Department of Health
An Roinn Sláinte
Männystrie O Poustie
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INFORMATION ANALYSIS DIRECTORATE

General Practice Quality and Outcomes Framework Achievement and Exceptions Reporting Statistics 2022/23

Based on administrative data for April 2022-March 2023 recorded on the General Practice Intelligence Platform (GPIP/QOF) at 30th June 2023

Introduction

This bulletin summarises the nineteenth year of Quality and Outcomes Framework (QOF) achievement and exception reporting data from general practices, relating to the period from April 2022 to March 2023.

QOF is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the general medical services (GMS) contract, introduced on 1st April 2004.

The QOF contains groups of indicators, against which practices score points according to their level of achievement. QOF awards surgeries achievement points for (i) managing chronic diseases, (ii) providing services for cervical screening and (iii) improving quality and productivity with regard to secondary care referrals; and (iv) improving patient experience. The overall structure of the Framework including number of indicators and maximum number of points available are provided on page 4.

All data used in this bulletin are from the GPIP/QOF (General Practice Intelligence Platform/QOF), a Northern Ireland (NI) IT system used by general practices to support the QOF payment process and is dated 1st April 2023.

Disease prevalence data are used to calculate QOF points and payments, with adjustments made to each practices pound per point, dependent on their prevalence of a disease or condition relative to the estimated regional Northern Ireland prevalence. These adjustments are known as the Adjusted Practice Disease Factor (APDF); further details on this process can be found on page 6.

QOF includes the concept of exception reporting. This was introduced to allow practices to pursue the quality improvement agenda and not be penalized where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side effect. Further details can be found on page 21.

This bulletin presents achievement statistics by domain, and at LCG and GP Federation levels. A time series of 2018/19 to 2022/23 clinical achievement data is also presented.

Summaries of exception rates are presented by indicator group, and at LCG and GP Federation levels. Accompanying data files including general practice data and an interactive dashboard are available on the DoH website.

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Structure of the 2022/23 Quality & Outcomes Framework

The Quality and Outcomes Framework consists of 4 domains (Clinical, Public Health, Records & Systems and Patient Experience) each containing a range of areas described by a total of 55 indicators and a maximum of 547 points available to achieve. These indicators have points attached that are given to GP practices based on how they are performing against these measures. The structure of the QOF for 2022/23 is detailed in Figure 1 below. The QOF has remained relatively unchanged since 2016/17; some definitional changes and re-allocation of points occurred within Records & Systems in 2021/22. However, 2022/23 brought a significant overhaul to the Framework, in terms of indicators, definitions and points. Changes in terms of indicators removed and new indicators added for 2022/23 are detailed in Figure 2 below. A full detailed list of the indicators is presented in Annex A. Note below the introduction of Reprioritisation of Care (RoC) and the differential requirements of those practices contracting to provide RoC versus those practices opting into QOF.

Reprioritisation of Care (RoC)

During 2022/23, Reprioritising of Care (RoC) was introduced in recognition of issues and delays with regards to monitoring progress towards QOF targets and the pressures facing general practice/patient services. With this Reprioritising of Care, practices were required to contract to provide NI Local Enhanced Services (LES) in respect of Proactive GP Care for Nursing & Residential Homes and Managing Winter Pressures. As a result, QOF requirements were revised, with Practices who opted into RoC required to continue to report on a total of 7 non-clinical indicators only (all Quality Improvement indicators and selected indicators within the Records & Systems and Patient Experience domains). There would be no financial detriment to practices as a result of RoC and a replacement payment process was developed for all practices who chose to avail of this option. For those general practices who did not opt into RoC, revised QOF requirements did not apply and they were required to aspire to achieve all QOF indicator thresholds in order to generate reimbursement. The structure of QOF for 2022/23 is presented in Figure 1 below; those non-clinical indicators that RoC practices were required to report on are highlighted in yellow.

Presentation of Results in this Report

Whilst RoC practices were only required to report on the 7 non-clinical indicators, ***ALL RoC practices*** actually aspired to achieve points across all areas in the Clinical Domain and the Public Health Domain (Cervical Screening). Additionally, a number of RoC practices aspired to achieve and report on the other 6 non-clinical indicators not required under the terms of the RoC. The number of RoC practices reporting these non-clinical indicators varies by indicator; care should be taken to note the number of practices in each case. Data in this report is therefore presented as detailed in Figure 3 below.

Figure 1: Structure of the Quality & Outcomes Framework 2022/23

Non-Clinical Indicators required for reporting by RoC practices

Domain	RoC	Area	No. of Indicators	Max. Points Available
Clinical		Asthma	1	20
		Atrial Fibrillation	2	22
		Cancer	1	6
		Coronary Heart Disease	3	41
		Chronic Kidney Disease	3	15
		Chronic Obstructive Pulmonary Disease	2	14
		Dementia	2	21
		Diabetes Mellitus	7	47
		Heart Failure	3	21
		Hypertension	2	20
		Mental Health	5	23
		Palliative Care	1	5
		Stroke and Transient Ischaemic Attack	5	19
		Influenza Vaccination	2	25
		Non diabetic hyperglycaemia	1	8
		Domain Total	*40*	*307*
Non-Clinical Indicators within Clinical		Asthma	1	14
		Palliative Care	1	15
		Sub-Domain Total	*2*	*29*
Public Health		Cervical Screening	2	11
		Domain Total	*2*	*11*
Records & Systems		Records & Systems RS001	1	20
		Records & Systems RS002	1	20
		Records & Systems RS006	1	20
		Records & Systems RS004	1	20
		Records & Systems RS005	1	20
		Domain Total	5	100
Patient Experience		Patient Access AC001	1	15
		Patient Access AC002	1	15
		Patient Access AC003	1	10
		Quality Improvement	3	60
		Domain Total	*6*	*100*
		Framework Total	55	*547*

Changes to QOF for 2022/23

A number of changes were made to QOF for 2022/23, with some indicators being retired and others introduced. In some cases, entire diseases or conditions were removed from QOF, as all of their component indicators were removed. These were Blood Pressure, Sexual Health, Cardiovascular Disease – primary prevention, Depression, Osteoporosis, Rheumatoid Arthritis, and Smoking. There were also new areas added for 2022/23, namely Chronic Kidney Disease, Non-Diabetic Hyperglycaemia, Influenza vaccination, Patient Access and Quality Improvement.

Figure 2: Changes to QOF for 2022/23

Indicators removed from QOF
AST002, AST004
BP002
CHD007
CON003
COPD002, COPD004, COPD007
CS002
CVDPP011, CVDP012
DEP001
DM002, DM003, DM004, DM007, DM010, DM015
HYP002, HYP003NI, HYP007
MH008, MH009, MH010
OST002, OST005
RA002, RA003, RA004
SMOK001
STIA003, STIA008, STIA009

Indicators added to QOF
AC001, AC002
AST006NI
CKD005NI, CKD006NI, CKD007NI
CS003NI, CS004NI
DM022NI, DM023NI, DM024NI
HYP003NI, HYP007
VI01NI, VI02NI
MH011NI, MH012NI
NDH001
STIA010NI
QI001, QI002, QI003

Figure 3: Presentation of Data in this Report

Domain	Area	Data Presented	Number of Practices Presented
Clinical	All Clinical Areas	ALL QOF and ALL RoC practices	316
Non-Clinical Indicators within Clinical	Asthma - AST006NI	ALL QOF and a SUBSET of RoC practices	108
	Palliative Care - PC002	ALL QOF and a SUBSET of RoC practices	114
Public Health	Cervical Screening	ALL QOF and ALL RoC practices	316
Records & Systems	Records & Systems RS001 & RS005	ALL QOF and ALL RoC practices	316
	Records & Systems RS002	ALL QOF and a SUBSET of RoC practices	107
	Records & Systems RS004	ALL QOF and a SUBSET of RoC practices	111
	Records & Systems RS006	ALL QOF and a SUBSET of RoC practices	111
Patient Experience	Patient Access AC001 & Patient Access AC003	ALL QOF and ALL RoC practices	316
	Patient Access AC002	ALL QOF and a SUBSET of RoC practices	112
	Quality Improvement	ALL QOF and ALL RoC practices	316

Prevalence data and Adjusted Practice Disease Factors

Prevalence data are used within the QOF to calculate points and payments within each of the clinical domain areas. The number of pounds per point (£178.25 in 2022-23) in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the estimated regional Northern Ireland prevalence for that disease or condition. The aim of the prevalence adjustments in each of the QOF clinical domain areas is to deliver a more equitable distribution of payments in the light of different workloads that practices face in achieving the same number of points. Practices with a high prevalence of a specific disease or condition will receive more pounds per point for that clinical domain area than practices with a low prevalence of the same disease or condition. The amount by which the pounds per point is adjusted up or down is known as the Adjusted Practice Disease Factor (APDF). For example, a practice with an APDF of 1.20 for Asthma has a 20% higher adjusted prevalence than the Northern Ireland figure, and the adjusted pounds per point for asthma would equal = £178.25 * 1.20 = £213.90 per point. The QOF User Guidance Notes detail how prevalence is calculated and how it is used in the final payment calculations. The guidance includes a worked example.

The cervical screening indicator within the Public Health Domain does not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to a particular target population. The relevant target population is: (i) for Cervical screening services - females who have attained the age of 25 years but not yet attained the age of 65 years. The basic pounds per point, £178.25 in 2022/23, in each additional services area is adjusted up or down by a Target Population Factor. Details of this adjustment are given in the QOF User Guidance Notes.

Limitations on the use of QOF data

The data collected for the Quality & Outcomes Framework provides some useful information for researchers and public health officials regarding disease prevalence and care quality information about general practices. However, it is important to note the limitations of using QOF data to make further inferences and conclusions.

The following points should be noted:

- It may be inappropriate to use the data to make comparisons between practices in terms of the quality of care offered. For instance, the clinical disease areas chosen for the Quality & Outcomes Framework represent the minority of patients in Northern Ireland and therefore achievement in these areas does not reflect the full workload of general practices.

- As the Quality & Outcomes Framework system takes into account practice list size and disease prevalence before calculating payment, comparing practices by isolating particular domain points achieved does not account for the full system of QOF.

- The achievement of each practice will be partly dependent on the number of points each practice aspired to, therefore not all practices will have commenced QOF from the same baseline and not all will have improved to the same extent. Standards of recording diagnoses and other administrative procedures may also differ between practices.

The Impact of the Covid-19 Pandemic

During 2021/22, due to the continuing Covid-19 pandemic, the DoH agreed with NIGPC and the HSCB to continue standing down elements of the GMS contract. The majority of Quality and Outcomes Framework (QOF) activity and reporting remained suspended in 2021/22. Therefore, where QOF achievement time series data is presented, data for 2021/22 may have been impacted upon and it is recommended that the use of this data in publications or drawing conclusions from it includes appropriate caveats acknowledging the unprecedented impact of Covid-19.

Key Points: Quality and Outcomes Framework Achievement and Exception Reporting 2022/23

- Achievement data was received from 318 practices whilst data is reported on 316 practices*. The 269 RoC practices received a total of £27.60 million, with an average award of £102,594 per practice. The 47 QOF practices received a total of £3.74 million, with an average award of £79,672 per practice.

- Whilst not possible to report fully on domain level achievement as in previous years, it is possible to note average achievement with the addition of some caveats.
  - **Clinical**:
    - An average of 259.7 (84.6%) points was achieved by all 316 practices, but note that this excludes two non-clinical indicators (AST006 and PC002) which are within two of the clinical areas.
    - 108 practices completed the AST006 indicator, achieving an average of 13.5 points (96.7%)
    - 114 practices completed the PC002 indicator, achieving an average of 14.2 points (94.7%).
  - **Public Health**: an average of 7.7 points (70.3%) was achieved by all 316 practices. This domain consists only of the Cervical Screening area.
  - **Records & Systems**:
    - An average of 18.9 points (94.6%) were achieved for the RS001 indicator and 19.7 points (98.7%) for the RS005 indicator, both completed by all 316 practices.
    - 107 practices completed the RS002 indicator, achieving an average of 19.8 points (99.1%).
    - 111 practices completed the RS004 indicator, achieving an average of 19.3 points (96.4%).
    - 111 practices completed the RS006 indicator, achieving an average of 19.6 points (98.2%).
  - **Patient Experience**: This domain consists of the Quality Improvement and Patient Access groups of indicators.
    - An average of 59.4 points (98.9%) was achieved in the Quality Improvement area; all three indicators were completed by all 316 practices.
    - An average of 14.9 points (99.1%) were achieved for the AC001 indicator and 9.7 points (96.8%) for the AC003 indicator, both were completed by all 316 practices.
    - 112 practices completed the AC002 indicator, achieving an average of 14.7 points (98.2%).

- Of the clinical registers collected for QOF that measure actual disease prevalence, the highest prevalence was for Hypertension (141.0 per 1,000 GP patients) and the lowest was for Heart Failure due to Left Ventricular Systolic Dysfunction (4.7 per 1,000 GP patients).

- As all practices participated in all of the Clinical domain, Exception Reporting was not affected by Reprioritisation of Care arrangements.

- The overall Northern Ireland exception rate was 5.1%. Of the 36 indicators for which exception data are published, the lowest exception rate at Northern Ireland level was for NDH001 at 0.2% and the highest rate was for AF006 at 42.9%

- The overall exception rates for GP practices* range from 2.2% to 15.9%.

* An agreement regarding QOF achievement was in place between the SPPG and 2 GP practices in relation to issues which the SPPG recognised would impact on QOF achievement in 2022/23. These 2 practices are excluded from all analysis.

Do's and Don'ts for QOF data

Do's

Use the information provided carefully

Note the limitations of the data

Note the differences between Reprioritisation of Care and QOF practices in terms of the indicators that they were required to achieve.

Be aware of how QOF works in terms of accounting for practice list size and disease prevalence

Note that patient details such as age or gender are not held – the data published is raw, unadjusted data

Take care to understand register definitions – especially when comparing with other prevalence sources. QOF prevalence does not necessarily equate to prevalence as may be defined by epidemiologists

You can re-use or publish QOF data, however you should source it to the Department of Health (NI)

Users of the data should be aware of practices serving different communities, e.g. practice lists with student populations

Don'ts

Don't use QOF data to make comparisons between practices in terms of the quality of care offered

Don't use QOF data to rank practices into league tables - QOF is only one measure of the quality of clinical care provided to patients

Don't compare practices by isolating particular QOF Domain points achieved

Don't add prevalence figures for conditions together, as this may result in double-counting and overestimation of combined prevalence - the GPIP system does not hold information on co-morbidity

Don't compare prevalence across years (or between countries) without checking for changes to indicators or definitions

Don't sum practice data without checking if any have been suppressed

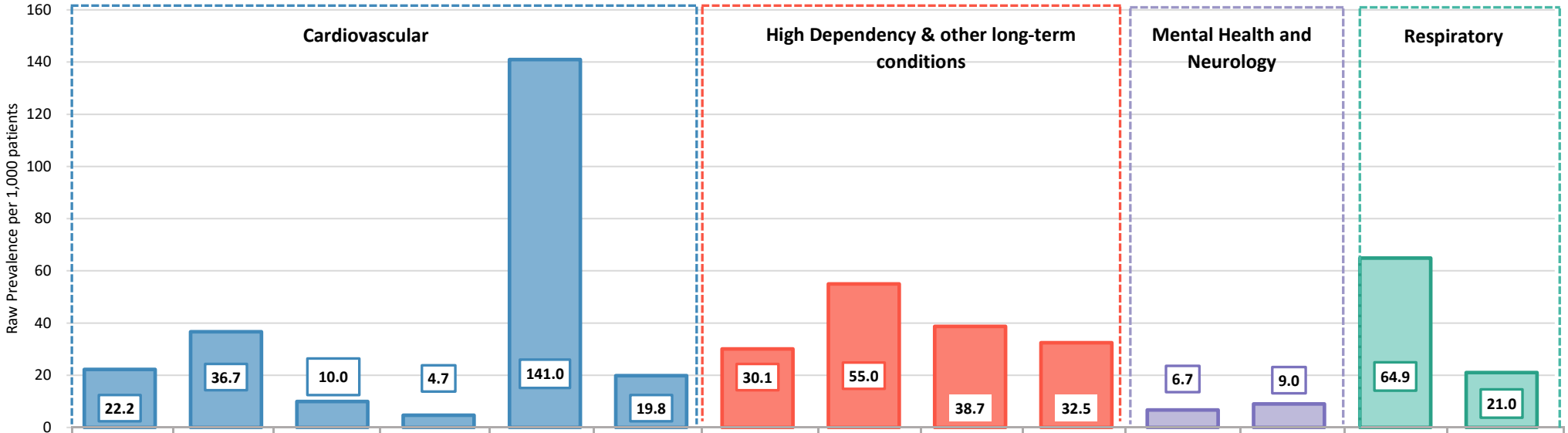
Disease Prevalence in the Framework

An important feature of QOF is the establishment of registers from which the prevalence of various conditions can be estimated. These conditions are all included in the Clinical Domain where registers can be used to estimate the raw prevalence of 14 diseases/conditions within the population. There are no registers suitable for estimating prevalence within the Public Health, Patient Experience or Records & Systems domains.

A statistical release on 'Raw Disease Prevalence in Northern Ireland' is available from the DoH website and this provides a more detailed explanation of how prevalence is calculated alongside a summary of the latest statistics. An interactive dashboard containing data by LCG and GP Federation Areas for the last 5 years is also available.

The chart below shows the raw prevalence rates for 14 of the registers that count patients with specific conditions or diseases in the 2022/23 Framework. The raw prevalence rate ranged from 141.0 per 1,000 patients for Hypertension to 4.7 per 1,000 patients for Heart Failure due to left ventricular systolic dysfunction (LVSD).

Figure 4: Raw Prevalence of 14 disease/ conditions included in the QOF Clinical Domain, per 1,000 GP Patients, at 31st March 2023, All Ages



	Atrial Fibrillation	CHD	Heart Failure	Heart Failure LVSD	Hypertension	STIA	Cancer	Diabetes Mellitus	CKD	NDH	Dementia	Mental Health	Asthma	COPD
Number of patients on register	45,207	74,549	20,231	9,523	286,603	40,348	61,166	111,806	78,735	66,009	13,625	18,323	131,949	42,757

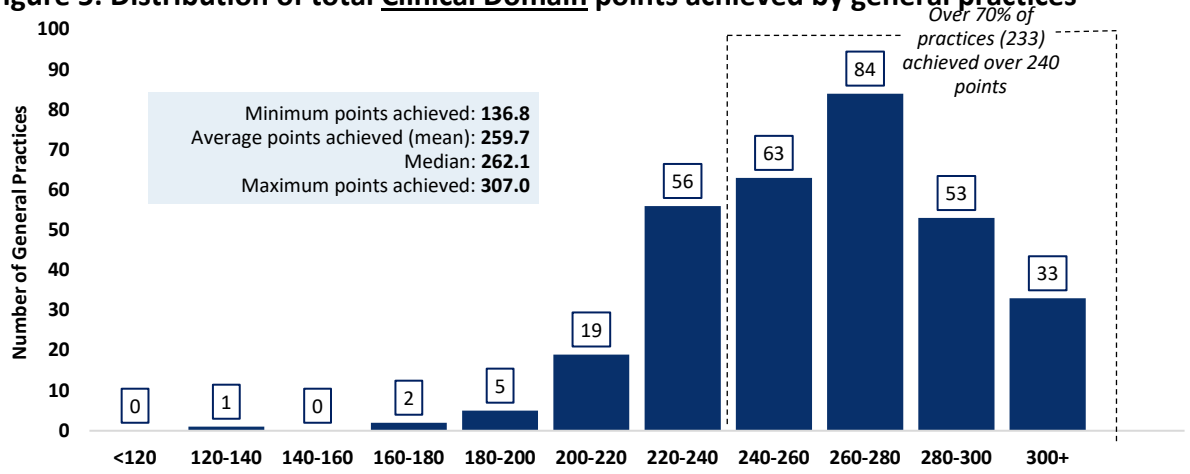
CHD – Coronary Heart Disease; Heart Failure LVSD – Heart Failure due to left ventricular systolic dysfunction; STIA – Stroke and Transient Ischaemic Attack; CKD – Chronic Kidney Disease; NDH – Non-Diabetic Hyperglycaemia; COPD – Chronic Obstructive Pulmonary Disease

Quality and Outcomes Framework Achievement Statistics 2022/23

- Achievement by Domain
- Achievement by QOF Grouping
- Clinical Domain by LCG and GP Federation Area
- Clinical Time Series (2018/19-2022/23)

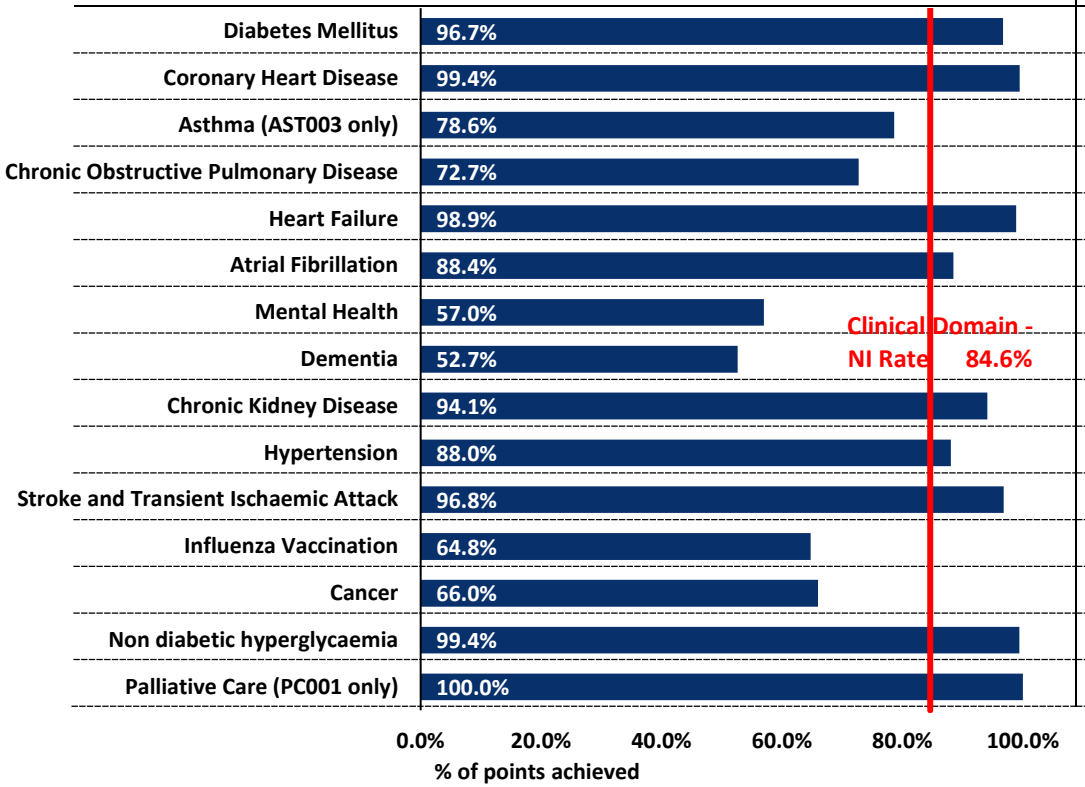
Achievement by Quality and Outcomes Framework Area – Clinical Domain (excluding AST006 and PC002 indicators)

Figure 5: Distribution of total Clinical Domain points achieved by general practices



- Figure 5 shows the distribution of total Clinical points achieved across all 316 practices. Fourteen practices achieved the full 307 points available.
- Average achievement was 259.7 points, which equates to 84.6% of total points achievable. Median QOF achievement was 262.1 points (85.4%).
- Figure 6 shows the achievement rates and the minimum, maximum and average points values for each Clinical Domain area. Full descriptions of the indicators are presented in Annex A.

Figure 6: Achievement rate in each Clinical Domain Area

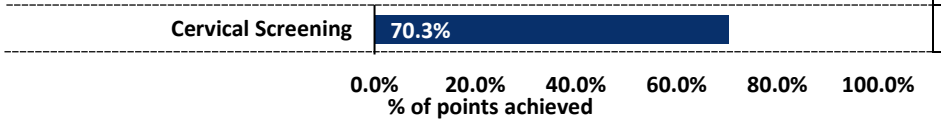


Across the 316 practices ….

	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
Diabetes Mellitus	47	22.95	45.46	45.81	47.00	83
Coronary Heart Disease	41	18.92	40.77	41.00	41.00	309
Asthma (AST003 only)	20	0.00	15.73	20.00	20.00	217
Chronic Obstructive Pulmonary Disease	14	0.00	10.18	12.52	14.00	132
Heart Failure	21	16.00	20.77	21.00	21.00	266
Atrial Fibrillation	22	10.00	19.46	22.00	22.00	216
Mental Health	23	0.00	13.11	12.08	23.00	45
Dementia	21	0.00	11.06	6.00	21.00	89
Chronic Kidney Disease	15	5.94	14.11	15.00	15.00	224
Hypertension	20	0.20	17.60	20.00	20.00	164
Stroke and Transient Ischaemic Attack	19	8.96	18.39	19.00	19.00	220
Influenza Vaccination	25	0.00	16.19	16.36	25.00	32
Cancer	6	0.00	3.96	6.00	6.00	168
Non diabetic hyperglycaemia	8	0.00	7.95	8.00	8.00	312
Palliative Care (PC001 only)	5	5.00	5.00	5.00	5.00	316

Figure 7: Achievement rate in the Public Health Domain

The Public Health domain consists of one indicator area, which is Cervical Screening. All practices completed the Cervical Screening areas; achievement of the 316 practices in the Cervical Screening area is shown below.

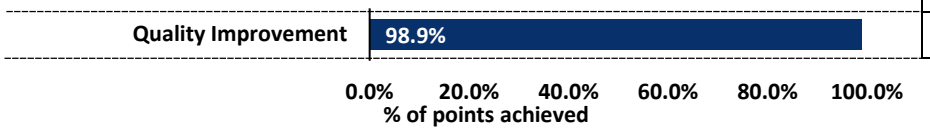


Across the 316 practices ….

Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
11	0.13	7.73	7.87	11.00	45

Figure 8: Achievement rate in the Patient Experience Domain

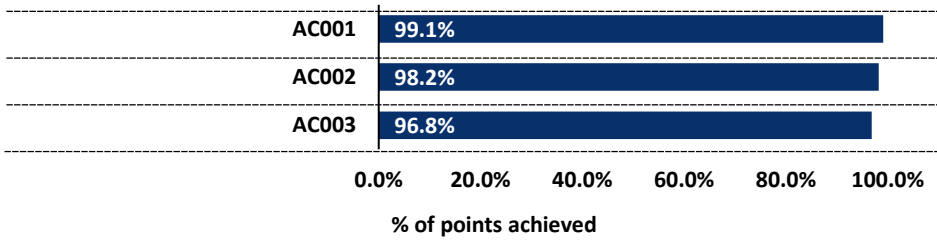
The Patient Experience domain consists of the Patient Access and Quality Improvement areas. All practices completed all indicators in the Quality Improvement area; achievement of the 316 practices for the Quality Improvement area is shown below.



Across the 316 practices ….

Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
60	0.00	59.37	60.00	60.00	312

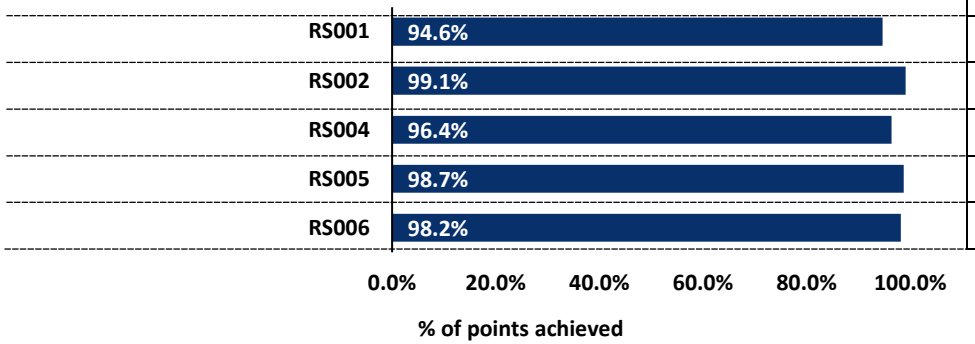
Whilst RoC and QOF practices were required to complete different indicators within the Patient Access area, some RoC practices completed all of the Patient Access indicators (i.e. some RoC practices completed AC002 which they were not required to do). The data below is for all practices who completed the indicators, with the number of practices included in the data for each indicator clearly shown.



	Number of practices	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
AC001	316	15	0.00	14.86	15.00	15.00	313
AC002	112	15	0.00	14.73	15.00	15.00	110
AC003	316	10	0.00	9.68	10.00	10.00	306

Figure 9: Achievement rate in the Record & Systems Domain

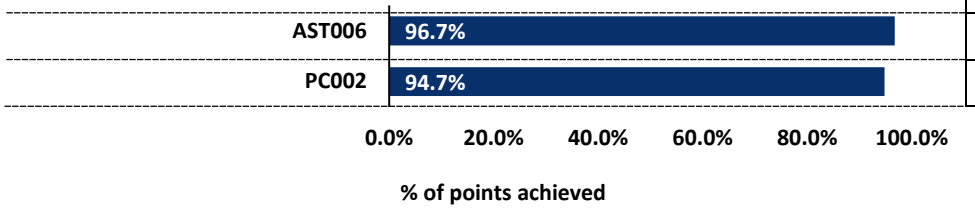
The Records & Systems domain consists of the Records & Systems area, which contains 5 indicators. Whilst RoC and QOF practices were required to complete different indicators within the Records & Systems area, some RoC practices completed all of the Records & Systems indicators (i.e Roc practices were only required to complete RS001 and RS005). The data below is for all practices who completed the indicators, with the number of practices included in the data for each indicator clearly shown.



	Number of practices	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
RS001	316	20	0.00	18.92	20.00	20.00	299
RS002	107	20	0.00	19.81	20.00	20.00	106
RS004	111	20	0.00	19.28	20.00	20.00	107
RS005	316	20	0.00	19.75	20.00	20.00	312
RS006	111	20	0.00	19.64	20.00	20.00	109

Figure 10: Achievement rate for the Non-clinical indicators that are within clinical areas

AST006 and PC002 are non-clinical indicators that are within the respective clinical areas of Asthma and Palliative Care. Although only QOF practices (those practices which did not sign up to Roc) were required to complete these indicators, a number of RoC practices also completed them; the data below is for all practices who completed the indicators.



	Number of practices	Maximum Points Available	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
AST006	108	14	0.00	13.54	14.00	14.00	103
PC002	114	15	0.00	14.21	15.00	15.00	108

Achievement by Clinical QOF Grouping

The QOF clinical indicators are presented here using 'QOF Groups'.

Table 1 shows achievement according to these clinical QOF groups and Table 2 lists the conditions within each of the clinical QOF groups. A detailed list of the QOF clinical indicators may be found at Annex A.

Table 1: Total points available and achieved (Northern Ireland) by QOF group

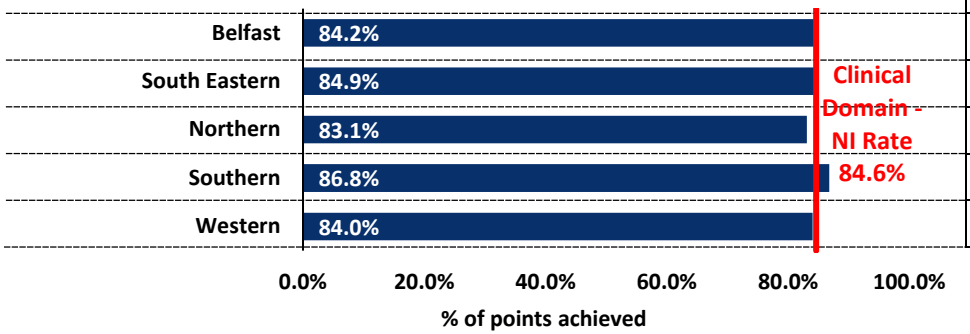
QOF Group	Number of Indicators	Total points available	Total points achieved	% Points Achieved
Cardiovascular	15	38,868	36,969	95.1%
High Dependency & other long-term conditions	13	25,596	24,169	94.4%
Mental Health and Neurology	7	13,904	7,636	54.9%
Respiratory	3	10,744	8,188	76.2%
Undefined group	2	7,900	5,117	64.8%

Table 2: QOF Group categorisations

QOF Group	Condition/Measure
Cardiovascular	Atrial Fibrillation Coronary Heart Disease Heart Failure Hypertension Stroke and Transient Ischaemic Attack
High Dependency & other long-term conditions	Cancer Diabetes Mellitus Palliative Care* (PC001 indicator only) Chronic Kidney Disease Non-diabetic hyperglycaemia
Mental Health and Neurology	Dementia Mental Health
Respiratory	Asthma* (AST003 indicator only) Chronic Obstructive Pulmonary Disease
Undefined group	Influenza Vaccination

* Non-clinical indicators (AST006NI and PC002) within the respective clinical areas of Asthma and Palliative Care are excluded in the Clinical QOF Groups above.

Figure 11: Clinical Achievement* by LCG

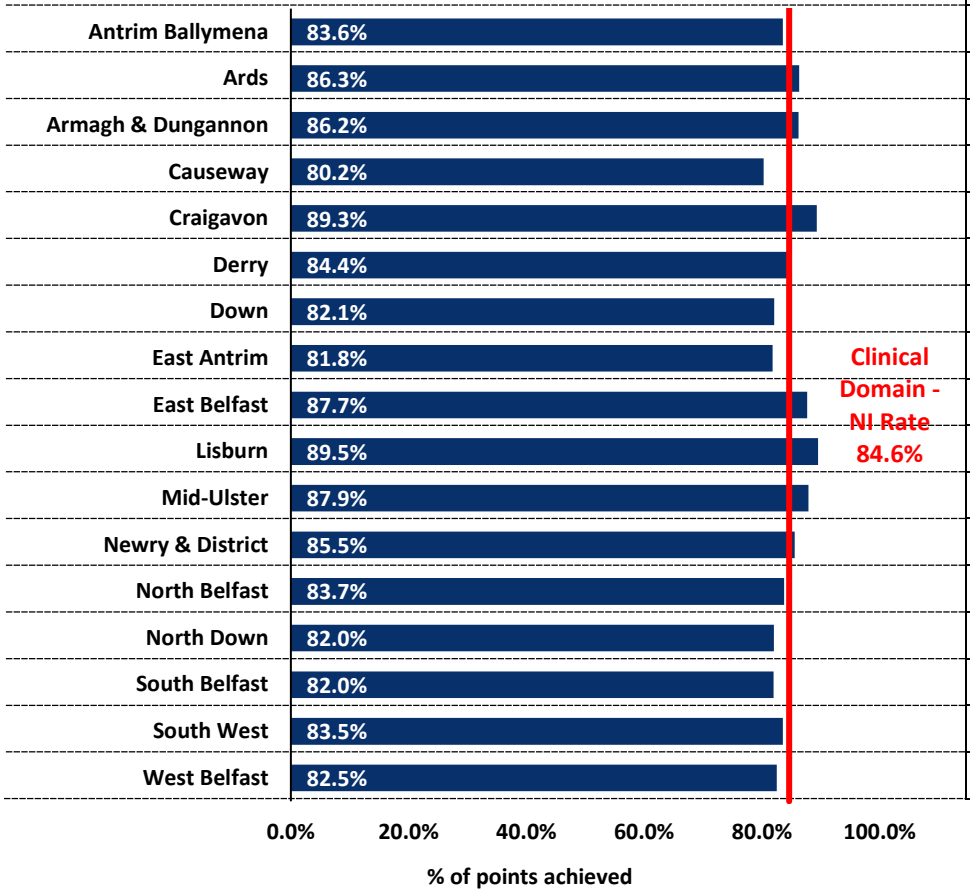


	Number of practices	Maximum Points Available (per practice)	Minimum Points Achieved (by a practice)	Average points achieved (mean)	Median	Maximum Points Achieved (by a practice)	Practices achieving maximum points
Belfast	76	307	176.76	258.63	262.76	307.00	2
South Eastern	49	307	169.16	260.69	263.78	306.42	0
Northern	73	307	136.82	255.04	255.23	307.00	2
Southern	70	307	193.50	266.40	263.96	307.00	9
Western	48	307	203.67	258.00	259.42	307.00	1

- Overall achievement in the Clinical domain* was similar across the five LCGs, ranging from 83.1% in the Northern LCG to 86.8% in the Southern LCG.
- The lowest points achieved was by a practice in the Northern LCG area (136.82), while the maximum points (307) were achieved in all LCGs other than the Southern Eastern LCG.
- Only a small number of practices in the other 4 LCGs achieved the maximum points available, with the Southern LCG having the greatest number of practices achieving the maximum 307 points.

*excluding the non-clinical indicators AST006NI and PC002 that are within the respective clinical areas of Asthma and Palliative Care

Figure 12: Clinical Achievement* by GP Federation Area



	Number of practices	Maximum Points Available (per practice)	Minimum Points Achieved	Average points achieved (mean)	Median	Maximum Points Achieved	Practices achieving maximum points
Antrim Ballymena	25	307	191.62	256.53	262.06	307.00	1
Ards	12	307	209.29	264.98	276.91	300.12	0
Armagh & Dungannon	23	307	222.18	264.70	263.38	307.00	3
Causeway	18	307	136.82	246.36	241.52	306.39	0
Craigavon	19	307	193.50	274.11	281.34	307.00	2
Derry	28	307	222.68	259.12	263.70	307.00	1
Down	13	307	169.16	251.96	259.03	305.92	0
East Antrim	17	307	204.62	251.11	244.28	302.08	0
East Belfast	22	307	225.94	269.09	266.33	307.00	1
Lisburn	12	307	220.12	274.85	277.93	306.42	0
Mid-Ulster	12	307	213.60	269.85	270.67	307.00	1
Newry & District	29	307	203.98	262.58	262.04	307.00	4
North Belfast	22	307	176.76	257.06	262.64	307.00	1
North Down	12	307	183.48	251.71	251.99	294.76	0
South Belfast	16	307	197.92	251.66	260.08	299.40	0
South West	20	307	203.67	256.44	254.97	299.73	0
West Belfast	16	307	203.38	253.37	253.46	299.72	0

- Overall achievement in the Clinical domain* ranged from 80.2% in the Causeway GP Federation to 89.5% in the Lisburn GP Federation.
- The practice that achieved the lowest points was in the Causeway GP Federation, while the maximum 307 points were achieved by practices in 8 GP Federations. Only a few practices in each of these GP Federations achieved the maximum 307 available points.

*excluding the non-clinical indicators AST006NI and PC002 that are within the respective clinical areas of Asthma and Palliative Care

Time Series: 2018/19 - 2022/23

Achievement by Domain - Clinical Domain*

Figure 13: Clinical Domain achievement rate, 2018/19-2022/23

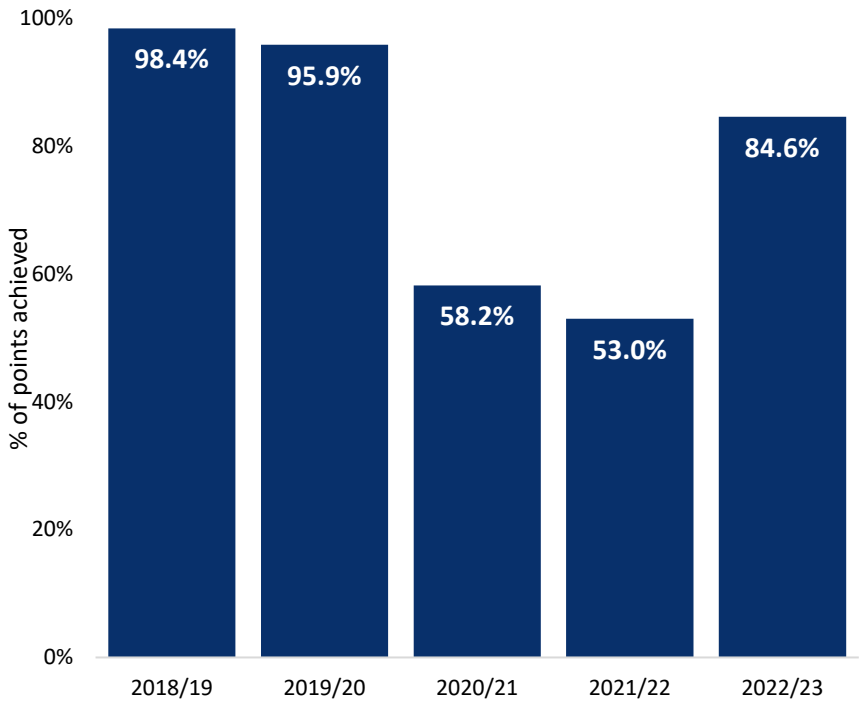
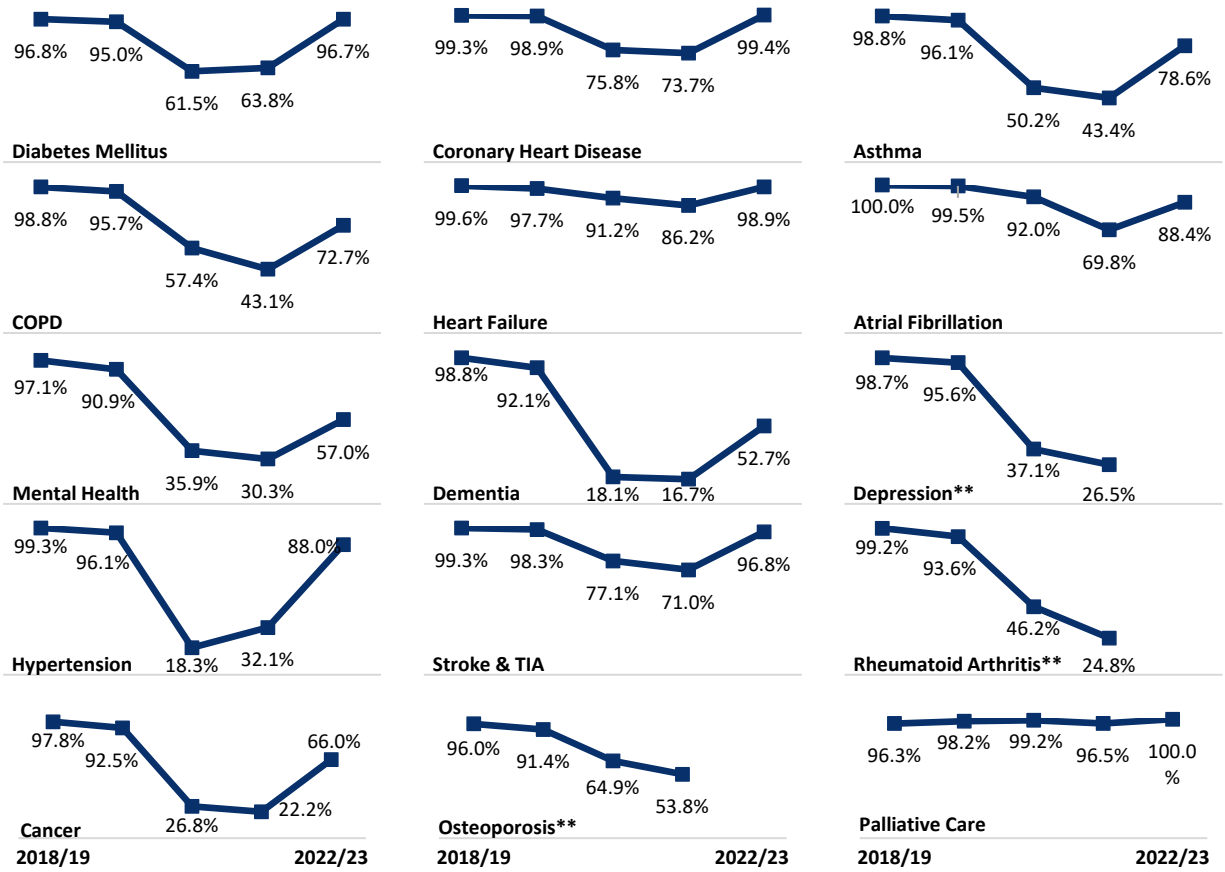


Figure 14: Achievement rate by Clinical Domain Area, 2018/19-2022/23



- Overall achievement in the Clinical domain has increased following noticeably lower achievement in the past two years, with an achievement rate of 84.6% for 2022/23 (Figure 13).
- Figure 14 shows that all the clinical domain areas in QOF this year show this improvement in achievement. Of particular note are the clinical domain areas of Diabetes Mellitus, Coronary Heart Disease, Heart Failure, Stroke and Transient Ischaemic Attack, which have returned to pre 2021/22 achievement levels.
- The clinical domain area of Hypertension, whilst not quite returned to pre 2020/21 levels, is notable because it had fallen to such a low achievement rate and achievement has subsequently improved greatly. The same is true to a lesser extent for Cancer and Dementia.

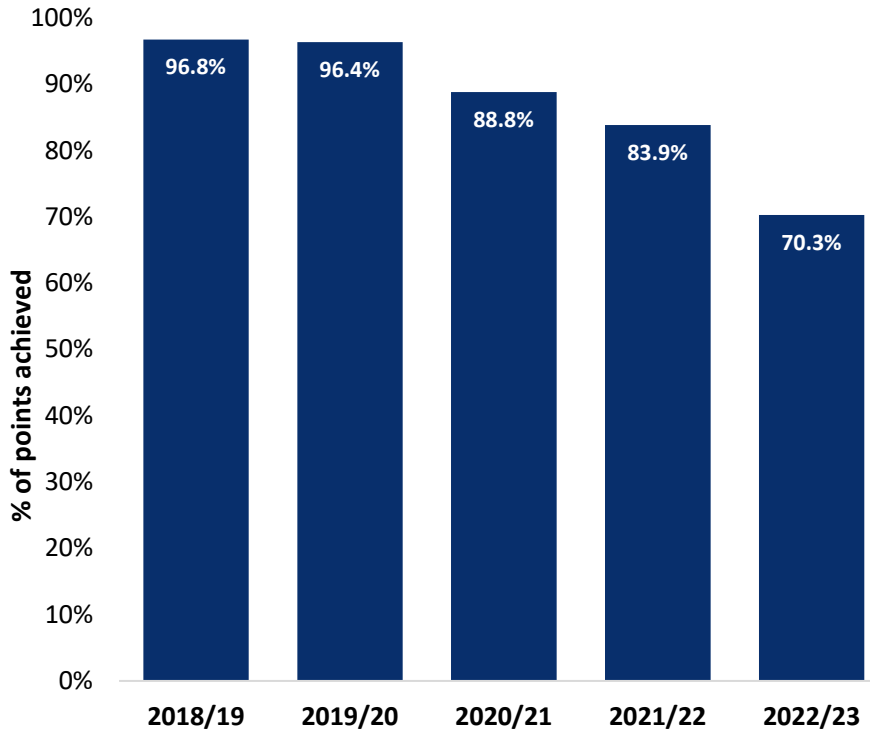
*excluding the non-clinical indicators AST006NI and PC002 that are within the respective clinical areas of Asthma and Palliative Care

** Osteoporosis, Depression and Rheumatoid Arthritis have been removed from the QOF for 2022/23

Time Series: 2018/19 - 2022/23

Achievement by Domain – Public Health Domain
The Public Health Domain now consists of only the Cervical Screening area*.

Figure 15: Cervical Screening achievement rate, 2018/19-2022/23



- Overall achievement in the Cervical Screening area for 2022/23 was 70.3%, a notable decrease on the achievement level seen last year (Figure 15). Unlike many areas within the Clinical domain, achievement for the Cervical Screening area has not returned to pre 2020/21 levels.

**The chart compares achievement in the Cervical Screening area ONLY; the Public Health Domain previously comprised a number of areas, comparison over time is therefore inappropriate.*

Quality and Outcomes Framework Exception Reporting Statistics 2022/23

- Criteria for Exception
- Calculation of Exception rates
- Exception reporting summaries
- By LCG, GP Federation Area and GP Practice

Criteria for Exception

The criteria for a patient being excepted are detailed in Annex D12 of the Statement of Financial Entitlement as follows,

a) patients who have been recorded as refusing to attend review who have been invited on at least 3 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 3 occasions during the period specified in the indicator during which the achievement is to be measured i.e. the preceding 5 years ending on 31st 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, contraindication or have experienced an adverse reaction;
f) where a patient has not tolerated medication;
g) where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their medical records 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; or
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 has not been delivered. For example, in the case of a contractor with 100 patients on the Coronary Heart Disease (CHD) register, of which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95, with the 5 patients being excepted. However, all 100 patients with CHD would be included in the calculation of the Adjusted Practice Disease Factor (APDF) (see page 2). 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 Annex D12(c)-(i), for example a patient who has heart failure due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin receptor converting enzyme inhibitors (ACE inhibitors) and angiotensin receptor blocker (ARB) could be exception reported from Heart Failure (HF) indicator HF003NI. 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 should be identifiable in the patient record.

It is **not possible to publish exception rates by specific reason** of exception due to practices using different IT systems. The sequence by which the clinical system of each practice (such as EMIS, InPractice, iSoft and Merlok) searches for exception reasons varies, and if a patient has been excepted for more than one reason, the hierarchy of exception reasons may differ between these systems and it is therefore unclear which exception reason was chosen.

Calculation of Exception Rate

Summaries of exception rates for 2022/23 are presented in this report. The denominator is the number of patients that can appropriately be included in an indicator.

The exception rate calculation is: $\left[\frac{Number\ of\ Exceptions}{(Exceptions+Denominator)}\right] \times 100$

Exception Reporting Summaries

Table 3 summarises exception rates for 36 individual indicators by indicator group. Tables 4 and 5 show the ten highest and ten lowest exception rates by indicator.

Table 3: Northern Ireland Exception Rates by Indicator Group

Clinical Area	Denominator	Exceptions	Exception rate
Asthma	129,917	1,625	1.24%
Atrial Fibrillation	57,313	19,719	25.60%
Cancer	7,030	1,340	16.01%
CHD	219,231	3,792	1.70%
CKD	76,334	2,062	2.63%
COPD	59,441	1,179	1.94%
Cervical Screening	474,013	59,101	11.09%
Dementia	16,180	906	5.30%
Diabetes	443,120	12,439	2.73%
Heart Failure	34,832	1,039	2.90%
Hypertension	278,734	6,947	2.43%
Influenza	329,154	13,640	3.98%
Mental Health	86,140	1,420	1.62%
Non-diabetic hyperglycaemia	65,701	131	0.20%
STIA	122,317	2,405	1.93%

- The highest exception rate at Northern Ireland level, at 42.9%, is attributed to AF006 (Atrial Fibrillation 6, defined as '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).
- At 0.2%, the lowest exception rate at Northern Ireland level is for NDH001, defined as 'The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 24 months. NDH is defined as an HbA1c on 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l'.

Table 4: Ten highest exception rates, at Northern Ireland level, by indicator

Indicator Code	Denominator	Exceptions	Exception Rate
AF006	25,723	19,352	42.93%
CS004	163,673	33,313	16.91%
CAN003	7,030	1,340	16.01%
CS003	310,340	25,788	7.67%
DEM002	12,713	885	6.51%
DM012	106,653	4,748	4.26%
VI002	329,154	13,640	3.98%
STIA005	27,082	1,062	3.77%
CHD003	71,843	2,498	3.36%
HF004	7,461	257	3.33%

Table 5: Ten lowest exception rates, at Northern Ireland level, by indicator

Indicator Code	Denominator	Exceptions	Exception Rate
CHD002	73,410	931	1.25%
AST003	129,917	1,625	1.24%
AF007	31,590	367	1.15%
STIA004	27,867	277	0.98%
HYP007	53,521	442	0.82%
DEM003	3,467	21	0.60%
CHD005	73,978	363	0.49%
COPD005	17,969	78	0.43%
STIA007	28,027	117	0.42%
NDH001	65,701	131	0.20%

* Indicator code definitions can be found in Annex A.

Exception Rates by Local Commissioning Group (LCG) and GP Federation Areas

Figures 19 and 20 show the overall exception rates in each LCG and GP Federation Area, with the NI Exception rate included on each.

Figure 19: Overall Exception rates by LCG

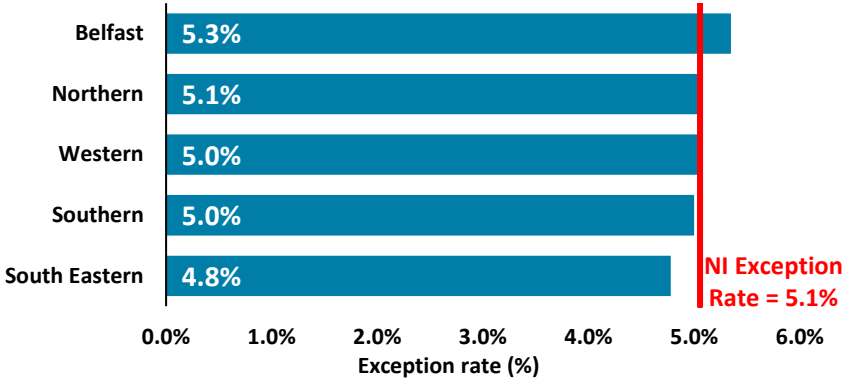
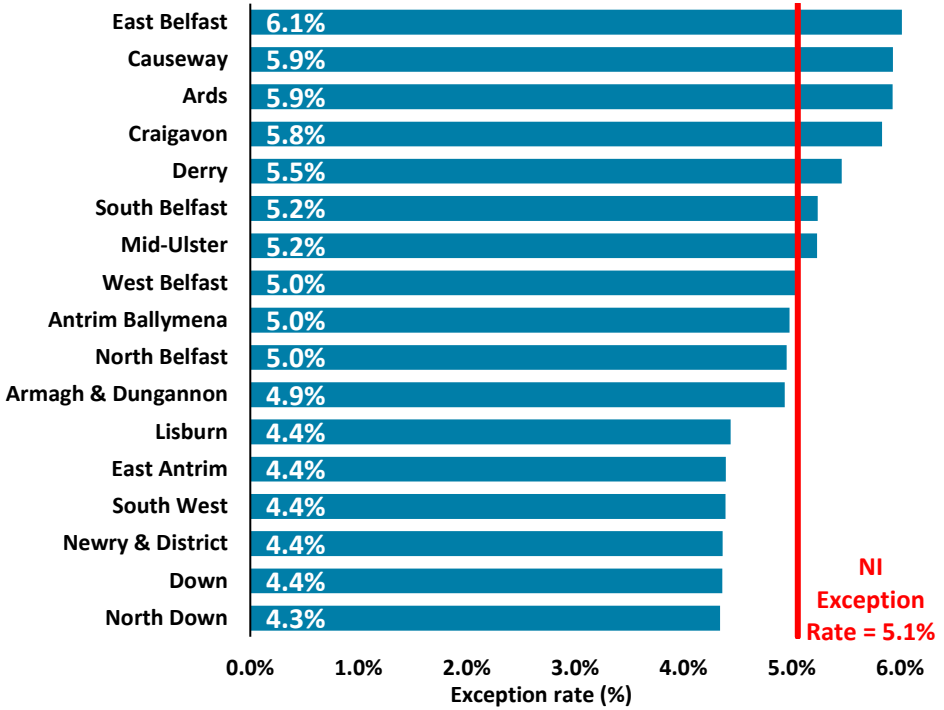


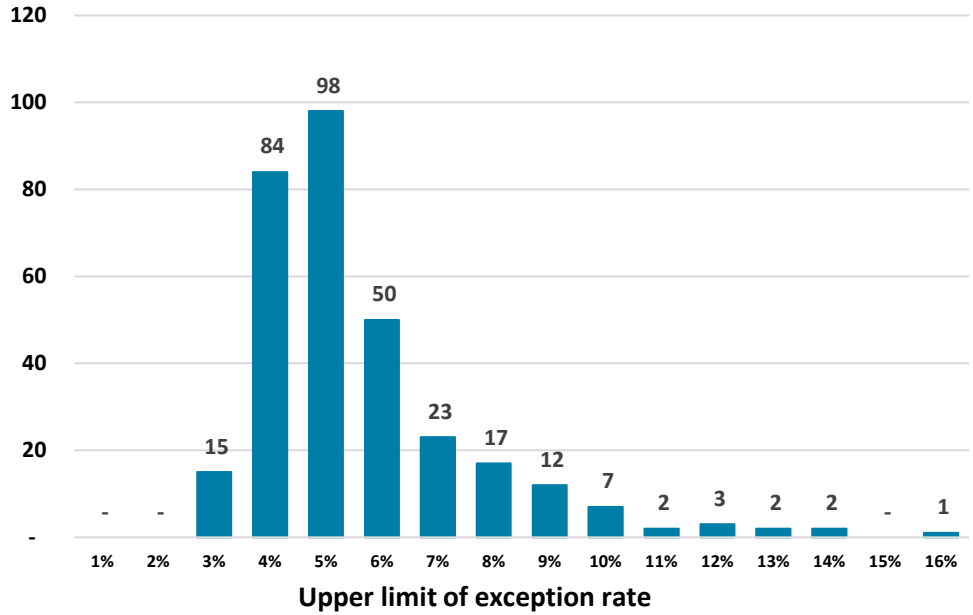
Figure 20: Overall Exception rates by GP Federation Area



Exception Rates by Practice

Figure 21 shows the Distribution of exception rates recorded by general practices.

Figure 21: Distribution of exception rates recorded by general practices



- The South Eastern LCG has the lowest overall exception rate at 4.8% and the Belfast LCG has the highest overall exception rate at 5.3%.
- The North Down GP Federation has the lowest overall exception rate at 4.3% and the East Belfast GP Federation has the highest overall exception rate at 6.1%
- The majority of general practices (299, 94.6% of practices) had exception rates in the range of 2% to 10%. 17 practices had exception rates greater than 10%.

Annex A:

QOF Indicators and Maximum Points Available

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Asthma (AST)	AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 24 months that includes an assessment of asthma control using the 3 RCP questions.	20
Asthma (AST)	AST006NI	Mean carbon emissions per salbutamol inhaler prescribed to patients between 01/10/22 and 31/12/2022 (KgCO2e).	14
Atrial fibrillation	AF006NI	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).	12
Atrial fibrillation	AF007	In those patients with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.	10
Cancer (CAN)	CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 9 months of the contractor receiving confirmation of the diagnosis.	6
Secondary prevention of coronary heart disease (CHD)	CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 24 months) is 150/90 mmHg or less.	17
Secondary prevention of coronary heart disease (CHD)	CHD003NI	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.	17
Secondary prevention of coronary heart disease (CHD)	CHD005	The percentage of patients with coronary heart disease with a record in the preceding 24 months that aspirin, an alternative anti-platelet therapy, or an anticoagulant is being taken.	7

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Chronic Kidney Disease (CKD)	CKD005NI	The practice establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5).	5
Chronic Kidney Disease (CKD)	CKD006NI	The percentage of patients aged 18 or over on CKD register in whom the last BP reading is 140/90mmhg or less in preceding 24 months	5
Chronic Kidney Disease (CKD)	CKD007NI	The percentage of patients aged 18 or over on CKD register with hypertension and proteinuria (UACR >30) on ACEi or ARB.	5
Chronic obstructive pulmonary disease (COPD)	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 24 months.	9
Chronic obstructive pulmonary disease (COPD)	COPD005NI	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 24 months, with a record of oxygen saturation value within the preceding 24 months.	5
Dementia (DEM)	DEM002	The percentage of patients diagnosed with dementia whose care has been reviewed in review in the preceding 24 months.	15
Dementia (DEM)	DEM003	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 24 months before and 6 months after entering on to the register.	6

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Diabetes mellitus (DM)	DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).	3
Diabetes mellitus (DM)	DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 24 months.	8
Diabetes mellitus (DM)	DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 24 months.	10
Diabetes mellitus (DM)	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 24 months.	2
Diabetes mellitus (DM)	DM022NI	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years).	4
Diabetes mellitus (DM)	DM023NI	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin.	2
Diabetes mellitus (DM)	DM024NI	The percentage of patients with diabetes, on the register in whom the last blood pressure reading (measured in the preceding 24 months) is 150/90mmHg.	18

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Heart failure	HF002NI	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 24 months after entering on to the register.	2
Heart failure	HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.	10
Heart failure	HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a betablocker licensed for heart failure.	9
Hypertension	HYP003NI	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 24 months is 140/90 mmHg or less.	15
Hypertension	HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 24 months is 150/90 mmHg or less.	5
Influenza Vaccination (VI)	VI01NI	Percentage of at risk patients age 18-64 years inclusive who have received a seasonal influenza vaccine.	10
Influenza Vaccination (VI)	VI02NI	Percentage of patients age 65 years or over who have received a Seasonal influenza vaccine.	15

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Mental health (MH)	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 24months, agreed between individuals, their family and/or carers as appropriate.	7
Mental health (MH)	MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 24 months.	4
Mental health (MH)	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 24 months.	4
Mental health (MH)	MH011NI	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 24 months.	4
Mental health (MH)	MH012NI	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 24 months.	4
Non diabetic hyperglycaemia	NDH001NI	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 24 months. NDH is defined as an HbA1c on 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l.	8
Palliative Care (PC)	PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.	5
Palliative Care (PC)	PC002	The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.	15

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Stroke and transient ischaemic attack (STIA)	STIA004NI	The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years.	2
Stroke and transient ischaemic attack (STIA)	STIA005NI	The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.	5
Stroke and transient ischaemic attack (STIA)	STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.	4
Stroke and transient ischaemic attack (STIA)	STIA010NI	The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 24 months) is 140/90 mmHg or less.	5
Stroke and transient ischaemic attack (STIA)	STIA011NI	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 24 months) is 150/90 mmHg or less.	3
Cervical Screening	CS003NI	The percentage of females age 25-49 who have had a cervical screening test in the last 3 years.	8
Cervical Screening	CS004NI	The percentage of females age 50-65 years who have had a cervical screening test in the last 5 years.	3

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Records & Systems	RS001	The Practice submits weekly Covid monitoring reports using the Survey Monkey link that will be provided.	20
Records & Systems	RS002	The Practice reviews its own CCG Referral Data. Red flag, urgent and routine referrals made between April 2019 – June 2019 and April 2022 – June 2022. Referral levels and patterns between the two timeframes should be compared and discussed. Practice CCG referral data will be provided prior to 31 October 2022 to facilitate the review.	20
Records & Systems	RS004	The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter. Information should include Date of Admission, Speciality and Diagnosis.	20
Records & Systems	RS005	The Practice participates in the General Practice Intelligence Platform (GPIP). The Practice works with the SPPG on data quality initiatives identified through GPIP.	20
Records & Systems	RS006	The Practice participates in the recording of data relating to the impact of waiting lists on patient care and primary care workload.	20
Patient Access	AC001	The practice maintains a register of patients who have hearing loss and adopt a consistent approach to identify, record, flag and share relevant information with other healthcare providers as appropriate.	15
Patient Access	AC002	The practice has a robust system of triage to assist with the management of demand for appointments, routine, urgent and emergency while ensuring that patients with respiratory symptoms are managed in accordance with public health guidance.	15
Patient Access	AC003	All practice receptionist and administrative staff have received training on care navigation awareness as outlined in the guidance document in the previous 12 months to 31/3/23.	10

Annex A: QOF Indicators and Maximum Points Available

Indicator area	Indicator ID	Indicator definition	Points available (per practice)
Quality Improvement	QI001	The practice can demonstrate continuous quality improvement activity.	20
Quality Improvement	QI002	The practice has participated in peer review meetings to regularly share and discuss learning from QI activity as outlined in the guidance.	20
Quality Improvement	QI003	There is a record of all practice team members having completed training on how to perform Quality Improvement Activity.	20

Annex B:

Timeline of changes to the QOF Framework

Annex B: Timeline of changes to the QOF Framework

Timeline of changes to the QOF Framework

In 2015/16, the majority of the register-focused indicators of conditions in QOF were subsumed into the core funding for practices. The points previously allocated for practices keeping and maintaining a register for patients with Asthma (AST), Atrial Fibrillation (AF), Cancer (CAN), Chronic Obstructive Pulmonary Disease (COPD), Coronary Heart Disease (CHD), Dementia (DEM), Diabetes Mellitus (DM), Epilepsy (EP), Heart Failure (HF), Hypertension (HYP), Learning Disability (LD), Mental Health (MH), Obesity (OB), Osteoporosis (OST), Peripheral Arterial Disease (PAD), Rheumatoid Arthritis (RA), Sexual Health (CON) and Stroke and Transient Ischaemic Attack (STIA) were consequentially removed from the maximum QOF achievement, reducing it by 71 points.

There is no longer any financial incentive associated with keeping a register for the clinical areas listed above, as these register-focused indicators and their associated funding were subsumed into core funding. Registers for some clinical areas still exist if other indicators still assessed for QOF remain on the system (Asthma or CHD, for example), however the subsuming of registers for other conditions resulted in their complete removal in 2015/16 from the QOF assessment (Epilepsy, Learning Disabilities, Peripheral Arterial Disease and Obesity).

The majority of indicators remained unchanged in 2016/17, in terms of both definitions and points available. Only the Records & Systems domain saw changes to indicators, with the wording for all indicators being amended (although largely keeping the same meanings) and the points available for each indicator changing. However, the overall total points available for the Records & Systems domain remained unchanged at 100 points. Indicator RS006 was retired in 2016/17, but the points for it were incorporated into the changes to the points for the other Records & Systems indicators. There was therefore no change to the overall maximum QOF points available to practices (547). With the retirement of RS006, there were a total of 63 indicators in the Quality & Outcomes Framework in 2016/17.

The QOF has remained relatively unchanged since 2016/17; some definitional changes and re-allocation of points occurred within Records & Systems in 2021/22. However, 2022/23 brought a significant overhaul to the Framework, in terms of indicators, definitions and points. In some cases, entire diseases or conditions were removed from QOF, as all of their component indicators were removed. These were Blood Pressure, Sexual Health, Cardiovascular Disease – primary prevention, Depression, Osteoporosis, Rheumatoid Arthritis, and Smoking. There were also new areas added for 2022/23, namely Chronic Kidney Disease, Non-Diabetic Hyperglycaemia, Influenza vaccination, Patient Access and Quality Improvement. The overall number of indicators was reduced from 63 to 55 with the overall number of points remaining unchanged at 547 points; points from redundant areas and indicators being re-allocated to new indicators within the overall framework.

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