

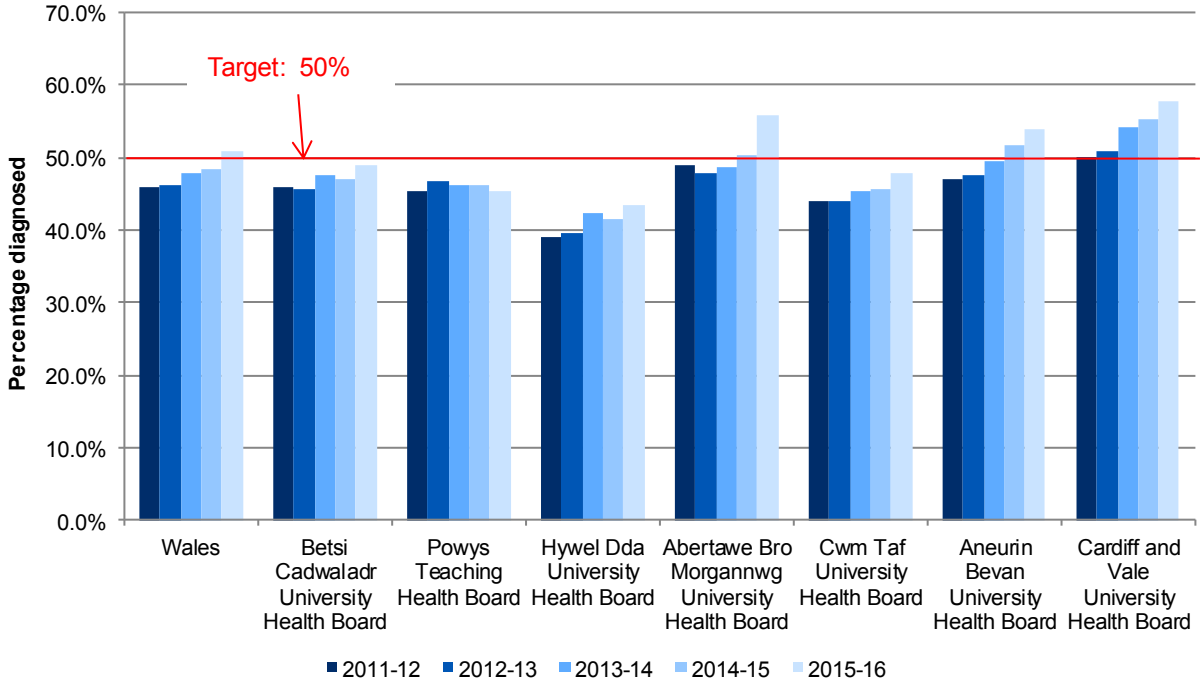
Estimates using the methodology outlined in the 2014-15 statistical release, for adults aged 30 or over, would have produced 43,052 people with dementia in Wales in 2015-16 and a diagnosis rate of 47 per cent, an increase of 2 percentage points from the 2014-15 estimated diagnosis rate of 45 per cent.

Although the Dementia disease register includes patients of all ages, in practice the majority are aged 65 or over. Audit+ data for Welsh practices shows that the proportion of patients on dementia registers who are aged under 65 is around 3%; the register figures in Table 2 and Chart 2 have been reduced by this amount so that numbers diagnosed and with dementia both relate to those aged 65 or over.

Table 2 shows the estimated proportion of patients diagnosed with dementia (i.e on the QOF register) as a percentage of the resident population aged 65 or over who are calculated to have dementia. This shows that in 2015-16 there were 51.0 per cent of people with dementia who had been diagnosed in Wales. Cardiff and Vale University had the highest diagnoses rate of 57.8 per cent whilst Hywel Dda had the lowest (43.4 per cent).

It is estimated that in 2015-16 there were 38,835 people aged 65 or over in Wales who had dementia, an increase from 38,454 in 2014-15. In 2015-16 it was estimated that just over 19,800 people aged 65 or over were recorded on GP registers for dementia and approximately 19,000 people aged 65 or over with dementia remained undiagnosed.

Chart 2: Estimated percentage of the population in Wales, aged 65 years or over with dementia, who are diagnosed (QOF register) by health board (a)



Source: CM Web

(a): People aged 65 or over (dementia register reduced by 3% to exclude under 65 year olds)

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 556.5 (Powys Teaching) and 564.3 (Cwm Taf University). The 'median total points' achieved by practices in Wales was 560.9.

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

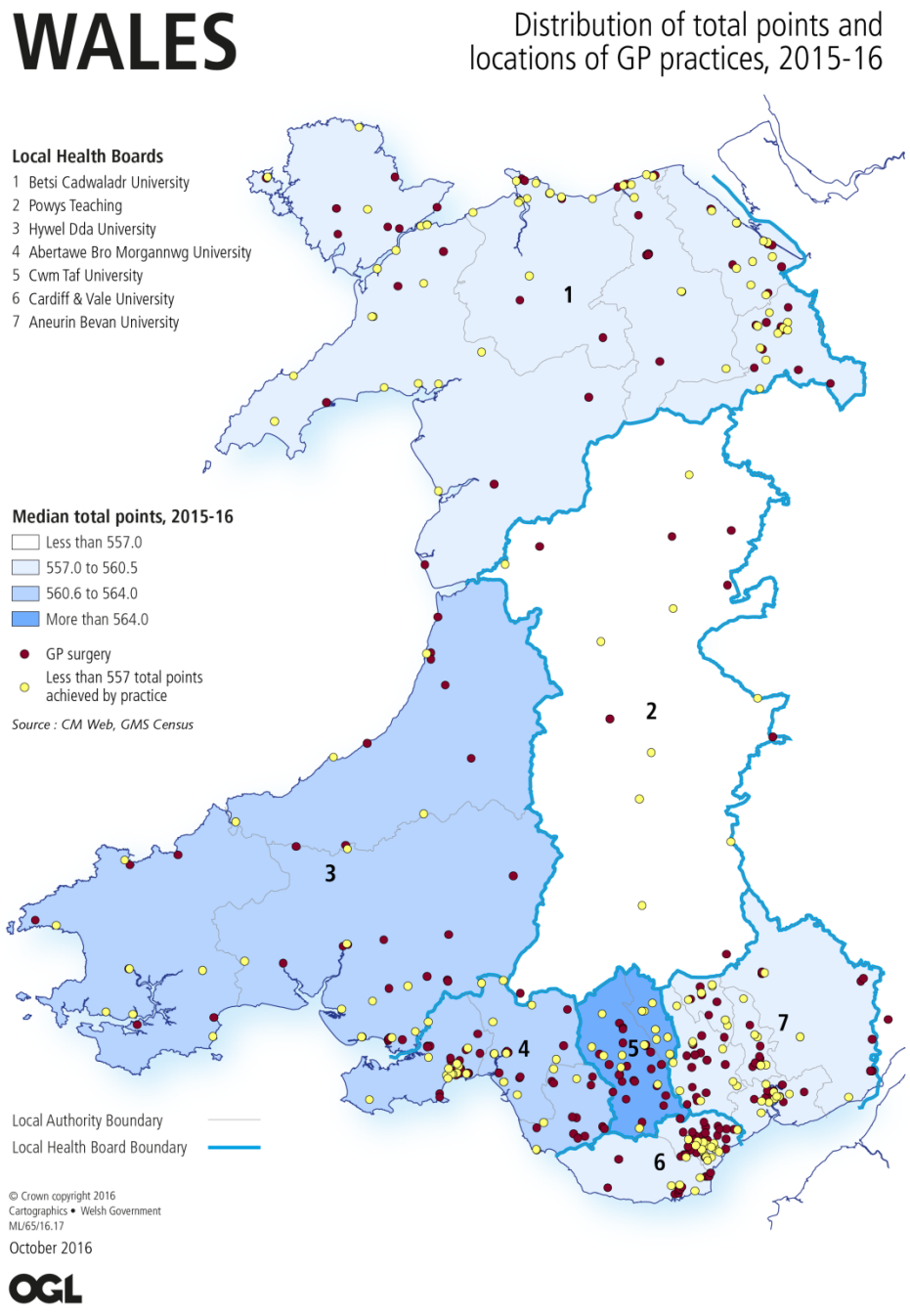


Chart 3: Historical achievement, total points

Source: CM Web

Chart 3 shows that for the last 10 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 3: Domain level achievement

	2013-14			2014-15			2015-16		
		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	604.0	577.5	95.6%	389.0	376.1	96.7%	272.0	263.6	96.9%
Public Health (a)	157.0	151.4	96.5%	102.0	98.4	96.5%	117.0	112.4	96.1%
Cluster Network Development (b)	.	.	.	160.0	156.8	98.0%	160.0	154.3	96.4%
Medicines Management(b)	.	.	.	18.0	17.7	98.3%	18.0	17.1	95.2%
Organisational	59.0	57.8	97.9%	.	.	.	.	.	.
Patient Experience	33.0	32.5	98.5%	.	.	.	.	.	.
Quality and Productivity (c)	116.0	109.6	94.5%	.	.	.	.	.	.
All domains	**969.0**	**928.9**	**95.9%**	**669.0**	**649.0**	**97.0%**	**567.0**	**547.5**	**96.6%**

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 547.5 (96.6 per cent of the maximum 567 points available). 76 (16.9 per cent) practices achieved the maximum 567 points and 13 practices (2.9 per cent) achieved fewer than 450.0 points.

The average points achieved, for the clinical domain, was 263.6 (96.9 per cent of the maximum 272 points available).

As Table 3 shows, there has been a change of points in 2015-16. Further miscellaneous changes can be found on the BroTaf website.

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

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

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

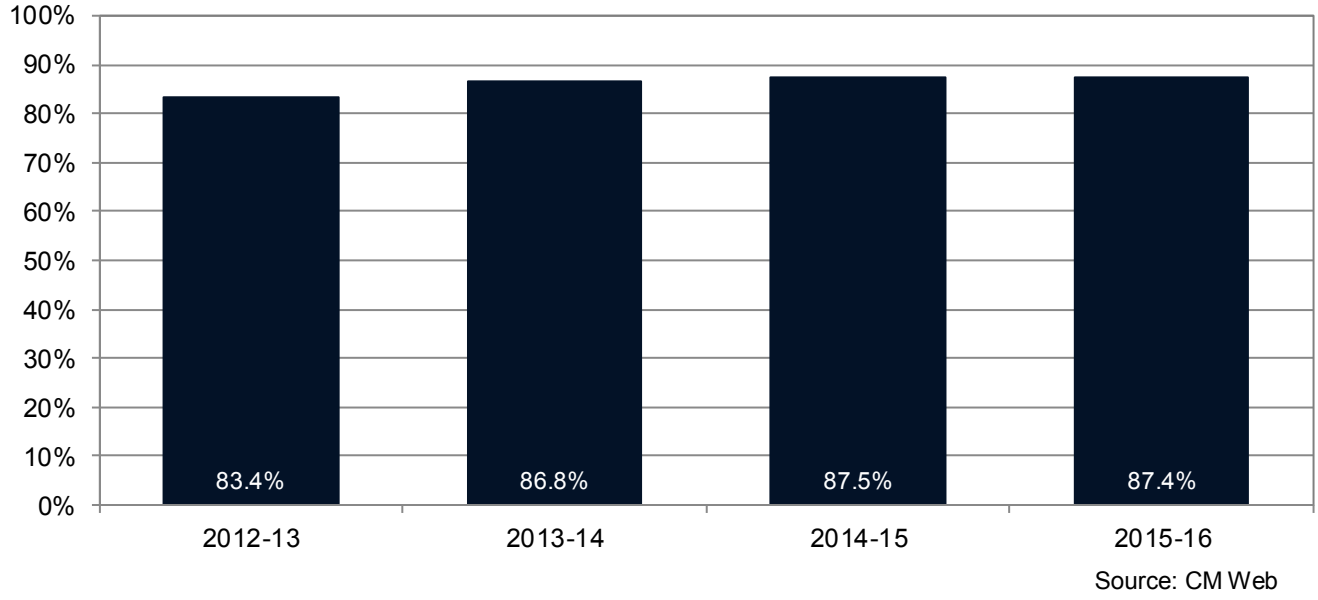
6. Public health domain

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 4: 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 2015-16



Source: CM Web

During 2015-16, 87.4 per cent of patients aged 15 and over who smoked in Wales were offered support and treatment, a slight decrease when compared to 2014-15.

7. Clinical domain

This is the largest domain within the QOF with 17 registers and 42 indicators. A number of delivery plans have been refreshed which are relevant to the QOF registers including for heart disease, stroke, cancer, diabetes .

Atrial fibrillation (AF)

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. People who have Atrial fibrillation are more likely to have a stroke than those who do not due to causing the heart to pump blood inefficiently.

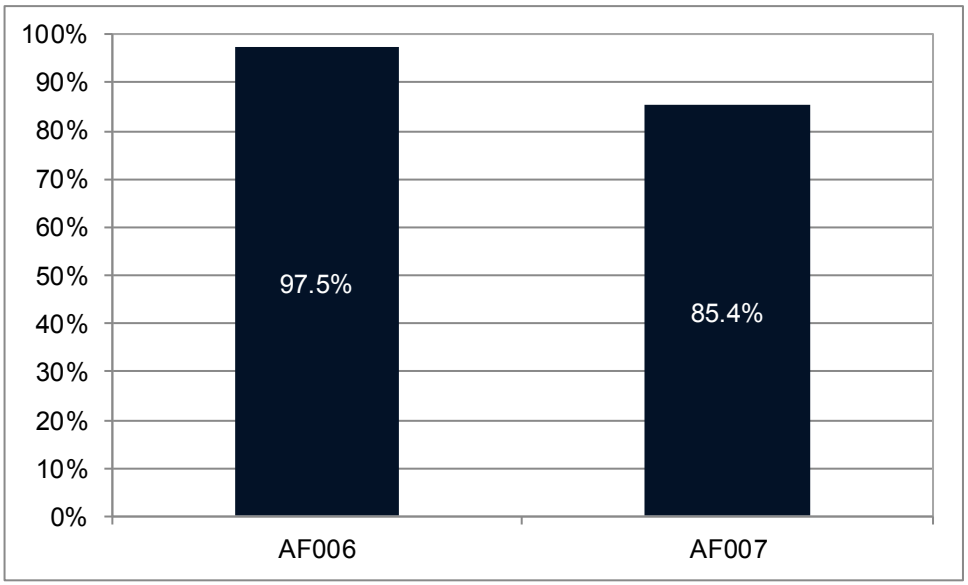
Atrial fibrillation is a common and significant cause of morbidity and mortality. The age-specific prevalence of Atrial Fibrillation is rising, presumably due to improved survival of patients with CHD (the commonest underlying cause of AF).

In 2015-16 there were 2 new indicators introduced

Description	Indicator
The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	AF006

Description	Indicator
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	AF007

Chart 5: Percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)



Source: CM Web

In the most recent year, 97.5 per cent of patients with atrial fibrillation for whom stroke risk had been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more). 85.4 per cent of those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, were currently treated with anticoagulation drug therapy.

Influenza (FLU)

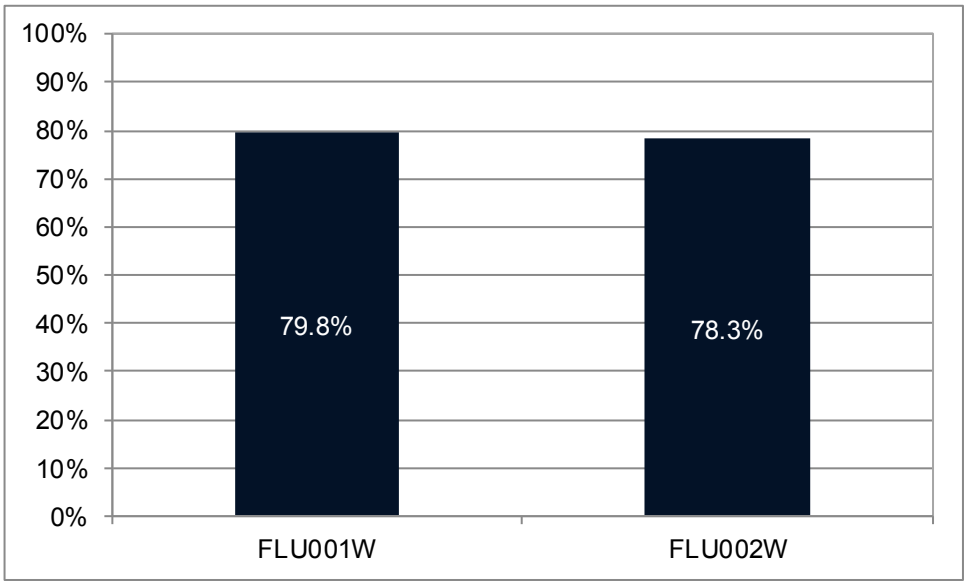
In 2015-16 there was a new flu register. These replaced indicators previously recorded separately in chronic condition registers and combined them to report on two indicators.

Flu is highly infectious, spreads easily and can cause serious illness. Influenza vaccination is recommended for all persons aged 65 or over or who have CHD, COPD, Diabetes or stroke.

Description	Indicator
FLU001W. The percentage of the registered population aged 65 years or more who have had influenza immunisation in the preceding 1 August to 31 March	FLU001W

Description	Indicator
FLU002W. The percentage of the patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March	FLU002W

Chart 6: Percentage of the registered population aged 65 years or more who have had influenza immunisation and percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March [(a)]



Source: CM Web

(a) Prior to 2015, the indictor were measured in the separate chronic disease registers

In 2015-16 nearly 423,300 patients, 79.8 per cent of patients of the registered population aged 65 and over had received an influenza immunisation in the preceding 1 August to 31 March. 78.3 per cent of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March

Palliative care

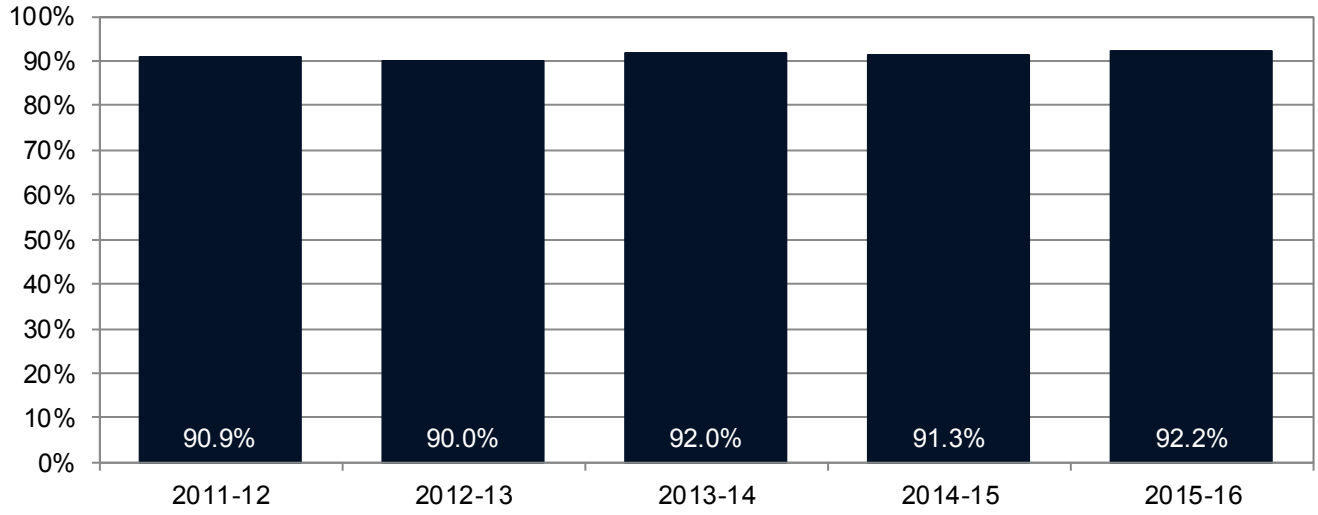
One of the strengths of primary care services is that they offer care across the life course. This includes continuity of care and a personalised approach as key priorities, of particular importance at the end of life.

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 7. 414 (92.2 per cent) of the practices in 2015-16 held these review meetings.

Chart 7: Percentage of GP practices holding review meetings, discussing their palliative care register patients, at least every 3 months [(a)]



Source: CM Web

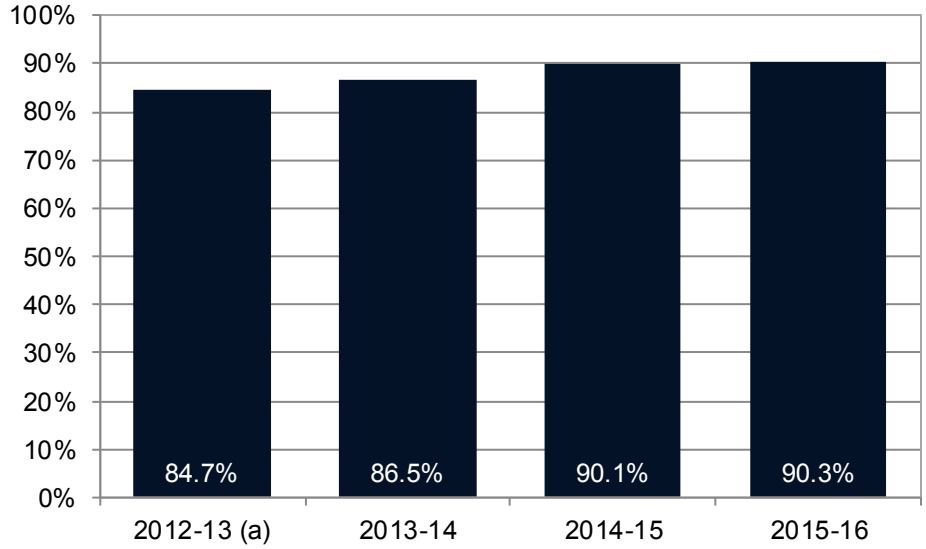
(a) Previously to 2014-15 multi-disciplinary case review meetings were discussed at least every 3 months, now they are discussed at least every 2 months.

8. Mental health

The mental health indicator reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs. The following indicators relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders.

Description	Indicator
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care and treatment plan documented in the records, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate.	MH002

Chart 8: 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

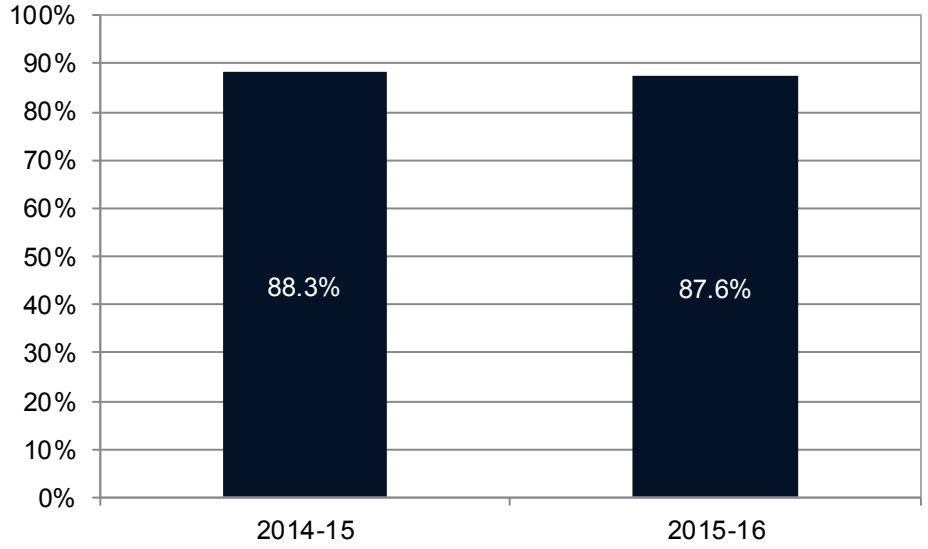


(a) In 2012-13 this indicator did not have a time period stated therefore there may be small definitional differences between the years

In 2015-16 90.3 per cent of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 15 months agreed between individuals, their family and/or carers as appropriate. This has gradually increased from 84.7 percent in 2012-13

Description	Indicator
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 of HbA1c in the preceding 15 months.	MH011W

Chart 9: 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



In 2015-16, 87.6 of patients had a record of blood glucose or HbA1c in the preceding 15 months. This was a decrease compared to the previous year.

9. Medicine management

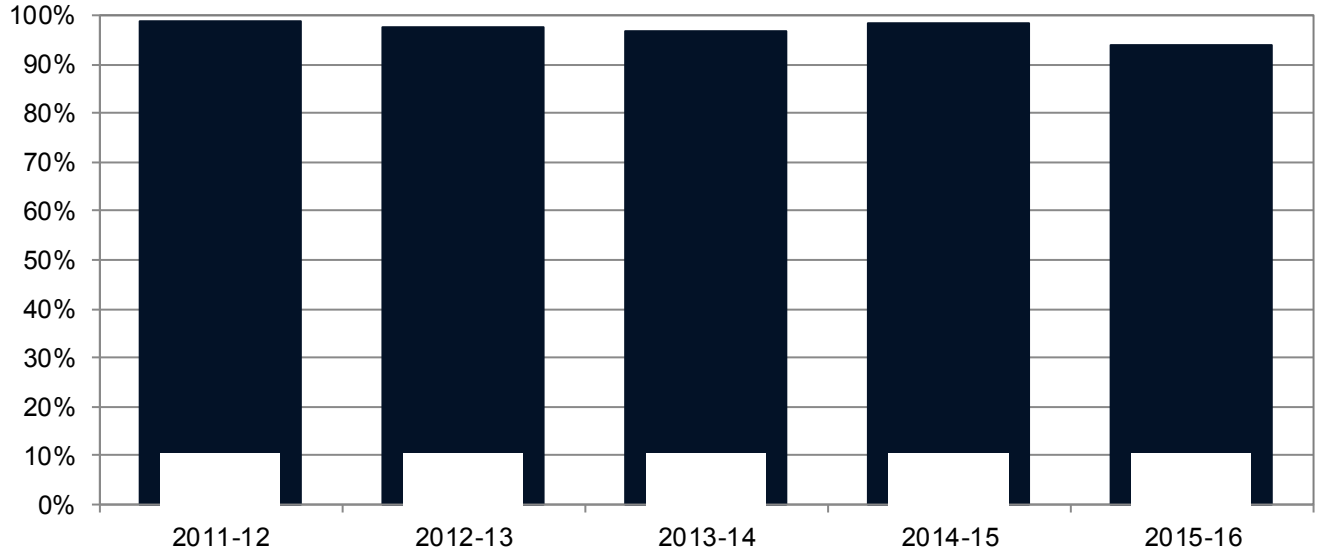
The quality and safety of clinical care is highly dependent upon the systems that support clinical practice. As prescribing levels increase, it is important that appropriate safeguards are developed to ensure regular reviews of care to minimise risk and harms.

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. Following an increase last year, the proportion decreased to 93.8 per cent which is the lowest percentage since the indicator was introduced. 421 (93.8 per cent) practices in 2015-16 held a medication review for all patients being prescribed four or more repeat medicines.

10. 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.

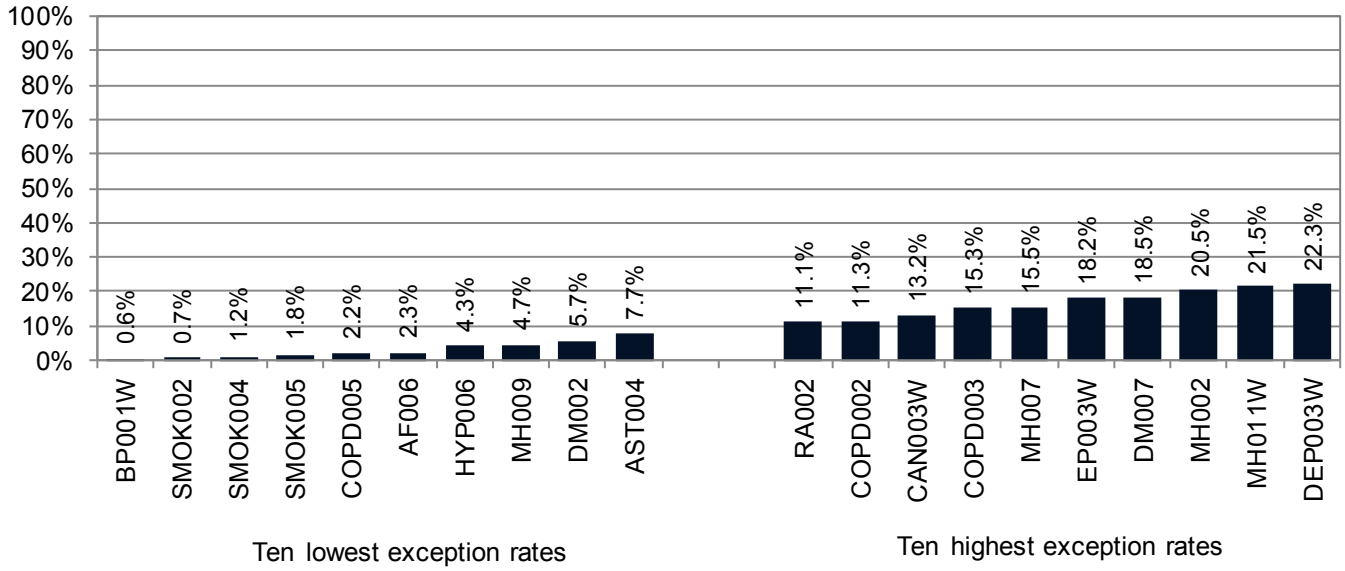
The exclusion rate, the percentage of patients on the register who are for definitional reasons not included in the indicator, is calculated as follows:

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

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.

Chart11 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 DEP003W at 22.3 per cent and the lowest exception rate was for BP001W at 0.6 per cent. Note that for some indicators these rates may be based on small numbers.

11. Health Board variations

Prevalence – Health Boards

Table 4 shows the percentages of patients recorded on the disease registers in 2015-16 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 4: 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	7.2	6.8	6.8	7.3	6.7	6.5	6.8	6.9
Atrial Fibrillation	2.2	2.3	2.5	2.1	1.9	1.5	1.9	2.0
Cancer	2.9	3.2	3.0	2.5	2.3	2.1	2.5	2.6
Cardiovascular Disease (PP)	4.6	4.3	3.1	2.6	2.9	2.5	3.9	3.4
Chronic Obstructive Pulmonary Disease	2.6	2.3	2.2	2.2	2.7	1.5	2.2	2.2
Coronary Heart Disease	4.0	4.1	4.1	3.9	3.8	2.8	3.8	3.8
Dementia	0.7	0.7	0.6	0.7	0.5	0.6	0.6	0.6
Depression (new cases of depression) (b)	6.9	6.1	4.9	6.2	5.7	7.3	7.6	6.6
Diabetes Mellitus (c)	5.7	6.1	6.2	6.1	6.1	4.7	6.4	5.9
Epilepsy (d)	0.7	0.7	0.8	0.8	0.9	0.6	0.8	0.8
Heart Failure	1.1	1.2	1.1	1.0	0.8	0.8	1.0	1.0
Hypertension	16.5	17.3	16.4	15.2	16.8	12.3	16.2	15.6
Learning Disabilities (e)	0.5	0.4	0.5	0.5	0.4	0.4	0.5	0.5
Mental Health	0.9	0.9	0.9	1.1	0.9	0.9	0.9	0.9
Obesity (f)	8.7	9.3	9.6	9.1	11.4	7.3	10.9	9.3
Osteoporosis (g)	0.3	0.3	0.2	0.2	0.1	0.2	0.2	0.2
Palliative Care	0.3	0.4	0.4	0.2	0.2	0.2	0.4	0.3
Rheumatoid arthritis (h)	0.7	0.9	0.9	0.7	0.7	0.5	0.7	0.7
Stroke and Ischaemic Attacks	2.0	2.5	2.3	2.2	2.0	1.7	2.0	2.0
Smoking register (patients with chronic conditions)	27.3	28.0	27.4	26.6	26.9	21.7	26.7	26.2
Smoking status register (patients aged 15 or over)	83.9	85.3	84.7	83.8	83.0	83.1	83.2	83.7
Age –specific prevalence rates for specific disease registers (j)								
Diabetes Mellitus (c)	7.1	7.4	7.6	7.5	7.7	5.9	7.9	7.3
Epilepsy (d)	0.9	0.9	1.0	1.0	1.1	0.8	1.0	0.9
Obesity (f)	10.5	11.2	11.6	11.1	14.0	8.9	13.4	11.4
Osteoporosis (g)	0.7	0.6	0.5	0.6	0.4	0.5	0.5	0.6
Rheumatoid arthritis (h)	0.8	1.0	1.1	0.8	0.9	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 (7.3 per cent) for the asthma register, and Cwm Taf University (11.4 per cent) for the obesity register.

For further information, refer to the 'Data summary for Wales and local health boards, 2015-16' spreadsheet on the website:

Chart 12: Estimated percentage of the population in Wales, aged 65 years or over with dementia, who are diagnosed (QOF register) by health board, 2015-16

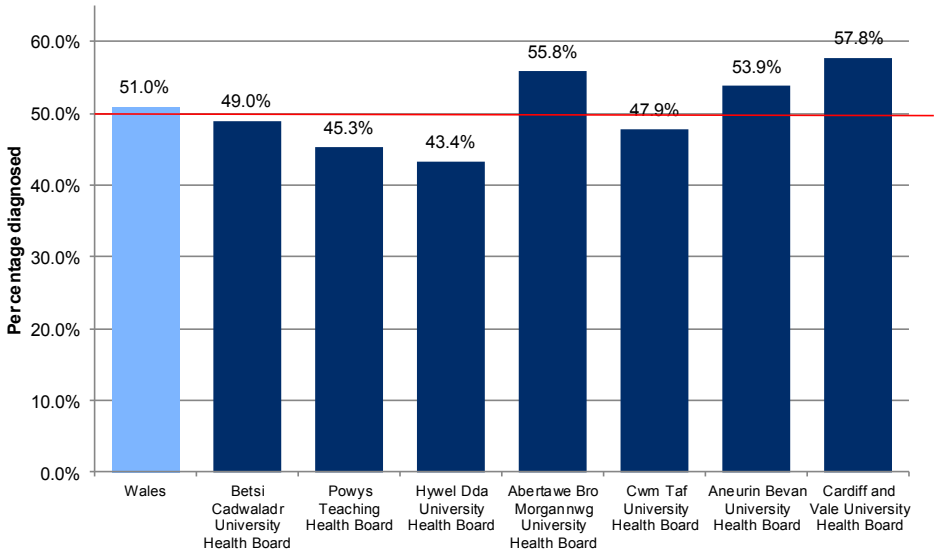
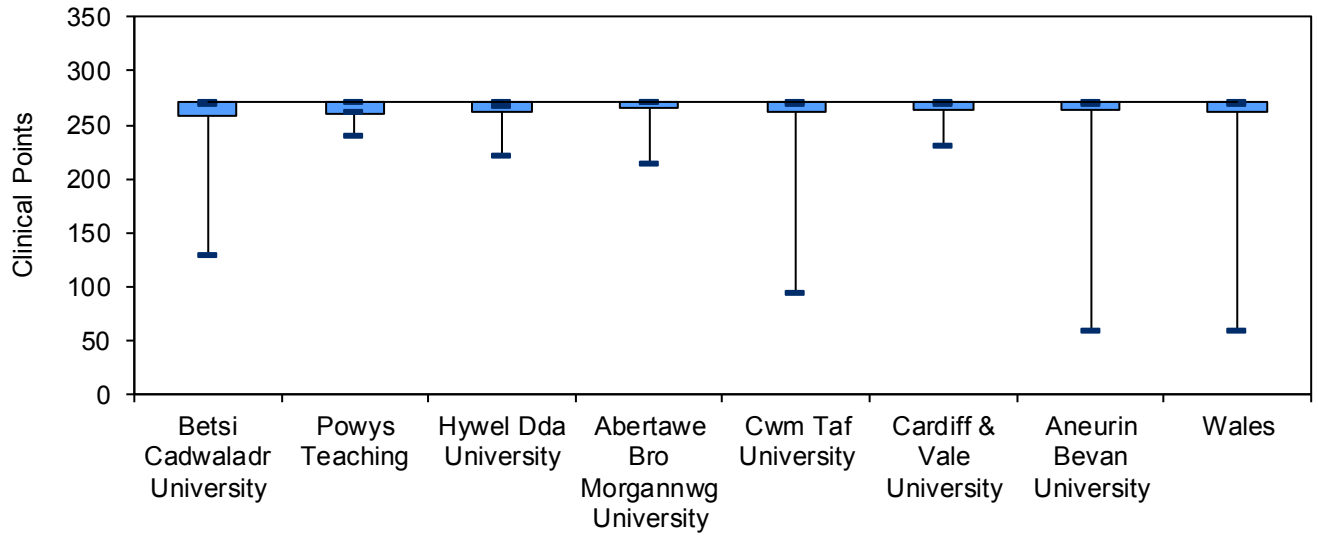


Chart 12 shows that the estimated proportion of patients diagnosed with dementia (i.e on the QOF register_ as a percentage of the resident population aged 65 or over who are calculated to have dementia. This shows that in 2015-16 Cardiff and Vale University had the highest diagnoses rate of 57.8 per cent whilst Hywel Dda had the lowest (43.4 per cent).

11.1 Clinical domain by Local Health Boards

Chart 13: Distribution of clinical points achieved by practices



Source: CM Web

The maximum point available for the clinical domain, in 2015-16, was 272 points. 113 (25.2 per cent) practices achieved the maximum 272 points. The line in chart 12 represents the maximum 272 points. Within Health Boards the median (middle value) clinical points were all between 262.5 (Powys Teaching) and 271.0 (Abertwawe Bro Morgannwg University).

Refer to the 'Clinical data by practice, 2015-16' spreadsheet for further information.

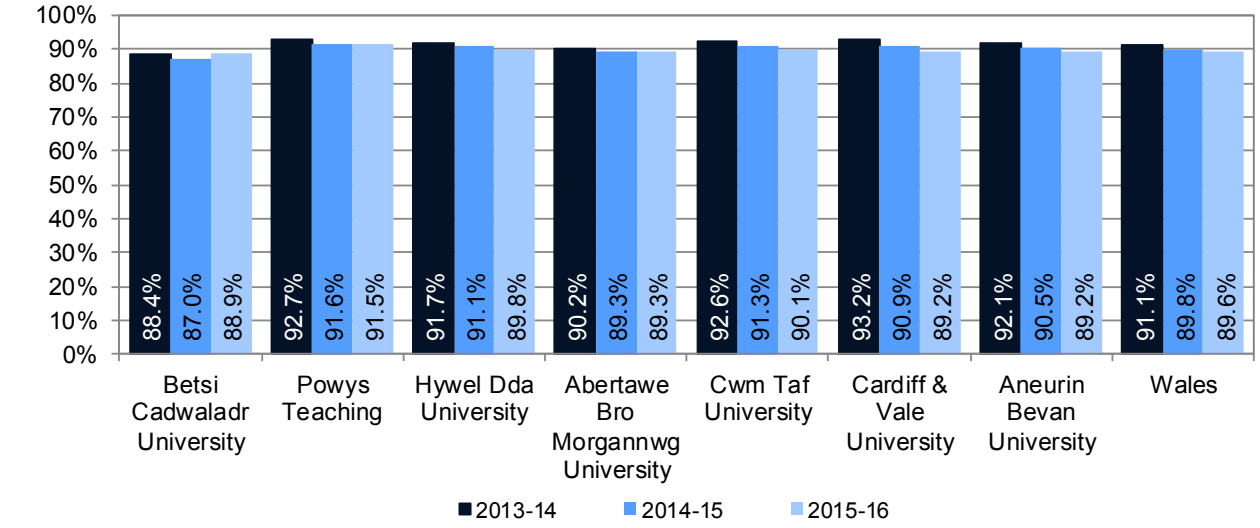
Diabetes

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 14 shows there was a decrease in the proportion of patients with diabetes with a record of foot examination in every health board in 2015-16 compared to 2014-15, apart from Betsi Cadwaladr University where there was an increase by 1.9 percentage points. In 2015-16, Powys Teaching Health Board recorded the highest proportion, accounting for 91.5 per cent of patients with a record of a foot examination.

Chart 14: Percentage of patients with diabetes with a record of a foot examination by Local Health Board



Chronic obstructive pulmonary disease (COPD)

Chronic Obstructive Pulmonary Disease is a common and disabling condition. Most acute exacerbations are triggered by community-acquired respiratory infections. Pulmonary rehabilitation is defined as a multidisciplinary programme of care for patients with chronic respiratory impairment.

Description	Indicator
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.	COPD08

Chart 15: Percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months by Local Health Board

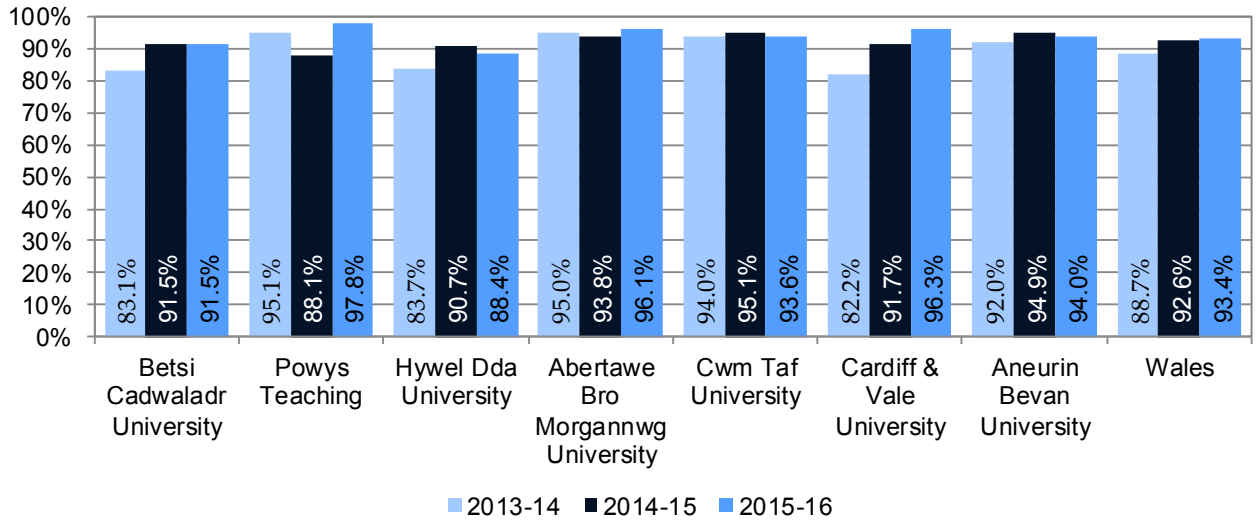
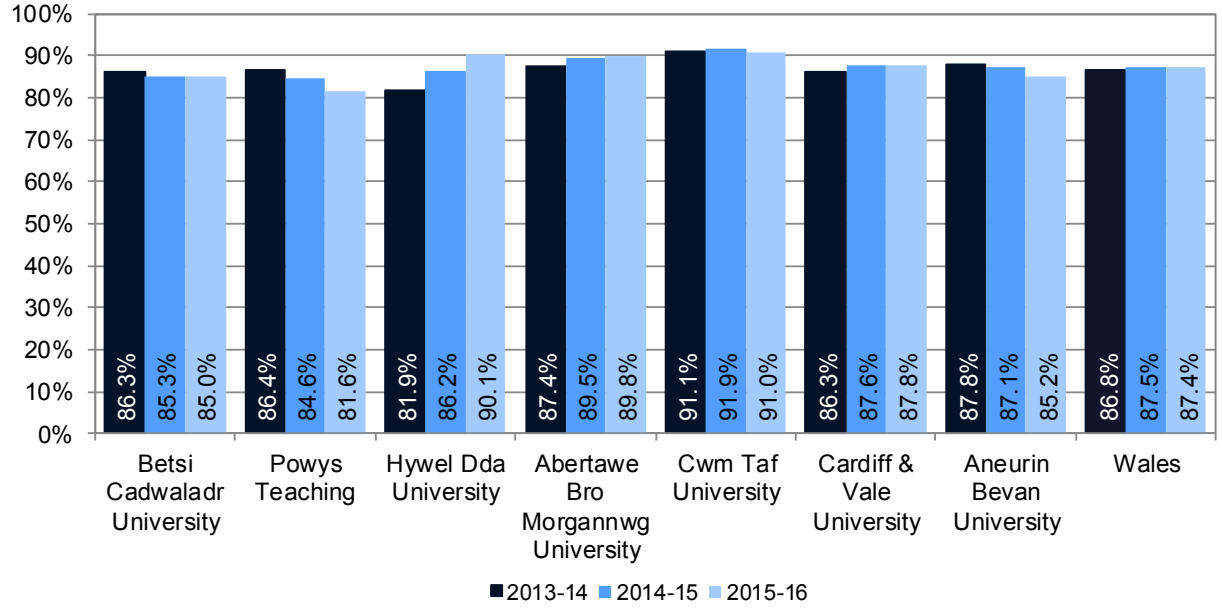


Chart 15 shows that there the proportion of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months varied between health boards in 2015-

16. In 2015-16, Powys Teaching Health Board recorded the highest proportion, accounting for 97.8 per cent of patients with COPD and Medical Research Council dyspnoea grade ≥3. In Cardiff and Vale University 96.3 percent of patients had a subsequent record of an offer of referral to a pulmonary rehabilitation programme, an increase of over 14 percentage points compared to 2013-14. Hywel Dda University Health Board recorded the lowest percentage at 88.4 per cent of patients.

11.2 Public Health domain by local health boards

Chart 16: 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

Three Health Boards saw an increase in the proportion of patients offered support and treatment in relation to smoking in 2015-16, when compared to the previous year. Hywel Dda University saw an increase of 4 percentage points when compared to the previous year.

In 2015-16, 91.0 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 81.6 per cent of current smokers were offered support a decrease of 3 percentage points when compared to the previous year.

12. 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.

In 2014-15 the QOF Quality and Productivity domain was replaced with a new GP Cluster Network Development Domain. This QOF Domain, which attracts 160 points, forms part of a three year development programme to support practices to work collaboratively within Cluster Networks. Of which this is the second year. 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, taking into account the work from the national and locally agreed priority areas from the previous year.	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 the individual Practice Development Plan that can be most effectively addressed as a GP cluster network action.	CND002W

Description	Indicator
The contractor participates in three 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

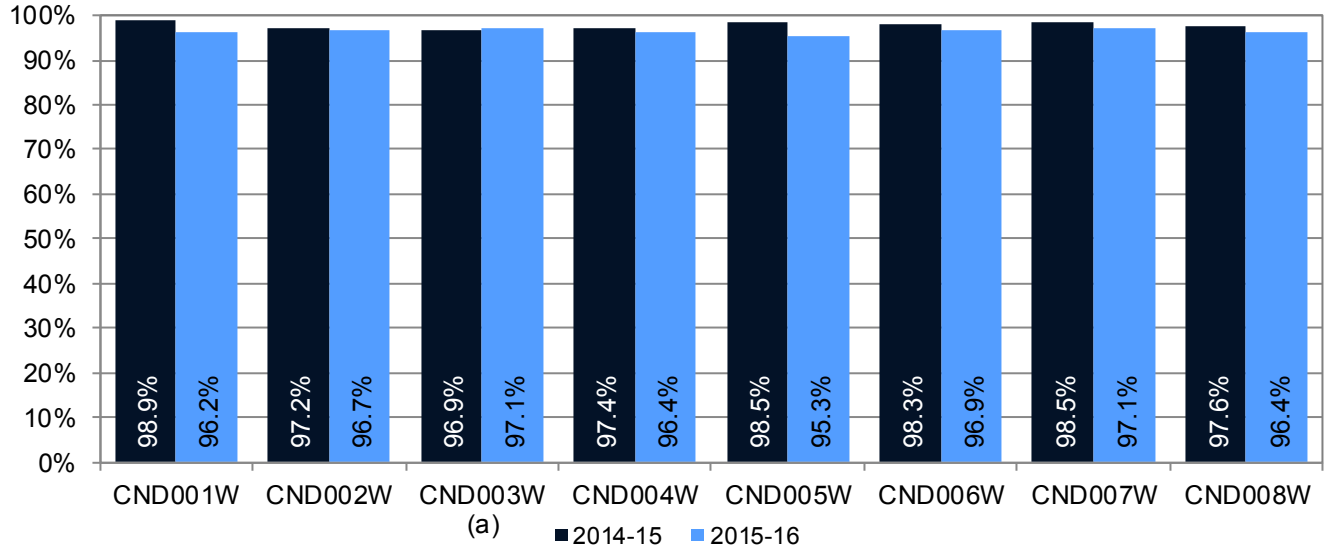
Description	Indicator
The contractor updates and completes the Clinical Governance Practice Self Assessment Toolkit (CGPSAT).	CND005W

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 2015 and 31st December 2015 with lung (including mesothelioma) or digestive system cancer using a Significant Event Analysis tool. 2. Review the care of all patients newly diagnosed with ovarian cancer between 1st January 2015 and 31st December 2015 using a Significant Event Analysis tool. 3. Summarise learning and actions to be shared with the network and the wider LHB. 4. Identify and include any relevant actions to be addressed in the Practice Development Plan. 4. Summarise themes and actions for discussion at GP cluster network meetings and share information with the LHB as required. This should be achieved through completion of the proforma	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 17: GP cluster network development indicator achievements



Source: CM Web

(a) In 2015-16 the number of GP Cluster network meetings the contractor participated in changed from four to three.

There were decreases in proportions of achievement in 7 of the 8 GP Cluster Network Development Indicators. 436 (97.1 per cent) practices participated in three GP cluster network meetings to review and implement and delivery of the GP cluster network action plan (CND003W), an increase compared to 96.9 per cent in 2014-15.

432 (96.2 per cent) practices produced an agreed practice development plan and shared it with their Health Board (CND001W), 434 (96.7 per cent) practices agreed to a GP cluster network action plan (CND002W). 433 (96.4 per cent) practices participated in a GP cluster meeting to develop and agree a GP cluster network annual report (CND004W) and 428 (95.3 per cent) practices completed the clinical governance practice self assessment toolkit (CND005W).

435 (96.9 per cent) practices reviewed the care of all patients newly diagnosed between 1 January 2015 and 31 December 2015 with lung (including mesothelioma) or digestive system cancer (CND006W), and 436 (97.1 per cent) practices identified all deaths between 1 January and 31 December 2015 and reviewed end of life care (CND007W). Also, 433 (96.4 per cent) practices identified and recorded the proportion of patients aged 85 or more receiving six or more medications (CND008W).

Chart 18: Cluster atrial fibrillation prevalence rates, 2015-16

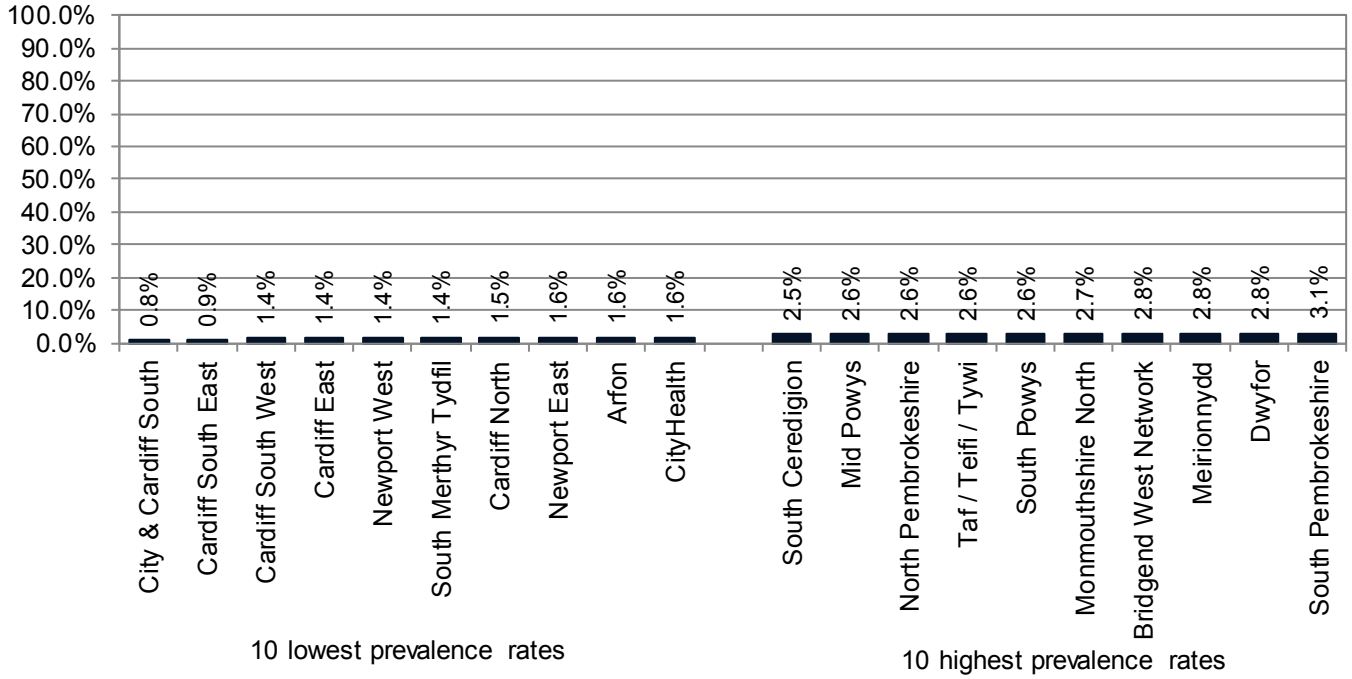


Chart 18 illustrates which clusters had the 10 highest and 10 lowest atrial fibrillation prevalence rates. The cluster with the highest prevalence rate was South Pembrokeshire East at 3.1 per cent and the cluster with the lowest prevalence rate was City and Cardiff South at 0.8 per cent.

Chart 19: Cluster palliative care prevalence rates, 2015-16

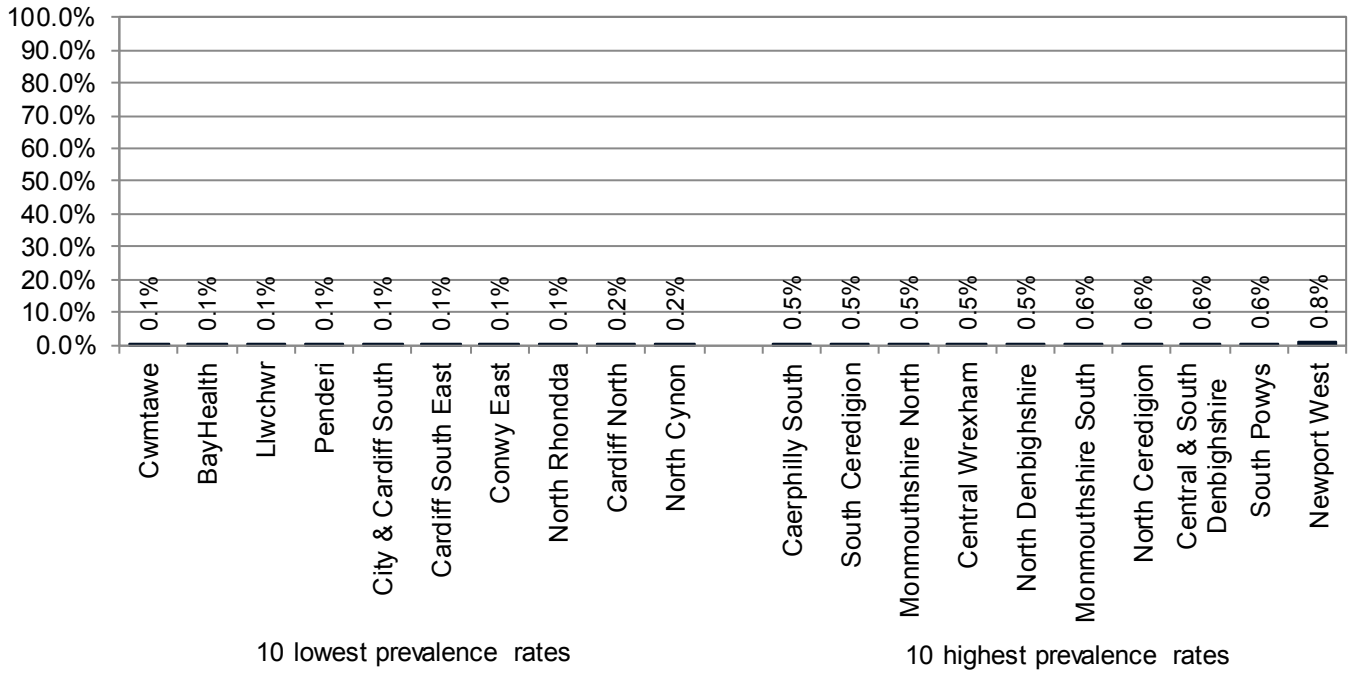


Chart 19 shows which clusters had the 10 highest and 10 lowest Palliative Care prevalence rates. Newport West had highest prevalence rate at 0.8 per cent and Cwmtawe had the lowest prevalence rate at 0.1 per cent.

Chart 20: Cluster mental health prevalence rates, 2015-16

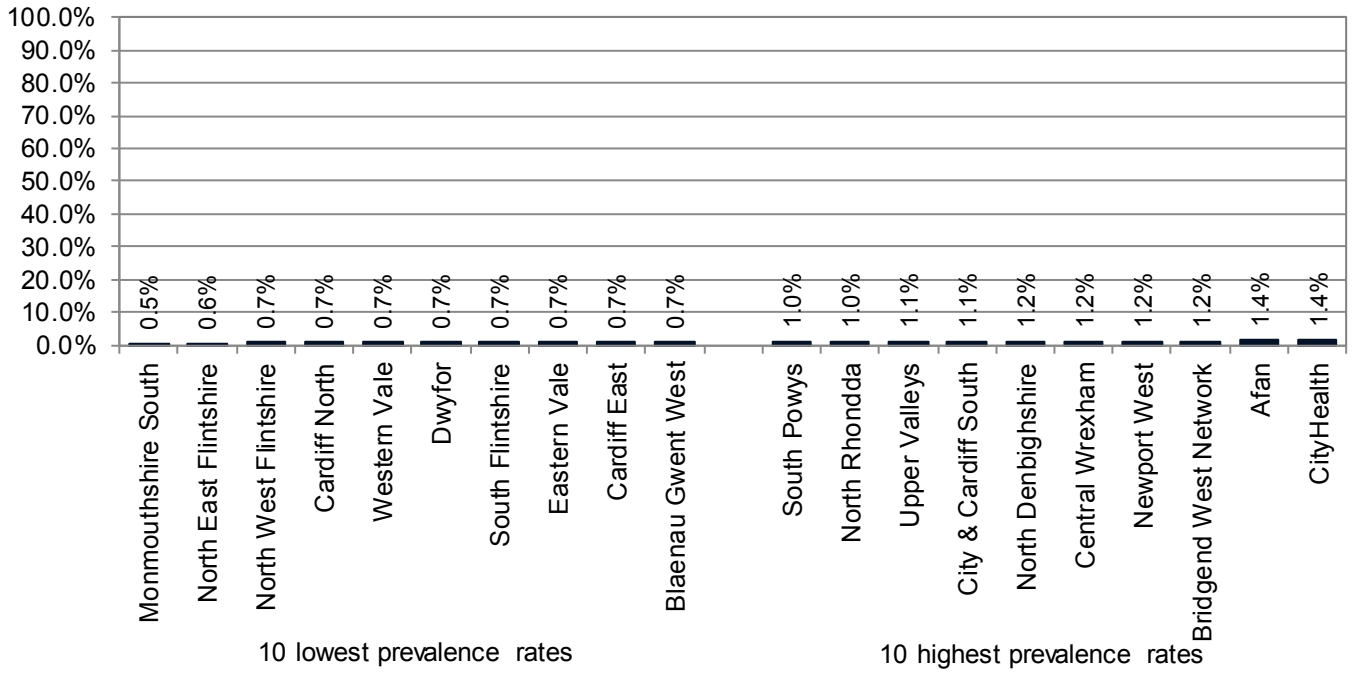


Chart 20 shows which clusters had the 10 highest and 10 lowest Mental Health prevalence rates. City Health had highest prevalence rate at 1.4 per cent and Monmouthshire South had the lowest prevalence rate at 0.5 per cent.

Chart 21: Cluster diabetes mellitus prevalence rates, 2015-16

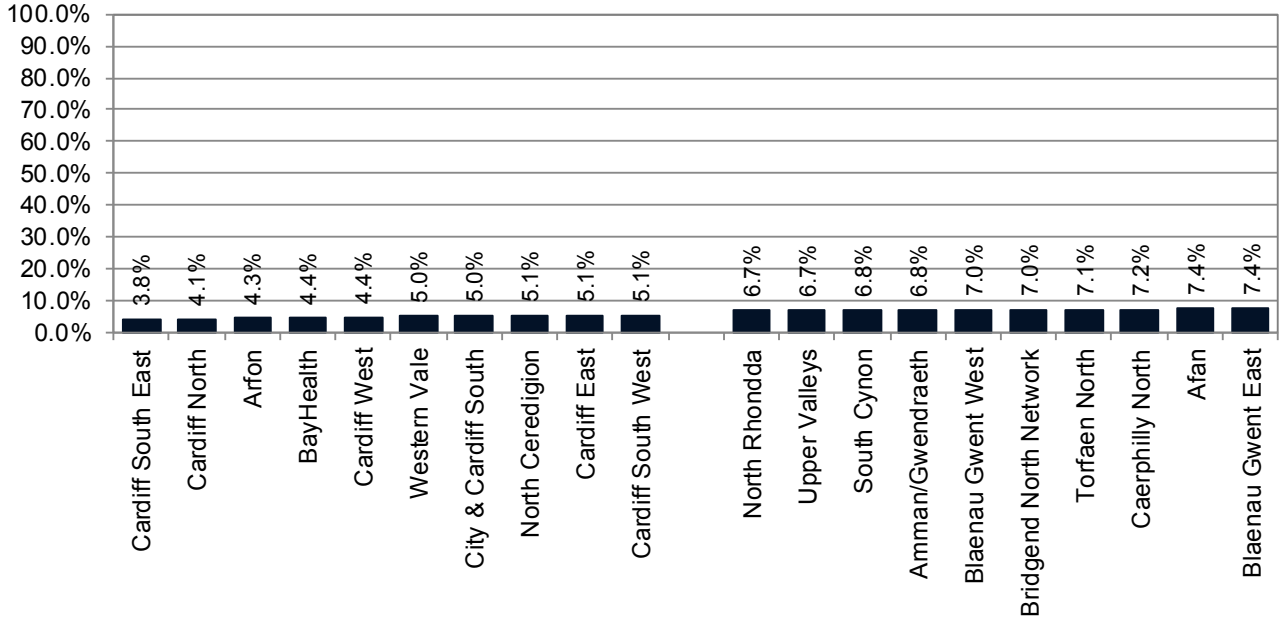


Chart 21 shows which clusters had the 10 highest and 10 lowest Diabetes Mellitus prevalence rates. Blaenau Gwent East had highest prevalence rate at 7.4 per cent and Cardiff South East had the lowest prevalence rate at 3.8 per cent.

Chart 22: Cluster dementia prevalence rates, 2015-16

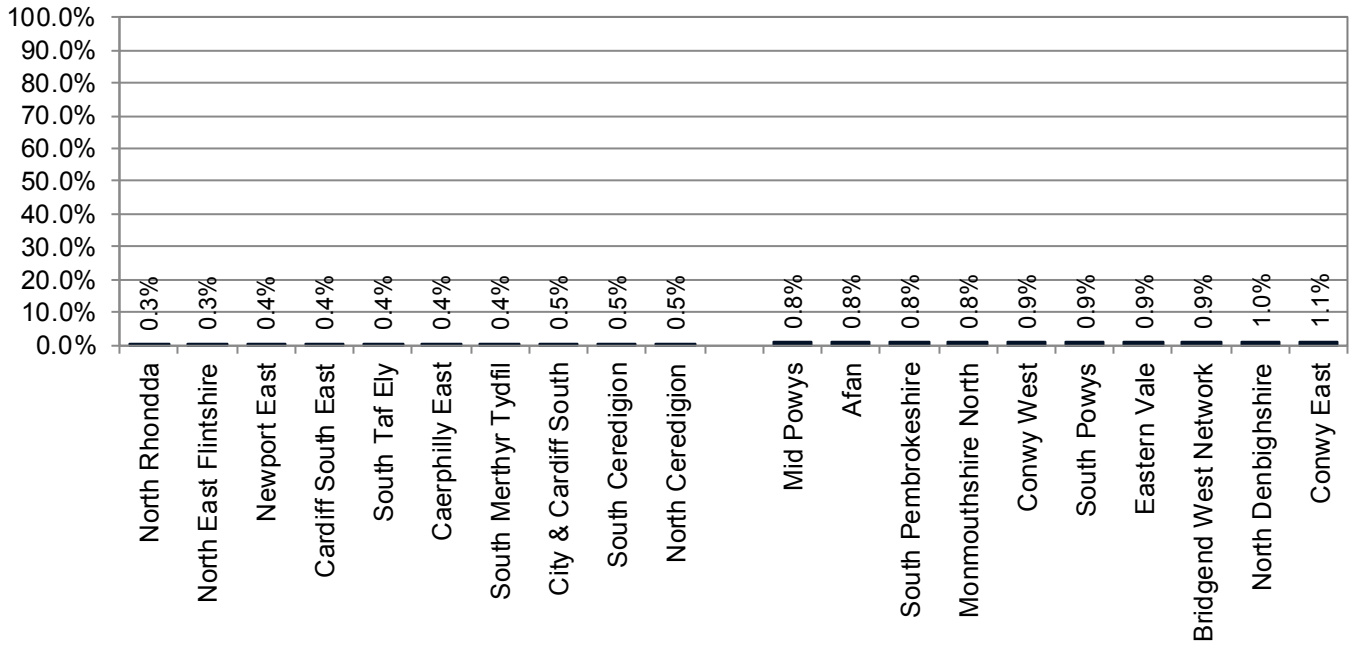


Chart 22 shows which clusters had the 10 highest and 10 lowest Dementia prevalence rates. Conwy East had highest prevalence rate at 1.1 per cent and North Rhondda had the lowest prevalence rate at 0.3.

Chart 23: Cluster chronic obstructive pulmonary disease prevalence rates, 2015-16

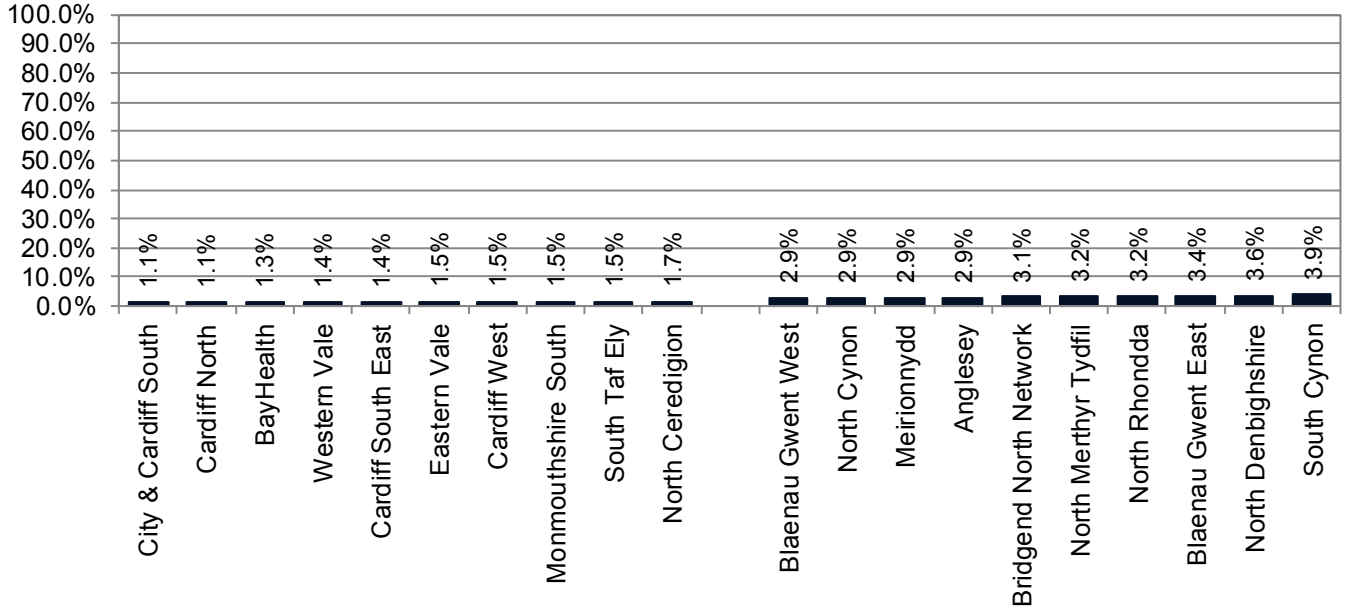
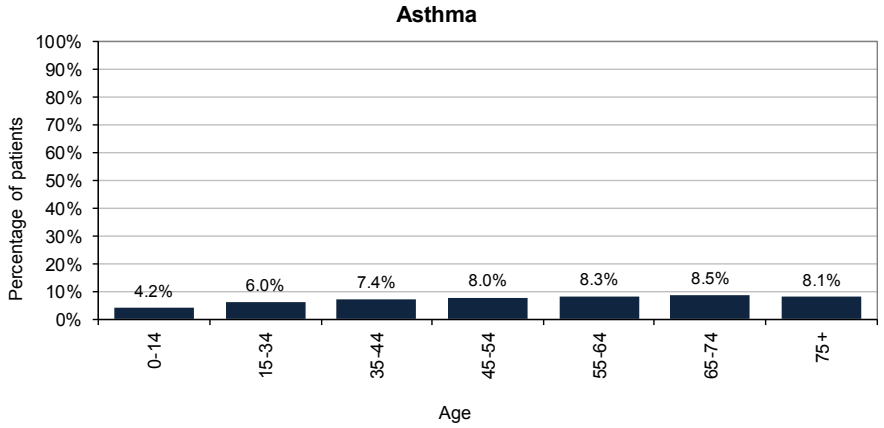


Chart 23 shows which clusters had the 10 highest and 10 lowest chronic obstructive pulmonary disease (COPD) prevalence rates. South Cynon had highest prevalence rate at 3.9 per cent and Cardiff North had the lowest prevalence rate at 1.1.

Charts 24: 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 2016 and is from 449 practices.



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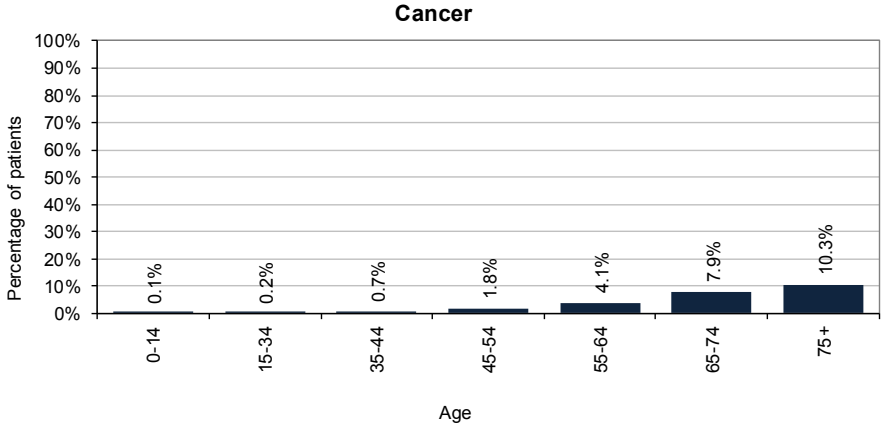

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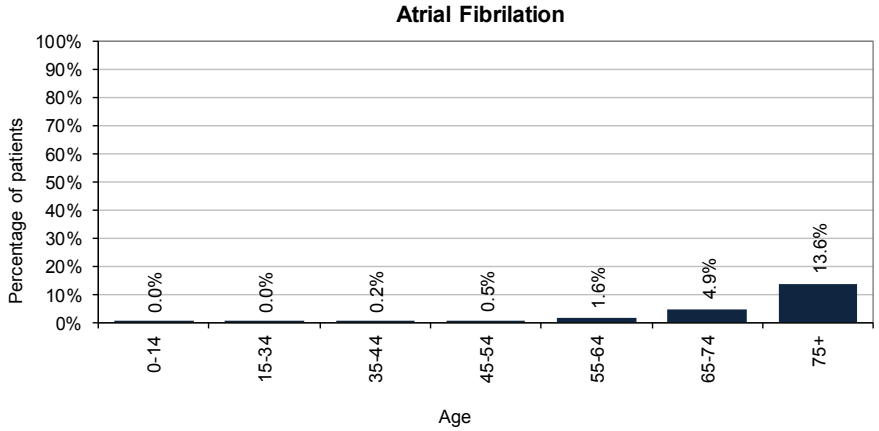

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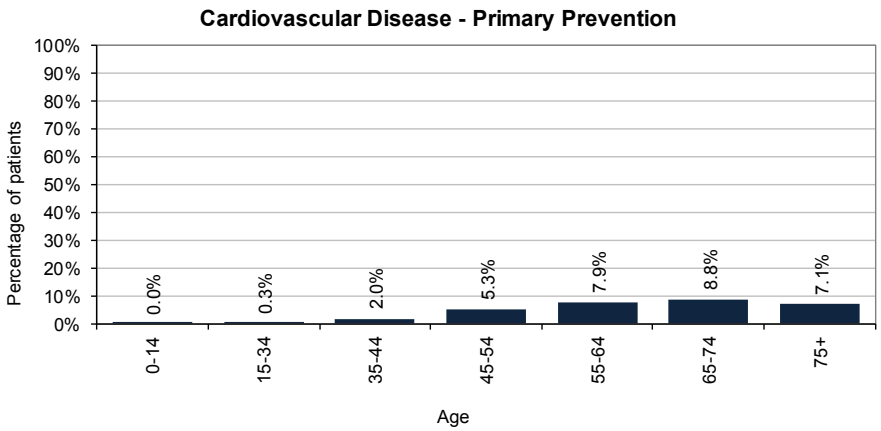

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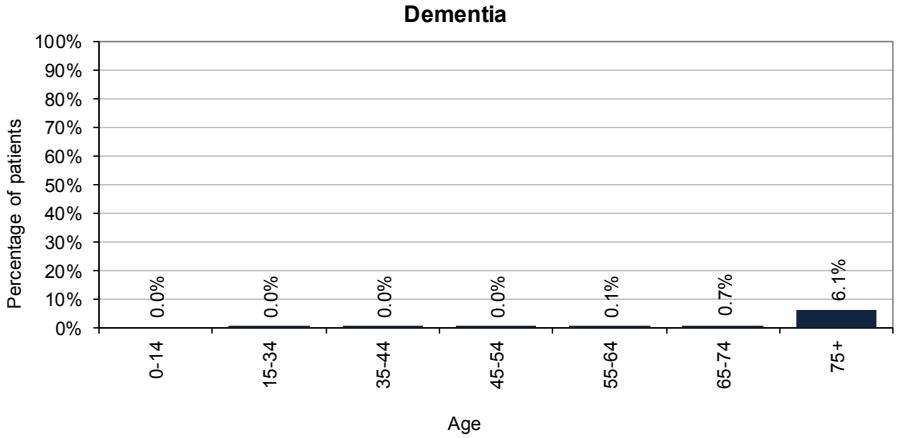

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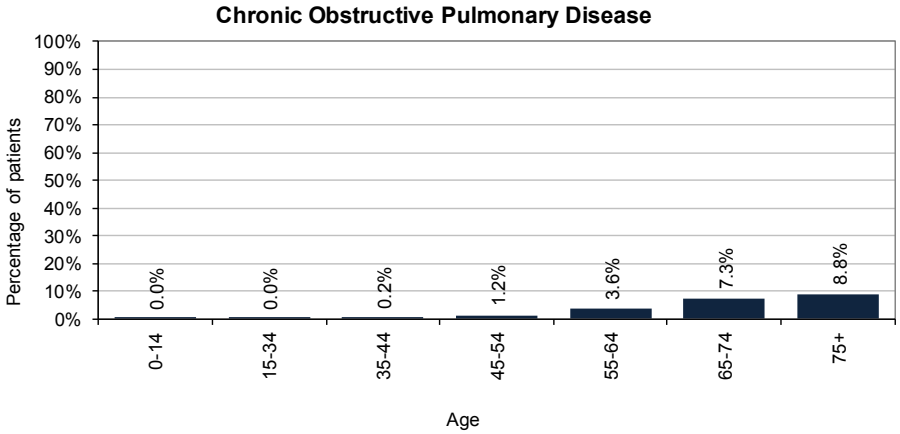

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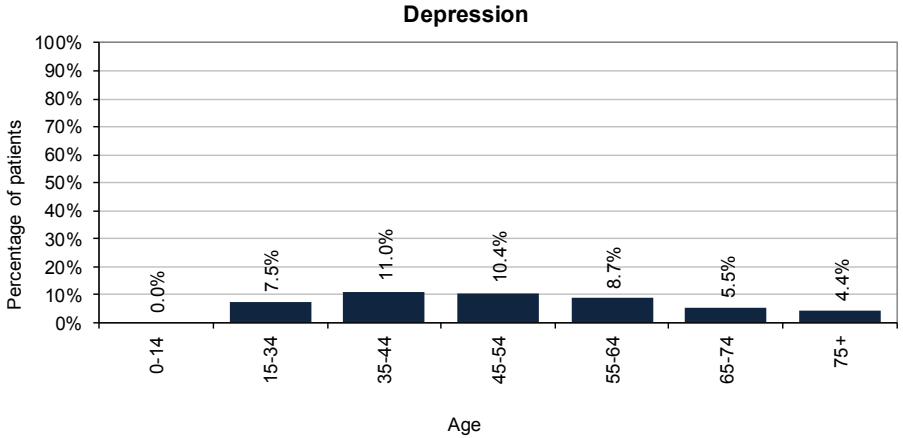

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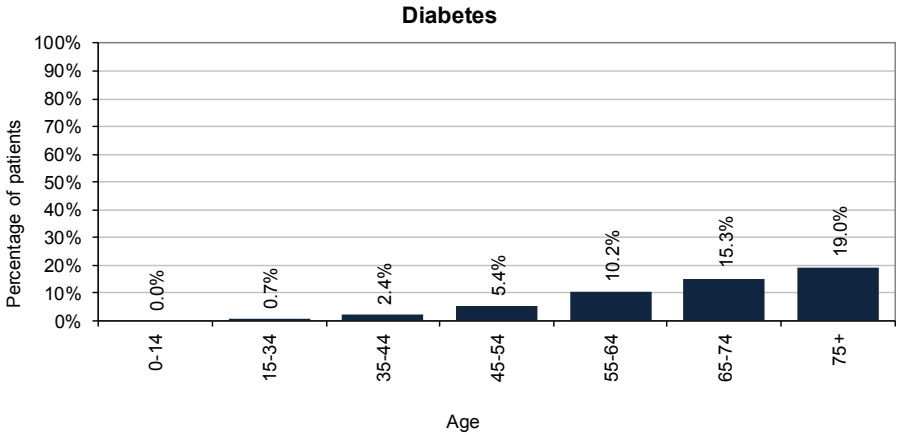

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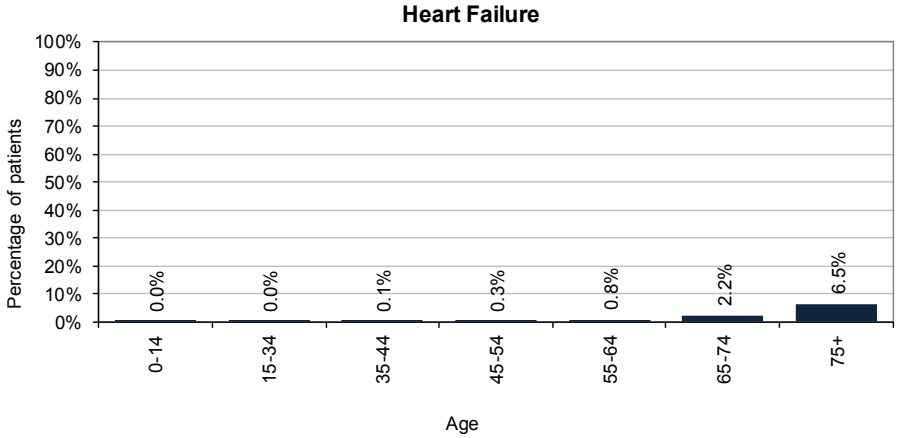

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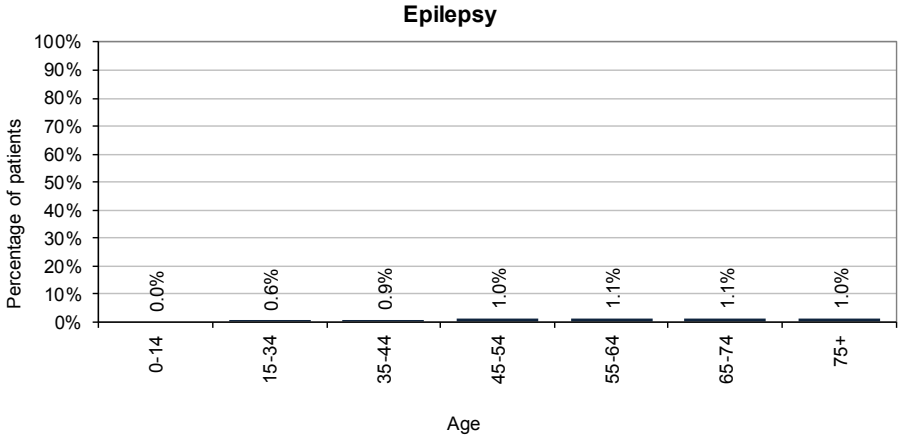

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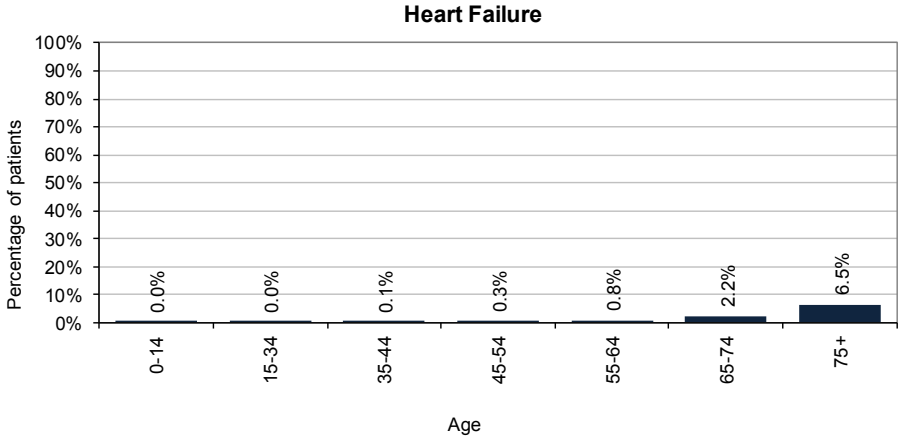

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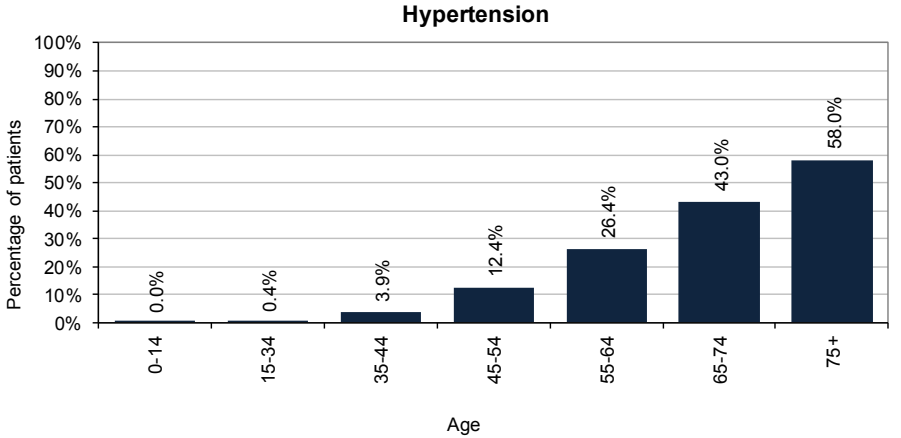

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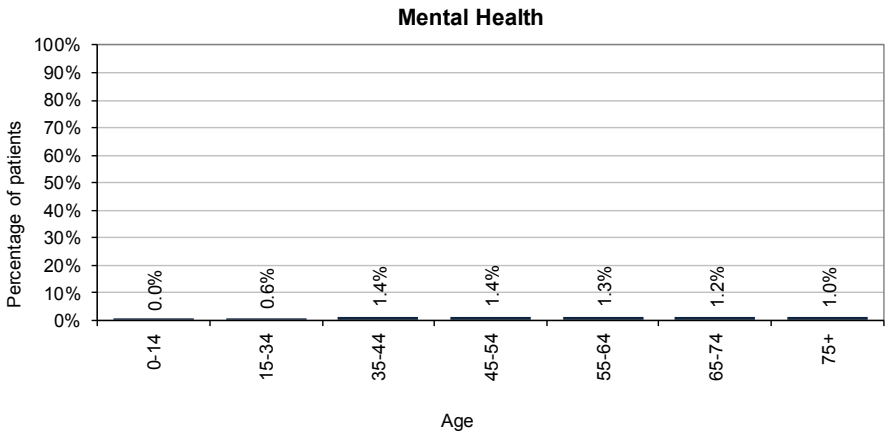

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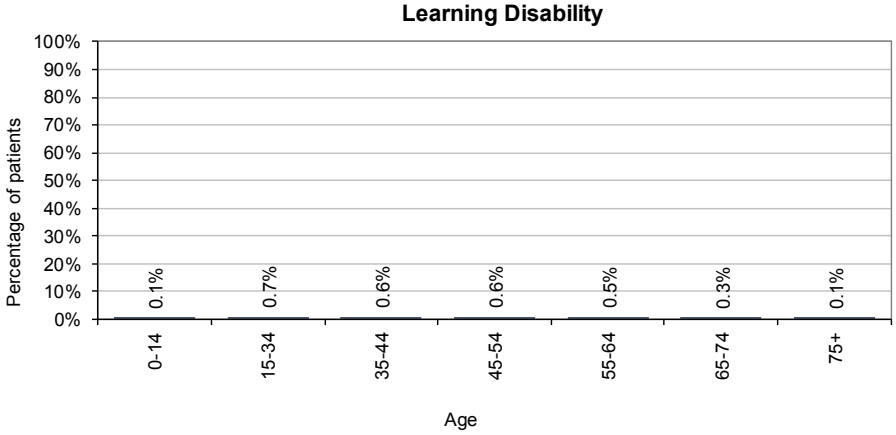

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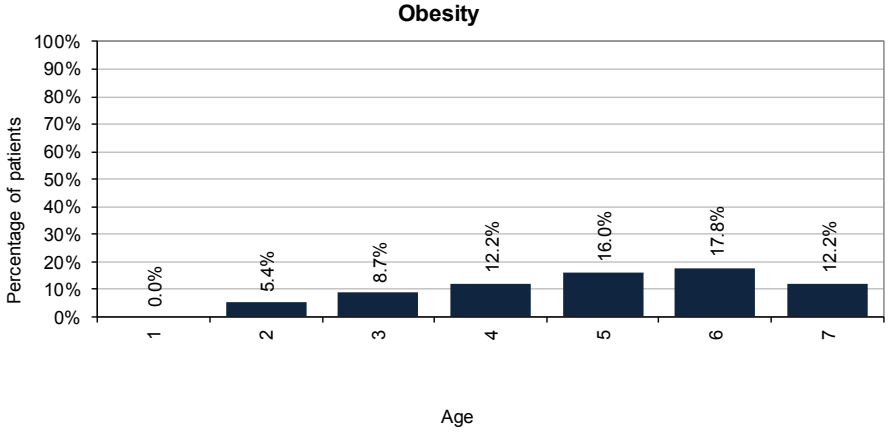

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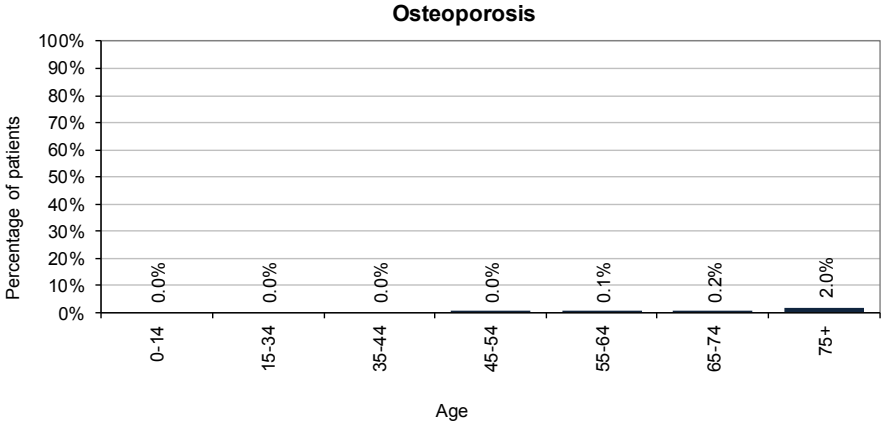

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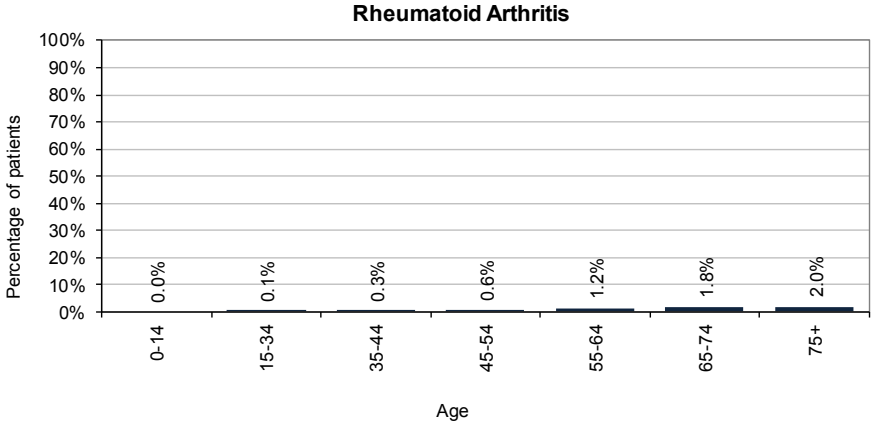

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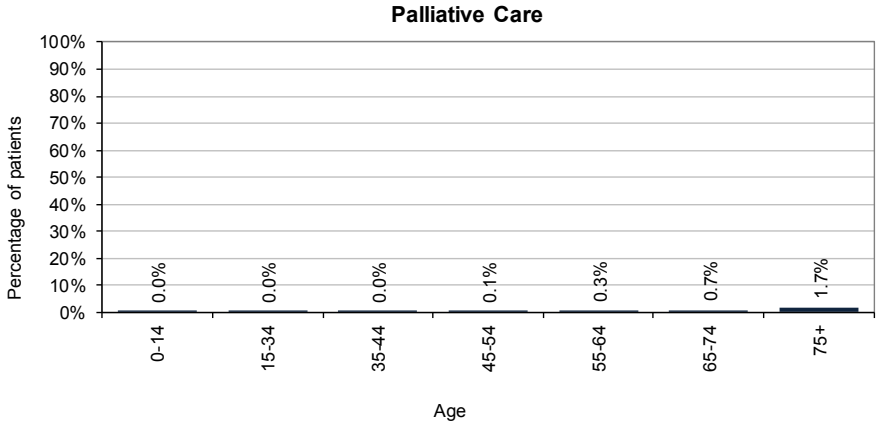

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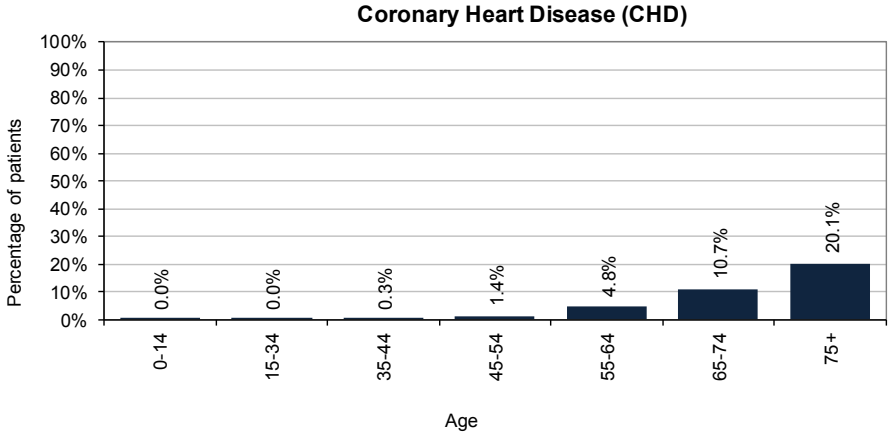

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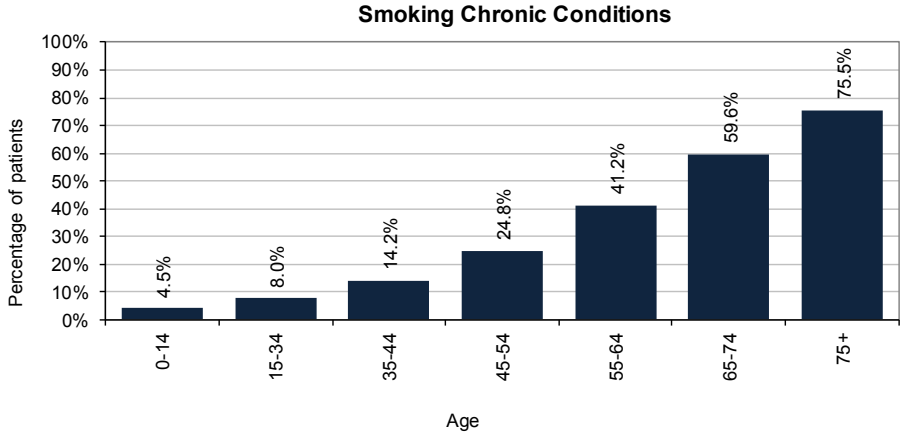

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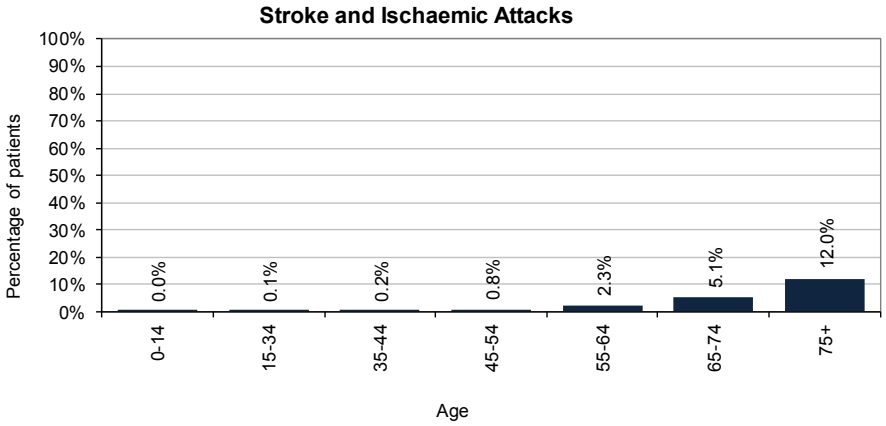

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Notes

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.

Disease areas

Descriptions of the 2015-16 disease areas are listed below:

Disease area	Register description	QOF indicators
Coronary Heart Disease (CHD)	Patients diagnosed with CHD ever.	CHD001
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, 005W,
Stroke and Transient Ischaemic Attack (TIA)	Patients diagnosed with stroke and/or TIA ever.	STIA001
Hypertension	Patients diagnosed with established hypertension ever.	HYP001, 006
Diabetes Mellitus	Patients aged 17 and over diagnosed Diabetes.	DM001-003, 007, 012, 014
Chronic Obstructive Pulmonary Disease	Patients diagnosed with COPD ever.	COPD001- 003, 005, 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, 009, 010, 011W

Asthma	Patients diagnosed with Asthma who have been prescribed asthma-related drugs in the preceding 12 months.	AST001, 003, 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, 006, 007
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
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
Rheumatoid Arthritis	Patients aged 16 or over with Rheumatoid arthritis	RA001, 002
Influenza (FLU)	Patients aged 65+ who have had influenza immunisation Patients under 65 included in (any of) the registers for CHD, COPD, Diabetes or stroke who have had influenza immunisation	FLU001W, FLU002W

Further information about QOF indicators.

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.

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

[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

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 2015/16 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 who have been diagnosed with dementia as a proportion of the number who are estimated to have the condition. They are calculated as follows:

- Estimates of the numbers of people with dementia in Wales have been made using prevalence rates by age (for people aged 65 or over) and sex published in a Lancet paper from the CFAS (Cognitive Function and Ageing Study) II study. 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.
- The UK age/sex prevalence rates were applied to mid year estimates for Wales to produce estimated counts of people with dementia. A small amendment (3 per cent reduction) has been made to account for the fact that the dementia register is for all ages. From Audit+ data it is estimated that around 3 per cent of people on the register are aged under 65 years old.

In the 2014-15 edition of this release, prevalence rates from the Dementia UK Report published by the Alzheimer’s Society in 2007 were used in this analysis but, as was mentioned in that release, the methodology was kept under review and has now been revised to use CFAS II prevalence rates. In England, until April 2015, dementia diagnosis rates were also calculated using estimates of dementia prevalence reported in the 2007 Alzheimer’s Society ‘Dementia UK’ report. Following a

consultation with other stakeholders, NHS England now believes that the best scientific evidence of rates of dementia prevalence in England are those reported in 2013 by the Cognitive Function and Ageing Study II (CFAS II). CFAS II provides authoritative empirically derived real data from three populations in England and, as such, is UK evidence-based rather than the evidence-led Alzheimer's Society 2007 Delphi consensus (a consensus agreement by experts based on a review of international studies).

NHS England publishes estimated diagnosis rates for dementia for England; these are available, together with FAQs and background and methodological notes.

Estimates using the methodology outlined in the 2014-15 statistical release, for adults aged 30 or over, would have produced 43,052 people with dementia in Wales in 2015-16 and a diagnosis rate of 47 per cent, an increase of 2 percentage points from the 2014-15 estimated diagnosis rate of 45 per cent.

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.

More information on the survey in relation to QOF.

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 2015-16 is presented for 449 general practices in Wales. This includes practices that had data automatically extracted by the CM Web system in June 2016, and data adjustments for the year 2015-16 submitted between April and June 2016. The 2015-16 disease prevalence tables are based on prevalence recorded on CM Web at 30 June 2016. 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 2015-16 QOF data use practice list sizes that have been derived from the practice clinical system as at 31 March 2016. 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 2015-16 financial year, and are correct as at 1 July 2016.

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.

Comparability

There were changes to the QOF indicators in 2015-16. These changes included the 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 2015-16 were:

- Reduction in the maximum number of QOF points available to 567 (669 in the previous year);
- 102 points released 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. These include
    - DEM002 decreased from 28 to 15 points and CS001 decreased from 7 to 5 points
    - RA002 increased from 5 to 10 points and MED006W increased from 4 to 9 points
    - New register Influenza (FLU)
    - New Indicators AF006 and AF007

These miscellaneous changes can be found in the links below:

Changes to the GP Contract 2015/16: Clinical QOF

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.

QOF Publications in other UK countries

England:Quality and Outcomes Framework

Scotland:

The final 2015-16 QOF publication was released on 11th October 2016. ISD will no longer be publishing the QOF after this date as the QOF is being dismantled, with all points being retired and funding transferred to practice core funding. QOF data will no longer be extracted for payment purposes. 2016-17 QOF data will continue to be extracted to support the peer led GP Cluster Continuous Quality Improvement process as part of the latest GMS contract agreement.

Northern Ireland: Quality & outcomes framework

Feedback

We actively encourage feedback from our users. If you have any comments or require further information please email stats.healthinfo@wales.gsi.gov.uk.

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Appendix 1 – Descriptions of 2015-16 QOF indicators

Clinical Domain

Atrial Fibrillation (AF)

AF001: The contractor establishes and maintains a register of patients with atrial fibrillation.
AF006 The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)
AF007 In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy

Secondary prevention of Coronary Heart Disease (CHD)

CHD001: The contractor establishes and maintains a register of patients with coronary heart disease.

Heart Failure (HF)

HF001: The contractor establishes and maintains a register of patients with 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.

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.
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.

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.
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.

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.
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.
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

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.

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.

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

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%.

Flu

FLU001W: The percentage of the registered population aged 65 years or more who have gad influenza immunisation in the preceding 1 August to 31 March Range 55% -75%
FLU002W: The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March Range 45% - 65%

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

Quality and Outcomes Framework (QOF) points by local health board and register.

Patients on Quality and Outcomes Framework (QOF) disease registers by local health board.

Appendix 3 - Well-being of Future Generations Act (WFG)

The Well-being of Future Generations Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. The Act puts in place seven well-being goals for Wales. These are for a more equal, prosperous, resilient, healthier and globally responsible Wales, with cohesive communities and a vibrant culture and thriving Welsh language. Under section (10)(1) of the Act, the Welsh Ministers must (a) publish indicators ("national indicators") that must be applied for the purpose of measuring progress towards the achievement of the Well-being goals, and (b) lay a copy of the national indicators before the National Assembly. The 46 national indicators were laid in March 2016.

Information on indicators and associated technical information - How do you measure a nation's progress? - National Indicators

Further information on the Well-being of Future Generations (Wales) Act 2015.

The statistics included in this release could also provide supporting narrative to the national indicators and be used by public services boards in relation to their local well-being assessments and local well-being plans.