NATIONAL ASSEMBLY FOR WALES

SUBORDINATE LEGISLATION

2006 No. 20

NATIONAL HEALTH SERVICE, WALES

The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2006

Made - - - -	*31 March 2006*
Coming into force - -	*1 April 2006*

The National Assembly for Wales, in exercise of the powers conferred by sections 28T and 126(4) of the National Health Service Act 1977(**1**) hereby gives the following Directions:

Title, commencement, application and interpretation

1.—(1) The title of these directions is the Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2006.

(2) These Directions come into force on 1 April 2006.

(3) These Directions are given to Local Health Boards and apply in relation to Wales.

Amendments to the SFE

2.—(1) The directions given by the National Assembly for Wales in the Directions to Local Health Boards as to the Statement of Financial Entitlements which came into force on 30 April 2005(**2**)*('the SFE')* are amended as follows.

3. In direction 2(1), omit the words "in relation to the financial year beginning on 1 April 2005".

Amendments to the Table of Contents

4. In the Table of Contents—

(a) in Part 2, Section 4 (Quality and Outcomes Framework: General), omit the last 2 headings in the list (which relate to the calculation of points in relation to the Quality Practice Payment and the QOF Access Payment);

(b) in Part 3, Section 7 (Improved Access Scheme), for the list of headings substitute "THIS SECTION IS A BLANK SECTION";

(**1**) 1977 c.49. Section 28T was inserted by section 171 of the Health and Social Care (Community Health and Standards) Act 2003 (c.43). Section 126(4) has been amended by section 65(2) of the National Health and Community Care 1990 (c.19), paragraph 37 of Schedule 4 to the Health Act 1999 (c.8) and paragraph 5(13)(b) of Schedule 5 to the Health and Social Care Act 2001 (c.15).

(**2**) These Directions were amended by the Statement of Financial Entitlement (Amendment)(No.2)(Wales) Directions 2005, which were made on 21 July 2005 and by the Statement of Financial Entitlement (Amendment)(Wales) Directions 2006

(c) in Part 4, Section 15 (Dispensing), at the end of the list of headings insert "Calculation and adjustment of VAT related allowance";

(d) in Part 6, section 18 (Administrative Provisions), for the heading "Overpayments" substitute the heading "Overpayments and withheld payments".

Amendment to Section 2

5.—(1) Section 2 (Global Sum Payments) is amended as follows—

(2) In paragraph 2.6 (which relates to first payable Global Sum Monthly Payments), omit the words ", subject to any appropriate adjustment to take account of paragraph 6.11(b),".

(3) In paragraph 2.8(a) (which relates to the revision of Payable Global Sum Monthly Payments), omit "(when the contractor may have a new Contractor Weighted Population for the Quarter)".

(4) In paragraph 2.11 (which relates to the determination of the gross amount of the contractor's new payable Global Sum Monthly Payments), omit ", subject to any appropriate adjustment to take account of paragraph 6.11 (b),".

Amendment to Section 3

6. In paragraph 3.12 of Section 3 (which relates to the uprating of the contractor's Correction Factor Monthly Payments)—

(a) for "2005 to 2006", substitute "2006 to 2007"; and

(b) for "2006 to 2007", substitute "2007 to 2008".

Amendment to Section 4

7.—(1) Section 4 (Quality and Outcomes Framework: General) is amended as follows.

(2) In paragraph 4.6 (which relates to the calculation of points in the clinical domain), for "ten" substitute "nineteen".

(3) In paragraph 4.25 (which relates to the entitlement to points as a basis of a Holistic Care Payment), for "100" substitute "20".

(4) In paragraph 4.26 (which relates to the calculation of points in respect of the Holistic Care Payment), for "100" substitute "20".

(5) Omit paragraphs 4.27 to 4.30 (which relate to the calculation of points in relation to the Quality Practice Payment and the QOF Access Payment) and their associated headings.

Amendment to Section 5

8.—(1) Section 5 (Aspiration Payments) is amended as follows.

(2) In paragraph 5.6 (which relates to determination of the QOF uprating index), for "The QOF uprating index for the financial year 2005 to 2006 is 1.607741935483871" substitute "The QOF Uprating Index for the financial year 2006 to 2007 is 1.0".

(3) For paragraph 5.7 (which relates to the calculation of the contractor's Monthly Aspiration Payment by the 60% method), substitute the following paragraph—

> "5.7 The total produced by paragraph 5.6 is then to be multiplied by 60%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided by the maximum number of points available under the QOF in the previous financial year. (By way of example, the figures used for this element of the calculation in the financial year 2006/07 will be 1000 and 1050 respectively, 1000 points being the maximum number of points available under the QOF for the financial year 2006/07 and 1050 being the maximum number of points available under the QOF for the financial year 2005/06.) The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraphs

5.9, 5.10, 6.10 and 6.11, is to be the contractor's Monthly Aspiration Payment, as calculated by the 60% method.".

(4) In paragraph 5.13 (which relates to the calculation of the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method), for "paragraphs 6.10 and 6.11" substitute "paragraph 6.10".

(5) In paragraph 5.17 (which relates to conditions attached to the Monthly Aspiration Payments)—

(a) at the end of sub-paragraph (d), insert "and";

(b) omit sub-paragraph (e); and

(c) renumber the sub-paragraph numbered "(f)" so that it is numbered "(e)".

Amendment to Section 6

9.—(1) Section 6 (Achievement Payments) is amended as follows.

(2) In paragraph 6.2 (which relates to the date in respect of which the assessment of achievement points is to be made)—

(a) omit sub-paragraph (a);

(b) renumber the sub-paragraph numbered "(b)" so that it is numbered "(a)", and

(c) renumber the sub-paragraph numbered "(c)" so that it is numbered "(b)".

(3) In paragraph 6.5 (which relates to the calculation of Achievement Payments)—

(a) after the words "clinical domain", in both places where they occur, insert "(other than the area relating to palliative care)", and

(b) after, but not as part of, sub-paragraph (b), insert "The part of the Achievement Payment that relates to the palliative care area of the clinical domain will be calculated in accordance with paragraph 6.6.".

(4) In paragraph 6.7 (which relates to the multiplication of cash totals by the contractor's CPI), after the words "contractor's CPI" insert ", calculated in accordance with the provisions of paragraph 2.18".

(5) For paragraph 6.11 (which relates to the recovery of Aspiration Payments which have been too high), substitute—

"6.11 Where the resulting amount from the calculation under paragraph 5.41 of the 2004/5 SFE is a negative amount, that negative amount, expressed as a positive amount ("the paragraph 5.41 amount"), is to be treated as an overpayment in respect of the contractor's Payable GSMPs for the financial year 2005 to 2006, and is to be recovered accordingly (i.e. in accordance with paragraph 18.1).".

Omission of Section 7

10. Omit Section 7 (which relates to the Improved Access Scheme) in its entirety and substitute "7. THIS SECTION IS A BLANK SECTION".

Amendment of Section 8

11.—(1) Section 8 (Childhood Immunisations Scheme) is amended as follows.

(2) In paragraph 8.3(b) (which relates to target payments in respect of two-year-olds), for paragraphs (i) and (ii) substitute—

"(i) diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenzae type B (HiB);

(ii) measles/mumps/rubella, and

(iii) Meningitis C.".

(3) In paragraph 8.4 (which relates to the calculation of Quarterly Two-Year-Olds Immunisation Payment)—

(a) for the word "two" where it appears before "disease groups", substitute "three";

(b) in sub-paragraph (a), for "(0.7 x **A** x 2)" substitute "(0.7 x **A** x 4)"; and

(c) in sub-paragraph (b), for "(0.9 x **A** x 2)" substitute "(0.9 x **A** x 4)".

(4) For paragraph 8.5 (which relates to the calculation of which target is achieved), substitute—

"8.5 LHBs will then need to calculate which, if any, target was achieved. To do this, a LHB will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed immunisation courses in each of the three disease groups (C1 + C2 + C3). In this section 8, C1 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(i); C2 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(ii) and C3 is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(iii). Only completed immunisation courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation (which provides for an additional weighting factor of 2 to be given to immunisation courses in respect of the diseases referred to in paragraph 8.3(b)(i)) is then to be made of whether or not the targets are achieved–

(a) if $(C1 \times 2) + C2 + C3 \geq B^1$, then the 70% target is achieved; and

(b) if $(C1 \times 2) + C2 + C3 \geq B^2$, then the 90% target is achieved.".

(5) For paragraph 8.6 (which relates to the number of completed immunisation courses for two-year-olds carried out before the end of the relevant quarter), substitute—

"8.6 Next the LHB will need to calculate the number of the completed immunisation courses, notified under paragraph 8.11(b)(ii), that the contractor can use to count towards achievement of the targets (D). To do this, the contractor will need to provide the LHB with a breakdown of how many immunisation courses in each disease group were completed before the end of the quarter to which the calculation relates by a completing immunisation administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-

(a) the Contractor;;

(b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "GMS contractor" includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);

(c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "PMS Contractor" includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);

(d) an Alternative Provider Medical Services contractor ("APMS contractor") as part of primary medical services to a patient who was at that time registered with that contractor (where the term "APMS contractor" includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a

contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

(e) a Local Health Board Medical Services practice ("LHBMS practice") as part of primary medical services to a patient who was at that time registered with that practice (where the term "a LHBMS practice" includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under arrangements made under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).

For the purposes of this paragraph 8.6 and paragraph 8.7, an immunisation course is considered as being completed when the final immunisation needed to complete the immunisation course (the "completing immunisation") is administered.".

(6) For paragraph 8.7 (which relates to the calculation of the number of completed immunisation courses which count towards the achievement of the targets), substitute—

"8.7 Once the LHB has that information, (D) is to be calculated as follows–

	C1 x 2	minus	**E1** x 2
+	**C2**	minus	**E2**
+	**C3**	minus	**E3**
=	**D**		

For these purposes–

(a) ($\underline{E^X}$) is the number of completed immunisation courses in each disease group where the completing immunisation was carried out other than by a provider of primary medical services of the type specified in, and under the circumstances specified in, any of the sub-paragraphs 8.6(a) to (e) (e.g. for the diseases referred to in paragraph 8.3(b)(i), E1);

(b) (C^X) is the number of children in the cohort of children in respect of whom the calculation is to be made who have completed the immunisation course in respect of a particular disease group (e.g. for the diseases referred to in paragraph 8.3(b)(i), C1);

(c) in the case of the disease group referred to in paragraph 8.3(b)(i), the value of (C1 x 2) – (E1 x 2) can never be greater than (C1 x 2) x 0.7 or 0.9 (depending on which target is achieved); where it is, it is treated as the result of (C1 x 2) x 0.7 or, as the case may be, 0.9; and

(d) in any other case, the value of C^X-E^X can never be greater than C^X x 0.7 or 0.9 (depending on which target achieved); where it is, it is treated as the result of: C^X x 0.7 or, as the case may be, 0.9.".

(7) In paragraph 8.8 (which relates to the maximum amounts payable to the contractor), for the number "56", in the three places where it occurs, substitute "55".

(8) For paragraph 8.11(b)(iii) (which relates to the conditions attached to Quarterly Two-Year-Olds Immunisation Payments), substitute—

"(iii) of those completed immunisation courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.6 (a) to (e); and".

(9) In paragraph 8.13(b) (which relates to target payments in respect of five-year-olds), omit "acellular".

(10) For paragraph 8.16 (which relates to the number of completed immunisation courses for five-year-olds carried out before the end of the relevant quarter). substitute—

> "8.16 Next the LHB will need to calculate the number of the completed courses, notified under paragraph 8.21(b)(ii), that the contractor can use to count towards achievement of the targets (D), the initial value of which is (C) minus the number of children whose completed courses were not carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the sub-paragraphs (a) to (e) below. To do this, the contractor will need to provide the LHB with a breakdown of how many of the completed courses were carried out before the end of the quarter to which the calculation relates by a completing course administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-
>
> (a) the Contractor;
>
> (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "GMS contractor" includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
>
> (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term "PMS Contractor" includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
>
> (d) an Alternative Provider Medical Services contractor ("APMS contractor") as part of primary medical services to a patient who was at that time registered with that contractor (where the term "APMS contractor" includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or
>
> (e) a Local Health Board Medical Services practice ("LHBMS practice") as part of primary medical services to a patient who was at that time registered with that practice (where the term "a LHBMS practice" includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).".

(11) In paragraph 8.18 (which relates to the maximum amounts payable to the contractor), for the number "60", in the three places where it occurs, substitute "58".

(12) In paragraph 8.20 (which relates to the date the amount payable as a Quarterly Five-Year-Olds Immunisation Payment falls due), for "booster" substitute "completed".

(13) In paragraph 8.21 (which relates to the conditions attached to Quarterly Five-Year-Olds immunisation payments)—

(a) in sub-paragraph (b)(ii) omit "acellular"; and

(b) for sub-paragraph (b)(iii) substitute—

> "of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.16 (a) to (e); and".

Amendment to Section 9

12. For paragraph 9.5 of Section 9 (which relates to the maximum amount payable for locum cover) substitute—

"9.5 The maximum amount payable under this Section by the LHB in respect of locum cover for a GP performer is-

(a) in respect of the first two weeks for which the LHB provides reimbursement in respect of locum cover, £978.91 per week, and

(b) in respect of any week thereafter for which the LHB provides reimbursement in respect of locum cover, £1500 per week.".

Amendment to Section 15

13.—(1) Section 15 (Dispensing) is amended as follows.

(2) In paragraph 15.2 (which relates to dispensing costs for which reimbursement is payable) for sub-paragraph (b) substitute—

"(b) for personal administration, in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations,".

(3) For paragraph 15.3 (which relates to the amounts payable in relation to the provision of drugs and appliances)substitute—

"15.3 The amounts payable in relation to the provision of drugs and appliances are–

(a) the basic price of the drug or appliance, which is the price as calculated in accordance with Part II, Clause 8 (Basic Price), clause 10 (A, B and C) (Quantity to be Supplied), clause 11 (Broken Bulk), clause 13 (Drug Preparations Requiring Reconstitution from Granules or Powder) and Part VII (Lists of Drugs with a Commonly Used Pack Size) of the Drug Tariff, less a discount calculated in accordance with Part 1 of Annex G;

(b) the appropriate dispensing fee, as set out in Part 2 of Annex G (in respect of contractors authorised or required to provide dispensing services in accordance with Part 3 of Schedule 6 to the 2004 Regulations) or Part 3 of Annex G (in respect of all other contractors);

(c) an allowance to cover the VAT payable on the purchase of any products listed in paragraph 15.4 (a) to (e) and which are provided in accordance with paragraph 51(1)(b) in Part 3 of Schedule 6 to the 2004 Regulations. The allowance is to be calculated by applying the rate of VAT applying at the time of a claim to the basic price of the product after the discount calculated in accordance with Part 1 of Annex G has been deducted; and

(d) exceptional expenses, as provided for in Part II, clause 12 (Out of Pocket Expenses), of the Drug Tariff.".

(4) In paragraph 15.5 (which relates to the obligation on the LHB to make payments to contractors) omit "(a) or".

(5) For paragraph 15.13 (which relates to contractors that are to receive special payments) substitute—

"15.13 Where a contractor is reimbursed on the basis of special payment levels (see paragraph 15.12) any VAT allowance payable (see paragraph 15.3(c)) shall be calculated as a percentage of the special payment level.".

Amendment to Section 18

14. In paragraph 18.13 of Section 18 (which relates to the protocol in respect of locum cover payments)—

(a) omit "of £978.91" where it appears in the first sentence; and

(b) omit "£978.91" where it appears in the second sentence.

Amendment to Section 19

15.—(1) Section 19 (Superannuation Contributions) is amended as follows.

(2) In paragraph 19.2 (which relates to the payment of superannuation contributions)—

(a) omit "NHS Pensions Agency" in the first place where it occurs and substitute "NHS Pensions Division of the NHS Business Services Authority (NHSPD) (formerly the NHS Pensions Agency)"; and

(b) omit "NHS Pensions Agency" in the second place where it occurs and substitute "NHSPD".

(3) In paragraph 19.4(b) (which relates to the cost of additional voluntary contributions) for "NHS Pensions Agency" substitute "NHSPD".

(4) In paragraph 19.7 (which relates to superannuation contributions paid after the start of the financial year) for "NHS Pensions Agency" substitute "NHSPD".

(5) In paragraph 19.8 (which relates to the date by which money deducted by the LHB must be remitted) for "NHS Pensions Agency" substitute "the NHSPD".

(6) In paragraph 19.12 (which relates to the steps a LHB must take once a contractor's Pension Scheme Contributor's superannuable earnings have been agreed) for "NHS Pensions Agency", in both cases where these words occur, substitute "NHSPD".

Amendments to Annex A

16.—(1) In Part 1 of Annex A (Glossary – Acronyms)—

(a) omit "IASP – Improved Access Scheme Plan";

(b) insert "NHSPD- NHS Pensions Divisions of the NHS Business Services Authority" in the appropriate alphabetical position;

(2) In Part 2 of Annex A (Glossary – Definitions)—

(a) after the definition of "GMS contract" insert ""GMS contractor" means a contractor who provides primary medical services under a GMS contract;"; and

(b) omit the definition of "Improved Access Scheme plan".

Amendments to Annex B

17.—(1) Annex B (the Global Sum Allocation Formula) is amended as follows.

(2) At the end of paragraph B.8 (which relates to needs adjustment), insert "In this formula, as in all other formulae in this Annex B, the symbol "*" is used as the sign for multiplication.";

(3) For the formula set out in paragraph B.15 substitute—

"Practice List * average distance$^{0.05}$ * population density$^{-0.06}$";

(4) For paragraphs B.17 to B.22 (which relate to normalising and to combining the adjustments) substitute the following paragraphs—

" B.17 At each stage of the calculation, the weighted practice populations are normalised (scaled back) to the LHB normalised weighted population. This is done so that the impact of each of the adjustments is equal, and ensures that one adjustment does not dominate the others.

B.18 Using the age and sex adjustment as an example, the formula for normalising practice-weighted populations, for the specific Global Sum Allocation Formula adjustments, is as follows:

Normalised age and sex weighted practice population =

$$\frac{\text{age and sex weighted practice population}}{\text{sum of LHB age and sex weighted practice populations}} * \text{LHB normalised weighted population}$$

B.19 The LHB normalised weighted population used above is the LHB's registered population for the current quarter multiplied by its latest Quarterly LHB Normalising Index. The Quarterly LHB Normalising Index is a quarterly updated index derived by the Exeter System from the data used in the previous quarter's Global Sum Allocation Formula. Scaling back to this population ensures that the needs and costs of the LHB's population, relative to other LHBs in the country, are reflected in its practices' global sum payments.

B.20 The other five weighted practice populations produced by the other adjustments in the Global Sum Allocation formula are normalised in the same manner as outlined in B.18.

B.21 The normalised weighted practice populations for each adjustment are then divided by the practice's normalised list size to generate a practice index for each adjustment used in the Global Sum Allocation Formula. The formula for calculating the practice's normalised list size is as follows:

Practice normalised list size = CRP * Quarterly LHB Normalising Index

B.22 Using the age and sex adjustment as an example, the formula for then calculating the practice index for each adjustment is as follows:

$$\text{Practice age and sex index} = \frac{\text{Normalised age and sex weighted practice population}}{\text{Practice normalised list size}}$$

B.23 Indices are produced for each of the other five adjustments in the Global Sum Allocation Formula in the same manner as outlined in B.22.

Combining the adjustments

B.24 Each of the six indices are then applied simultaneously to the practice's normalised list size to calculate the overall weighted practice population, as follows:

Overall weighted practice population =

Practice normalised list size * age and sex index * nursing and residential homes index * list turnover index * additional needs index * MFF index * rurality index

B.25 This overall weighted practice population is then normalised to the national registered population to calculate the Contractor Weighted Population for the Quarter as follows:

Contractor Weighted Population =

$$\frac{\text{overall weighted practice population}}{\text{sum of LHB overall weighted practice populations}} * \text{LHB normalised weighted population}$$

B.26 LHBs will have use of software that will enable them to calculate the contractor weighting for each contractor, provided the necessary raw data have been collated.".

Amendment to Annex C

18.—(1) Annex C (Temporary Patients Adjustment) is amended as follow.

(2) In paragraph C.2 (which relates to the receipt of a payment of unregistered patients) omit all the words after "global sum allocation.";

(3) For paragraph C.3 (which relates to the calculation of the annual amount which is to be the basis for the Adjustment) substitute—

> "C.3 In the case of a contractor in respect of which a temporary patient adjustment was calculated for the financial year 2005/06, the temporary patient adjustment for the financial year 2006/07 will be the same amount as was calculated for the financial year 2005/06.";

(4) In paragraph C.4 (which relates to exceptional cases), at the end, insert "Before making such a determination, the LHB must discuss the matter with the contractor."; and

(5) For paragraph C.5 (which relates to contractors that do not have five years' worth of data) substitute—

> "C.5 In the case of a contractor in respect of which no temporary patient adjustment was calculated for the financial year 2005/06, the LHB is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the LHB must discuss the matter with the contractor.".

Substitution of Annex D

19. For Annex D (Quality and Outcomes Framework) substitute the Annex D (Quality and Outcomes Framework) contained in Schedule 1 to these Directions.

Amendment to Annex F

20.—(1) Annex F (Adjusted Practice Disease Factor Calculations) is amended as follows.

(2) In paragraph F.1 (which relates to the steps involved in the calculation) after "each disease area", in both places where that phrase occurs, insert "(other than the area relating to palliative care)".

(3) In paragraph F.5 (which relates to the calculation of a cash total) after "each disease area", in both places where that phrase occurs, insert "(other than the area relating to palliative care)".

Amendment to Annex G

21.—(1) Annex G (Dispensing Payments) is amended as follows.

(2) In Part 1 of Annex G (Dispensing Payments – Discount Scale) for the heading at the top of the left hand column of the table substitute "Total basic price per month of the prescriptions submitted by the Contractor - £ bandwidth".

(3) In Part 2 of Annex G (Dispensing Payments – Dispensing Feescale for contractors that are authorised or required to provide dispensing services) for the table in that Part substitute the following table—

Total prescriptions, calculated separately for each individual dispensing practitioner, in bands	***Prices per prescription in pence***
Up to 400	230.9
401 – 500	227.6
501 – 600	224.6
601 – 700	221.8
701 – 800	219.2
801 – 900	216.8
901 – 1250	214.5
1251 – 1750	212.5
1751 – 2000	210.7

2001 – 2500	209.0
2501 – 3000	207.6
3001 – 3500	206.4
3501 – 4000	205.3
4001 and over	204.5

(4) In Part 3 of Annex G (Dispensing Payments – Dispensing Feescale for contractors that are not authorised or required to provide dispensing services) for the table in that Part substitute the following table—

Total prescriptions, calculated separately for each individual practitioner, in bands	***Prices per prescription in pence***
Up to 400	240.6
401 – 500	237.3
501 – 600	234.3
601 – 700	231.5
701 – 800	228.9
801 – 900	226.5
901 – 1250	224.2
1251 – 1750	222.2
1751 – 2000	220.4
2001 – 2500	218.7
2501 – 3000	217.3
3001 – 3500	216.1
3501 – 4000	215.0
4001 and over	214.2

(5) In Part 4 of Annex G (Dispensing Payments – Oxygen and oxygen equipment)—

(a) in paragraph G.6 (which relates to payments in respect of prescriptions for oxygen and masks)—

(i) in sub-paragraph (a)(i), after "Part X" insert "(Home Oxygen Therapy Service)";

(ii) in sub-paragraph (a)(ii), after "Part X" insert "(Home Oxygen Therapy Service)";

(iii) in subparagraph (b), after "clause 12" insert "(Out of Pocket Expenses)";

(b) omit paragraph G.9 (which relates to Value Added Tax) and its associated heading and substitute "G.9 THIS PARAGRAPH IS A BLANK PARAGRAPH".

Signed on behalf of the National Assembly for Wales

Dr Brian Gibbons

31 March 2006

Minister for Health and Social Services

SCHEDULE 1

(Direction 19)

(The annex set out below is to be substituted for Annex D of the GMS Statement of Financial Entitlements which came into force on 30 April 2005)

"ANNEX D – QUALITY AND OUTCOMES FRAMEWORK

Quality and outcomes framework

Guidance 2006

Section 1: Principles

The following principles relating to the Quality and Outcomes Framework (QOF) were agreed by the negotiators.

1 Indicators should, where possible, be based on the best available evidence.
2 The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.
3 Data should never be collected purely for audit purposes.
4 Only data which are useful in patient care should be collected. The basis of the consultation should not be distorted by an over-emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.
5 Data should never be collected twice i.e. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

Section 2: Clinical Indicators

1. General format

The clinical indicators are organised by disease category. The disease categories have been selected for the following reasons:

1 Where the responsibility for ongoing management rests principally with the general practitioner and the primary care team.
2 Where there is good evidence of the health benefits likely to result from improved primary care – in particular if there is an accepted national clinical guideline.
3 Where the disease area is a priority in a number of the four nations.

Where evidence-based national guidance has not been included, this has usually either been to limit the size and complexity of the framework, or because it would be particularly hard for practices to record the relevant

information in a reliable way.

A summary of the indicators for each disease category is provided at the beginning of each section.

Indicators across all disease categories are numbered. In the guidance they are prefixed by the disease category to which they belong. In this revision of the Quality and Outcomes Framework, indicators are no longer numbered sequentially. Where indicators have been removed from the Framework, their number has not been reallocated to new indicators. Similarly where indicators have been amended, either in relation to the activity being measured or the frequency with which the activity should be completed, the indicator has been renumbered. The reason for this is to avoid inappropriate cross year comparisons between different indicators. Indicators have NOT been renumbered where the only change is in the threshold and range.

The term PCO (Primary Care Organisation) is used throughout, as the structures responsible for the organisation and management of primary care differ in the four countries.

For each indicator, two descriptions are given. This differs from the first version of the Guidance as the preferred coding section has been removed. These have been replaced by the Logical Query Indicator Specification and the Dataset and Business Rules.

1.1 Rationale

This sub-section explains why the indicator has been selected. Wherever possible, the evidence source is described and, if available, a web address (hyperlink in the electronic version of this guidance) is provided. When available, National Guidelines have been used as the main evidence source. A small number of individual papers are also quoted.

In some areas, more extensive information is provided. It has been difficult to achieve a balance of providing helpful information without providing a textbook of medicine or replicating guidelines.

The indicators are not intended to cover all the process issues or outcomes for each disease category. In some areas, the indicators cover only a very small part of the care for those conditions. The most obvious example of this is mental health, where it was not possible to develop indicators that could be rewarded in this type of Framework for many of the most important aspects of mental health care. Mental health care is however an example of a number of conditions where some markers of good clinical care have been included in the organisational indicators (e.g. through the inclusion of significant event auditing for mental health problems).

In many of the indicators an additional time factor is incorporated, recognising that in practice it may be difficult to ensure that all patients have attended for review and have completed the review process within any particular timescale.

For example, concerning indicator BP5, national guidance recommends that all patients with hypertension should have their blood pressure measured every six months. The actual indicator looks at the number of patients with hypertension who have had a blood pressure measured in the last nine months.

1.2 Read Codes

The Logical Query Indicator Specification and the Dataset and Business Rules that support the reporting requirements of The QOF in each home country are based entirely on Read codes (4 byte, version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Practices using proprietary coding systems and/or local/practice specific codes need to be advised that these codes will not be recognised within QOF reporting. Practices utilising such systems should develop strategies to ensure that they are utilising appropriate Read codes in advance of producing their achievement report.

1.3 Reporting and Verification

This section defines the audit information which practices will be required to submit annually. The term 'notes' is used throughout to indicate either electronic or paper records.

It is hoped that all reporting will be possible through the use of GP clinical systems and that practices will be able to run a report annually which can be submitted to the PCO. Separate guidance has been produced on the electronic queries which can be used to report on the Quality and Outcomes Framework in England. This can be found at the following location:

http://www.connectingforhealth.nhs.uk/delivery/programmes/qof/docs/establishing_accuracy_in_qof_data.pdf

Additional information on the process and content of QOF review visits in Scotland can be found at:

http://www.paymodernisation.scot.nhs.uk/gms/quality/index.htm
(Key Documents: "Winter Report"; "Introduction to the QOF Review-a Guide for Practices"; "Final QOF Guidance Reviewers Manual")

Practices that do not hold all the required information on computer may utilise the reporting criteria to undertake a manual audit. However, it is recommended that information be transferred to an electronic format as part of that audit process.

Criteria are also provided under a number of indicators that may be used by a PCO on a verification visit to a practice. In general, those that have been chosen have an identifiable source in the clinical record.

In general, PCOs will not expect or be expected to conduct detailed or intrusive verification procedures, unless they suspect that incorrect figures may have been returned, or where there is suspicion of fraud. PCOs may, however, select cases for more detailed investigation from

time to time on a random basis.

2. Exception reporting

The QOF includes the concept of exception reporting. This has been introduced to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

The following criteria have been agreed for exception reporting:

A) patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months

B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty

C) patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels

D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal

E) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contraindication or have experienced an adverse reaction

F) where a patient has not tolerated medication

G) where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records

H) where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease

I) where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B this would apply to the disease register and these patients would be subtracted from the denominator for all other indicators. For example, in a practice with 100 patients on the CHD disease register, in which four patients have been recalled for follow-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. This would apply to all relevant indicators in the CHD set.

In addition, practices may exception-report patients relating to single indicators, for example a patient who has heart failure due to left ventricular dysfunction

(LVD) but who is intolerant of ACE inhibitors could be exception-reported. This would again be done by removing the patient from the denominator.

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

3. Disease registers

An important feature of the QOF is the establishment of disease registers. While it is recognised that these may not be one hundred per cent accurate, it is the responsibility of the practice to demonstrate that it has systems in place to maintain a high quality register. Verification visits may involve asking how the practice constructed the register and how the register is maintained. PCOs will compare the reported prevalence with the expected prevalence. This is a relatively blunt instrument and there are likely to be good reasons for variations but it is anticipated these will be discussed with practices. An explanation on how points are calculated and how prevalence will be applied can be found in the Statement of Financial Entitlements for 2006/07.

Summary of Indicators

Clinical Domain

Secondary Prevention of Coronary Heart Disease

Indicator	Points	Payment Stages
Records		
CHD 1. The practice can produce a register of patients with coronary heart disease	4	
Diagnosis and initial management		
CHD 2. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment	7	40–90%
Ongoing Management		
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	40-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	19	40-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	40-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	17	40-70%
CHD 9. The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%
CHD 10. The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	7	40-60%
CHD 11. The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist	7	40-80%
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	40-90%

Heart Failure

Indicator	Points	Payment stages
Records		
HF1: The practice can produce a register of patients with heart failure.	4	
Initial diagnosis		
HF2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment.	6	40-90%
Ongoing management		
HF3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication.	10	40-80%

Stroke and TIA

Indicator	Points	Payment Stages
Records		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	2	
STROKE 11. The percentage of new patients with a stroke who have been referred for further investigation.	2	40-80%
Ongoing Management		
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	40-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	5	40-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the	2	40-85%

preceding 1 September to 31 March		

Hypertension

Indicator	Points	Payment Stages
Records		
BP 1. The practice can produce a register of patients with established hypertension	6	
Ongoing Management		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	20	40-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less	57	25-70%

Diabetes Mellitus

Indicator	Points	Payment Stages
Records		
DM 19.The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes.	6	
Ongoing Management		
DM 2.The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40-90%
DM 5. The percentage of diabetic patients who have a record of HbA_{1c} or equivalent in the previous 15 months	3	40-90%
DM 20. The percentage of patients with diabetes in whom the last HbA_{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40-50%
DM 7. The percentage of patients with diabetes in whom the last HbA_{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	11	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40-90%
DM 9.The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	40-90%

DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40-60%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	40-90%
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months	3	40-90%
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	40-80%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	40-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 mmol/l or less	6	40-70%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March.	3	40-85%

Chronic Obstructive Pulmonary Disease

Indicator	Points	Payment Stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 9. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	10	40-80%
Ongoing management		
COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-70%
COPD 11. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months	7	40-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1	6	40-85%

September to 31 March		

Epilepsy

Indicator	Points	Payment Stages
Records		
EPILEPSY 5. The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1	
Ongoing Management		
EPILEPSY 6. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	40-90%
EPILEPSY 7. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months	4	40-90%
EPILEPSY 8. The percentage of patients age 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months	6	40-70%

Hypothyroid

Indicator	Points	Payment stages
Records		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
Ongoing Management		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	40-90%

Cancer

Indicator	Points	Payment stage
Records		
CANCER 1. The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'	5	
Ongoing Management		

CANCER 3. The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	40-90%

Palliative Care

Indicator	Points	Payment Stages
Records		
PC1: The practice has a complete register available of all patients in need of palliative care/support.	3	
Ongoing Management		
PC2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.	3	

Mental Health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
Ongoing management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	2	40-90%
MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%
MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40-90%

Asthma

Indicator	Points	Payment stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months	4	
Initial Management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40-80%
Ongoing management		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Dementia

Indicator	Points	Payment Stages
Records		
DEM1: The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25-60%

Depression

Indicator	Points	Payment Stages
Diagnosis and initial management		
DEP1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40-90%
DEP2: In those patients with a new diagnosis of depression, recorded between the preceeding1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40-90%

Chronic Kidney Disease

Indicator	Points	Payment stages
Records		
CKD1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial Management		
CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40-90%
Ongoing Management		
CKD3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40-70%
CKD4: The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	4	40-80%

Atrial Fibrillation

Indicator	Points	Payment Stages
Records		
AF1: The practice can produce a register of patients with atrial fibrillation.	5	
Initial diagnosis		
AF2: The percentage of patients with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis.	10	40-90%
Ongoing management		
AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy.	15	40-90%

Obesity

Indicator	Points	Payment Stages
Records		
OB1: The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.	8	

Learning Disabilities

Indicator	Points	Payment Stages

Records		
The practice can produce a register of patients with learning disabilities	4	NA

1.Smoking Indicators

Indicator	Points	Payment Stages
Ongoing management		
Smoking 1: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis	33	40-90%
Smoking 2: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months	35	40-90%

Organisational Domain

Records and Information

Records 3 1 point	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours
Records 8 1 point	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded
Records 9 4 points	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%
Records 11 10 points	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients
Records 13 2 points	There is a system to alert the out-of-hours service or duty doctor to patients dying at home
Records 15 25 points	The practice has up-to-date clinical summaries in at least 60% of patient records
Records 17 5 points	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients
Records 18 8 points	The practice has up-to-date clinical summaries in at least 80% of patient records
Records 19 7 points	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice
Records 20 12 points	The practice has up-to-date clinical summaries in at least 70% of patient records
Records 21 1 point	Ethnic origin is recorded for 100% of new registrations
Records 22 11 points	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never

	smoked where smoking status need be recorded only once (payment stages 40 – 90%)

Information for Patients

	Indicator
Information 3 **1 point**	The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day
Information 4 **1 point**	If a patient is removed from a practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient
Information 5 **2 points**	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
Information 7 **1.5 points**	Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO

Education and Training

	Indicator
Education 1 **4 points**	There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months
Education 4 **3 points**	All new staff receive induction training
Education 5 **3 points**	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
Education 6 **3 points**	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
Education 7 **4 points**	The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include: • Any death occurring in the practice premises • New cancer diagnoses • Deaths where terminal care has taken place at home • Any suicides • Admissions under the Mental Health Act • Child protection cases • Medication errors A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different
Education 8	All practice-employed nurses have personal learning plans which have

5 points	been reviewed at annual appraisal
Education 9 **3 points**	All practice-employed non-clinical team members have an annual appraisal
Education 10 **6 points**	The practice has undertaken a minimum of three significant event reviews within the last year

Practice Management

	D. Practice Management
Management 1 **1 point**	Individual healthcare professionals have access to information on local procedures relating to Child Protection
Management 2 **1 point**	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
Management 3 **0.5 points**	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
Management 4 **1 point**	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
Management 5 **3 points**	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
Management 6 **2 points**	Person specifications and job descriptions are produced for all advertised vacancies
Management 7 **3 points**	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: • A defined responsible person • Clear recording • Systematic pre-planned schedules • Reporting of faults
Management 8 **1 point**	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
Management 9 **3 points**	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
Management 10 **2 points**	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Medicines Management

	E. Medicines Management
Medicines 2 **2 points**	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis
Medicines 3 **2 points**	There is a system for checking the expiry dates of emergency drugs on at least an annual basis
Medicines 4 **3 points**	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)
Medicines 6 **4 points**	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing
Medicines 7 **4 points**	Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend
Medicines 8 **6 points**	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)
Medicines 10 **4 points**	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change
Medicines 11 **7 points**	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%
Medicines 12 **8 points**	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%

2.Patient Experience Domain

PE Patient Experience
PE 1 Length of Consultations **33 points** The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face –to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.
PE 2 Patient Surveys (1) **25 points** The practice will have undertaken an approved patient survey each year
PE 3 Patient Surveys (2)

20 points

The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:

1. Summarises the findings of the survey.

2. Summarises the findings of the previous year's survey.

1. Reports on the activities undertaken in the past year to address patient experience issues.

PE 4 Patient Surveys (3)
30 points

The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:

1. Sets priorities for the next 2 years.

2. Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative).

3. Describes the plans for achieving the priorities, including indicating the lead person in the practice.

4. Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

Additional Services

For practices providing additional services the following organisational markers will apply.

Additional	Cervical Screening (CS)
CS 1 **11 points**	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 25 – 80%
CS 5 **2 points**	The practice has a system for informing all women of the results of cervical smears
CS 6 **2 points**	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years
CS 7 **7 points**	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/ recall, exception reporting and the regular monitoring of inadequate smear rates
Additional	**Child Health Surveillance (CHS)**

CHS 1 **6 points**	Child development checks are offered at intervals that are consistent with national guidelines and policy
Additional	**Maternity Services (MAT)**
MAT 1 **6 points**	Ante-natal care and screening are offered according to current local guidelines
Additional	**Contraceptive Services (CON)**
CON 1 **1 point**	The team has a written policy for responding to requests for emergency contraception
CON 2 **1 point**	The team has a policy for providing pre-conceptual advice

Secondary Prevention in Coronary Heart Disease (CHD)

Indicator	Points	Payment Stages
Records		
CHD 1. The practice can produce a register of patients with coronary heart disease	4	
Diagnosis and initial management		
CHD 2. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment	7	40–90%
Ongoing Management		
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	40-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	19	40-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	40-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	17	40-70%
CHD 9. The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%

CHD 10. The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	7	40-60%
CHD 11. The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist	7	40-80%
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	40-90%

CHD - Rationale for Inclusion of Indicator Set

Coronary heart disease is the single commonest cause of premature death in the UK. The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. This indicator set focuses on the management of patients with established CHD consistent with clinical priorities in the four nations.

CHD Indicator 1

The practice can produce a register of patients with coronary heart disease

CHD 1.1 Rationale

In order to call and recall patients effectively in any disease category and in order to be able to report on indicators for coronary heart disease, practices must be able to identify their patient population with CHD. This will include all patients who have had coronary artery revascularisation procedures such as coronary artery bypass grafting (CABG). Patients with Cardiac Syndrome X should generally not be included in the CHD register.

Practices should record those with a past history of myocardial infarction as well as those with a history of CHD.

CHD 1.2 Reporting and Verification

The practice reports the number of patients on its CHD disease register and the number of patients with CHD as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence with the reported prevalence.

CHD Indicator 2

The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment

CHD 2.1 Rationale

Diagnosis of coronary heart disease

The QOF does not specify how the diagnosis of angina is made or confirmed. This will vary from patient to patient, e.g. clinical history, response to medication, results of investigations, hospital letters etc.

In general, angina is a clinical diagnosis. Patients with suspected angina should have a 12 lead ECG performed. The presence of an abnormal ECG supports a clinical diagnosis of coronary heart disease.

An abnormal ECG also identifies a patient at higher risk of suffering new cardiac events in the subsequent year. However, a normal ECG does not exclude coronary artery disease.

Reference Grade B Recommendation SIGN Guideline 51

Further Information: http://www.sign.ac.uk/guidelines/fulltext/51/index.html

As an additional assessment (rarely for diagnosis), patients with newly diagnosed angina should be referred for exercise-testing or myocardial perfusion scanning.

The aim of further investigation is to provide diagnostic and prognostic information and to identify patients who may benefit from further intervention.

Exercise tolerance testing (ETT) has been shown to be of value in assessing prognosis of patients with coronary artery disease. An ETT is also helpful in patients at high risk of CHD, where a positive test can provide useful prognostic information.

Patients should not be referred for an ETT if:

- they are on maximal medical treatment and still have angina symptoms
- the diagnosis of CHD is unlikely (these patients should be referred to a cardiologist)
- they are physically incapable of performing the test
- they have clinical features suggestive of aortic stenosis or cardiomyopathy
- the results of stress testing would not affect management.

Reference Grade B Recommendation SIGN Guideline 51

Further Information: http://www.sign.ac.uk/guidelines/fulltext/51/section2.html

Specialist Referral:

An alternative to referral for exercise-testing is referral to a specialist for evaluation. Referral would normally be to a cardiologist, general physician or GP with a special interest. For the purposes of the QOF an appropriate referral being undertaken between three months before and twelve months after a diagnosis of angina has been made would be considered as having met the requirements of this indicator.

CHD 2.2 Reporting and Verification

The practice should report those patients who have had an exercise tolerance test or been referred to a specialist within 12 months of being added to the register in whom a new diagnosis of coronary heart disease has been made since 1 April 2003. The practice should also report patients who have been referred up to three months before being added to the register.

In verifying that this information has been correctly recorded, a number of approaches could be taken by the Primary Care Organisation:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with CHD diagnosed since 1 April 2003 to look at the proportion with recorded exercise tolerance testing or referral.
3 Inspection of a sample of records of patients for whom a record of exercise tolerance testing or referral is claimed, to see if there is evidence of this in the medical records.

CHD Indicator 5

The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months

CHD 5.1 Rationale

Epidemiological data indicate that continued hypertension following the onset of CHD increases the risk of a cardiac event and that the reduction of blood pressure reduces risk.

Patients with known CHD should have their blood pressure measured at least annually.

CHD 5.2 Reporting and Verification

Practices should report the percentage of patients on the CHD register who have had their blood pressure recorded in the last 15 months.

CHD Indicator 6

The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less

CHD 6.1 Rationale

The British Hypertension Society Guidelines propose an optimal blood pressure of 140 mm Hg or less systolic and 85 mm Hg or less diastolic for patients with CHD. This guideline also proposes a pragmatic audit standard of a blood pressure reading of 150/90 or less (http://www.bhsoc.org/, under 'Guidelines').

A major overview of randomised trials showed that a reduction of 5-6 mm Hg in blood pressure sustained over 5 years reduces coronary events by 20-25% in patients with coronary heart disease (Collins et al. Lancet 1990; 335: 827-38).

CHD 6.2 Reporting and Verification

Practices should report the percentage of patients on the CHD register whose last recorded blood pressure is 150/90 or less. This reading should have been taken in the previous 15 months.

CHD Indicator 7

The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months

CHD 7.1 Rationale

A number of trials have demonstrated that cholesterol lowering with statins significantly reduces cardiovascular or all-cause mortality in patients with angina or in patients following myocardial infarction.

Grade C Recommendation SIGN Guideline 51

Further Information: http://www.sign.ac.uk/guidelines/fulltext/51/section2.html

It is unclear from the literature how frequently cholesterol measurement should be undertaken, but the English National Framework (NSF) on CHD recommends annually.

The majority of trials include only patients under 75. However, most national guidance makes no distinction on the basis of age, and age 'cut-offs' are not

generally included.

CHD 7.2 Reporting and Verification

Practices should report the percentage of patients on the CHD register who have a record of total cholesterol in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol.
3 Inspection of a sample of records of patients for whom a record of serum cholesterol is claimed, to see if there is evidence of this in the medical records.

CHD Indicator 8

The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less

CHD 8.1 Rationale

A number of Randomised Controlled Trials of statin therapy in the secondary prevention of CHD have shown a reduction in relative risk of cardiac events irrespective of the starting level of cholesterol (see reference in 7.1). Recent trials have found greater relative benefit with more potent cholesterol lowering regimes. It is likely that National Guidelines relating to statin therapy in patients with CHD will change to recommend statin therapy for all patients with CHD irrespective of their starting level of total cholesterol.

However, currently the Joint British Recommendations on Prevention of Coronary Heart Disease in Clinical Practice (1998) and SIGN Guidelines 41 and 51 recommend that patients who have a cholesterol of greater than 5mmol/l should be offered lipid lowering therapy. This should be treated as an audit target below which to aim for all eligible CHD patients.

The guidance here is given in terms of total cholesterol, as this is used in national guidance and in trials.

CHD 8.2 Reporting and Verification

Practices should report the percentage of patients on the CHD register who have a record of total cholesterol in the previous 15 months which is 5mmol/l or less.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol 5mmol/l or less.
3 Inspection of a sample of records of patients for whom a record of serum cholesterol at 5mmol/l is claimed, to see if there is evidence of this in the medical records.

CHD Indicator 9

The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)

CHD 9.1 Rationale

Aspirin (75-150mg per day) should be given routinely and continued for life in all patients with CHD unless there is a contraindication. Clopidogrel (75mg/ day) is an effective alternative in patients with contraindications to aspirin, or who are intolerant of aspirin. Aspirin should be avoided in patients who are anticoagulated.

Grade A Recommendation SIGN Guidelines 41/51

Further Information:
http://www.sign.ac.uk/guidelines/fulltext/51/index.html
http://www.sign.ac.uk/guidelines/fulltext/41/index.html

Since the original GMS Guidance in 2003, NICE have released guidance on the appropriate use of clopidogrel:

- Clopidogrel alone (within its licensed indications) is recommended for people who are intolerant of low-dose aspirin and either have experienced an occlusive vascular event or have symptomatic peripheral artery disease. NICE define aspirin intolerance as either of the following: proven hypersensitivity to aspirin-containing medicines or history of severe dyspepsia induced by low-dose aspirin.
- Clopidogrel, in combination with low-dose aspirin, is recommended for use in the management of non-ST-segment-elevation acute coronary syndrome (ACS) in people who are at moderate to high risk of myocardial infarction (MI) or death. NICE recommend that treatment with clopidogrel in combination with low-dose aspirin should be continued for up to 12 months after the most recent acute episode of non-ST-segment-elevation ACS. Thereafter, standard care, including treatment with low-dose aspirin alone, is recommended. Moderate to high risk of MI or death in people presenting with

non-ST-segment-elevation ACS can be determined by clinical signs and symptoms, accompanied by one or both of the following:

1. The results of clinical investigations, such as new ECG changes (other than persistent ST-segment-elevation), indicating ongoing myocardial ischaemia, particularly dynamic or unstable patterns.
2. The presence of raised blood levels of markers of cardiac cell damage such as troponin.

Further information:
http://www.nice.org.uk/page.aspx?o=213432

CHD 9.2 Reporting and Verification

Practices should report the percentage of patients on the CHD register who have been prescribed aspirin, clopidogrel or warfarin within the previous 15 months or have a record of taking over-the-counter (OTC) aspirin updated in the previous 15 months.

CHD Indicator 10

The percentage of patients with coronary heart disease who are treated with a beta blocker (unless a contraindication or side-effects are recorded)

CHD 10.1 Rationale

Long-term beta blockade remains an effective and well-tolerated treatment that reduces mortality and morbidity in patients with angina and patients after myocardial infarction.

Although the trial evidence relates mainly to patients who have had a myocardial infarction, experts have generally extrapolated this evidence to all patients with CHD. Because the evidence is not based on all patients with CHD, the target levels for this indicator have been set somewhat lower than for other process indicators.

Recent evidence against the use of beta blockers in hypertension should not be extrapolated to patients with CHD.

Grade A Recommendation SIGN Guidelines 41/51

Further Information:
http://www.sign.ac.uk/guidelines/fulltext/51/index.html
http://www.sign.ac.uk/guidelines/fulltext/41/index.html

CHD 10.2 Reporting and Verification

The percentage of patients on the CHD register who have been prescribed a beta blocker in the last six months.

CHD Indicator 11

The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or angiotensin II antagonist

CHD 11.1 Rationale

A number of trials have shown reduced mortality following myocardial infarction with the use of ACE inhibitors. The Heart Outcome Prevention Evaluation (HOPE) showed that ACE inhibitors are also of benefit in reducing coronary events and progression of coronary arteriosclerosis in patients without left ventricular systolic dysfunction. There is evidence that angiotensin II antagonists have a similar effect.

Grade A Recommendation SIGN Guideline 41

Grade A Recommendation NICE Guideline A

Further Information:
http://www.sign.ac.uk/guidelines/fulltext/41/index.html
http://www.escardio.org

CHD 11.2 Reporting and Verification

The percentage of patients who have had a myocardial infarction after 1 April 2003 whose records show they have been prescribed an ACE inhibitor or A2 antagonist in the last six months.

CHD Indicator 12

The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March

CHD 12.1 Rationale

This is a current recommendation from the Department of Health and the Joint Committee on Vaccination and Immunisation.

CHD 12.2 Reporting and Verification

The percentage of patients on the CHD register who have had an influenza vaccination administered in the preceding 1 September to 31 March.

Heart Failure

Indicator	Points	Payment stages
Records		
HF1: The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40-90%
Ongoing management		
HF3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication	10	40-80%

Heart Failure- Rationale for Inclusion of Indicator Set

From April 2004 – March 2006, the QOF only included patients who had both CHD and LVD. This only represented around half of patients with heart failure (Davies et al. Lancet 2001; 358: 439-445).

Heart failure represents the only major cardiovascular disease with increasing prevalence and is responsible for dramatic impairment of quality of life, carries a poor prognosis for patients, and is very costly for the NHS to treat (second only to stroke).

Heart Failure (HF) Indicator 1

The practice can produce a register of patients with heart failure.

Heart Failure 1.1: Rationale

From April 2006, all patients with suspected heart failure should be included in the register.

Heart Failure 1.2 Reporting and Verification

The practice reports the number of patients on its heart failure register and the number of patients with heart failure as a proportion of total list size.

Heart Failure (HF) Indicator 2

The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment

Heart Failure 2.1: Rationale

From April 2006, all patients with suspected heart failure should be investigated (Senni et al. J Am Coll Cardiol. 1999; 33(1): 164 – 70; NICE clinical guideline 5. National Institute for Health and Clinical Excellence, London: 2003) and this is expected to involve, as a minimum, specialist investigation (such as echocardiography or natiuretic peptide assay) and often specialist opinion. Specialists may include GPs identified by their PCO as having a special clinical interest in heart failure. Many heart failure patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintography or angiography rather than

echocardiography. Current guidance (Remme et al. Eur Heart J 2001; 22: 1527-60) requires either echocardiography or specialist assessment for all patients with suspected heart failure, regardless of presumed aetiology.

Further information:

http://www.nice.org.uk/pdf/Full_HF_Guideline.pdf

Heart Failure 2.2: Reporting and Verification

The practice reports those patients in whom a new diagnosis of heart failure has been made since 1 April 2006 who have had an echocardiogram or been referred to a specialist within 12 months of being added to the register. The practice may also include patients who have been referred up to three months before being added to the register.

Heart Failure (HF) Indicator 3

The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contraindication

Heart Failure 3.1: Rationale

The evidence base for treating patients with LVD heart failure with angiotensin receptor blockers (ARBs) is strong, however, this should only be after first attempting to initiate ACE inhibitors (Pfeffer et al. Lancet 2003; 362: 759-766).

It should also be noted that it is possible to have a diagnosis of LVD without heart failure, for example, asymptomatic people who might be identified coincidentally but who are at high risk of developing subsequent heart failure. In such cases ACE inhibitors delay the onset of symptomatic heart failure, reduce cardiovascular events and improve long-term survival. This indicator only concerns patients with heart failure and thus excludes this other group of patients who should nevertheless be considered for treatment with ACE inhibitors.

Further information:
http://www.clinicalevidence.com/ceweb/conditions/cvd/0204/0204_I13.jsp

Heart Failure 3.2 Reporting and Verification

Practices report the number of patients on their heart failure register with heart failure due to LVD.

Practices report the percentage of these patients whose records show they have been prescribed an ACE inhibitor or an ARB in the previous six months.

Stroke and TIA

Indicator	Points	Payment Stages
Records		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 11. The percentage of new patients with a stroke who have been referred for further investigation	2	40-80%
Ongoing Management		
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	40-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	5	40-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40-85%

Stroke/TIA - Rationale for Inclusion of Indicator Set

Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65. There is evidence that appropriate diagnosis and management can improve outcomes.

Stroke Indicator 1

The practice can produce a register of patients with Stroke or TIA

Stroke 1.1 Rationale

A register is a prerequisite for monitoring patients with stroke or TIA.

For patients diagnosed prior to April 2003 it is accepted that various diagnostic

criteria may have been used. For this reason the presence of the diagnosis of stroke or TIA in the records will be acceptable. Generally patients with a diagnosis of Transient Global Amnesia or Vertebro-basilar insufficiency should not be included in the retrospective register. However, practices may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.

As with other conditions, it is up to the practice to decide, on clinical grounds, when to include a patient, e.g. when a 'dizzy spell' becomes a TIA.

Stroke 1.2 Reporting and Verification

The practice reports the number of patients on its stroke/TIA disease register and the number of patients on its stroke/ TIA register as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence with the reported prevalence.

Stroke Indicator 11

The percentage of new patients with a stroke who have been referred for further investigation

Stroke 11.1 Rationale

The previous stroke indicator 2 suggested that patients needed to be referred for confirmation of the diagnosis by CT or MRI scan. However specialist investigations are often only accessible by a referral to secondary care services and therefore this indicator has been changed to reflect referral activity rather than confirmation by specific scanning investigations. This indicator refers to patients diagnosed with a stroke from 1 April 2006.

For the purposes of the QOF, an appropriate referral being undertaken between three months before and twelve months after a diagnosis of presumptive stroke being made would be considered as having met the requirements of this indicator.

Stroke 11.2 Reporting and Verification

The practice should report those patients who have been referred for further investigation within 12 months of being added to the register in whom a new diagnosis of stroke has been made since 1 April 2006. The practice should also report those who have been referred up to three months before being added to the register.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with stroke diagnosed after 1 April 2006 to look at the proportion referred for further investigation.
3 Inspection of a sample of records of patients for whom a record of investigations such as CT or MRI scan is claimed, to see if there is evidence of this in the medical records.

Stroke Indicator 5

The percentage of patients with TIA or stroke whose notes have a record of blood pressure in the preceding 15 months

Stroke 5.1 Rationale

All patients should have their blood pressure checked and hypertension persisting for over two weeks should be treated. The British Hypertension Society Guidelines state that optimal blood pressure treatment targets are systolic pressure less than or equal to 140 mm Hg and diastolic blood pressure (DBP) less than or equal to 85 mm Hg. The proposed audit standard is less than or equal to 150/90.

In one major overview, a long-term difference of 5-6 mm Hg in usual DBP is associated with approximately 35-40 per cent less stroke over five years. (Collins et al. Lancet 1990; 335: 827-38). The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in people with prior stroke or TIA. (PROGRESS Collaborative Group, Lancet 2001; 358:1033-41).

Grade A Recommendation RCP Stroke Guideline 2004

Further Information:
http://www.rcplondon.ac.uk/pubs/books/stroke/index.htm

Stroke 5.2 Reporting and Verification

Practices should report the percentage of patients on the stroke/TIA register who have had their blood pressure recorded in the last 15 months.

Stroke Indicator 6

The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less

Stroke 6.1 Rationale

See STROKE 5.1.

Stroke 6.2 Reporting and Verification

Practices should report the percentage of patients on the stroke/TIA register in whom the last recorded blood pressure was 150/90 or less. This blood pressure reading should have been taken in the previous 15 months.

Stroke Indicator 7

The percentage of patients with TIA or stroke who have a record of total cholesterol in the past 15 months

Stroke 7.1 Rationale

The Heart Protection Study demonstrated that all cause mortality, vascular and stroke risk was significantly reduced by treating people at high risk of vascular disease with a statin (Heart Protection Study Collaborative Group, Lancet 2002; 360;7-22). Subsequent sub-group analyses demonstrated that in patients with prior stroke or TIA, statin therapy reduced risk of subsequent vascular events (Heart Protection Study Collaborative Group, Lancet 2004; 363:757-767). An economic analysis of this trial concluded that it was highly cost-effective to treat such patients (Heart Protection Study Collaborative Group, Lancet 2005; 365:1779-85).

Stroke 7.2 Reporting and Verification

Practices should report the percentage of patients on the stroke/TIA register who have a record of total cholesterol in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator
2 Inspection of a sample of records of patients with stroke/TIA to look at the proportion with recorded serum cholesterol
3 Inspection of a sample of records of patients with stroke/TIA for whom a record of serum cholesterol is claimed, to see if there is evidence of this in the medical records.

Stroke Indicator 8

The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less

Stroke 8.1 Rationale

See Stroke 7.1.

Stroke 8.2 Reporting and Verification

Practices should report the percentage of patients on the stroke/TIA register who have a record of total cholesterol in the previous 15 months which is 5mmol/l or less.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator
2 Inspection of a sample of records of patients with stroke to look at the proportion with recorded serum cholesterol of 5mmol/l or less
3 Inspection of a sample of records of patients for whom a record of serum cholesterol of 5mmol/l is claimed, to see if there is evidence of this in the medical records.

Stroke Indicator 12

The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)

Stroke 12.1 Rationale

Long-term antiplatelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. Antiplatelet therapy, normally aspirin, should be prescribed for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

Grade A recommendation SIGN 13

Further information:

http://www.sign.ac.uk/pdf/sign13.pdf

All patients who are not anti-coagulated should be taking aspirin (50-300mg) daily, or a combination of low-dose aspirin and dipyridamole modified release (MR). Where patients are aspirin-intolerant an alternative antiplatelet agent (clopidogrel 75mg daily) should be used.

Grade A Recommendation RCP Stroke Guideline

Further Information:

Http://www.rcplondon.ac.uk/pubs/books/stroke/ceeu_stroke_clinical11.htm#113

The National Clinical Guideline for Stroke (Royal College of Physicians of London, 2004) now allows for the use of dipyridamole on its own: 'all patients with ischaemic stroke or TIA who are not on anticoagulation, should be taking an antiplatelet agent, i.e. aspirin (50-300mg daily), clopidogrel, or a combination of low-dose aspirin and dipyridamole modified release. Where patients are aspirin intolerant an alternative antiplatelet agent (e.g.clopidogrel 75mg daily or dipyridamole MR 200mg twice daily) should be used.'

http://www.rcplondon.ac.uk/pubs/books/stroke/stroke_guidelines_2ed.pdf

Warfarin should be considered for use in patients with non-valvular atrial fibrillation.

Grade A recommendation SIGN 13

Stroke 12.2 Reporting and Verification

Practices should report the percentage of patients with non-haemorrhagic stroke or TIA who have a record in the last 15 months of prescribed aspirin, clopidogrel, dipyridamole MR or warfarin, or of taking OTC aspirin updated in the last 15 months.

Stroke Indicator 10

The percentage of patients with TIA or stroke who have a record of influenza immunisation in the preceding 1 September to 31 March

Stroke 10.1 Rationale

While there have been no randomised controlled trials (RCTs) looking at the impact of flu vaccination specifically in people with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke (Lavallee et al. Stroke 2002; 33: 513-518; Nichol et al. NEJM 2003; 348:1322-32).

Stroke 10.2 Reporting and Verification

Practices should report the percentage of patients on the stroke/TIA register who have had an influenza vaccination administered in the preceding 1 September to 31 March.

Hypertension

Indicator	Points	Payment Stages
Records		
BP 1. The practice can produce a register of patients with established hypertension	6	
Ongoing Management		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	20	40-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less	57	25-70%

Hypertension - Rationale for Inclusion of Indicator Set

Hypertension is a common medical condition which is largely managed in primary care and represents a significant workload for GPs and the primary health care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and coronary heart disease in patients with treated hypertension.

Hypertension (BP) Indicator 1

The practice can produce a register of patients with established hypertension

BP 1.1 Rationale

In order to call and recall patients effectively and in order to be able to report on indicators for hypertension, practices must be able to identify their population of patients who have established hypertension. A number of patients may be wrongly coded in this group, for example patients who have had one-off high blood pressure readings or women who have been hypertensive in pregnancy.

The British Hypertension Society recommends that drug therapy should be started in all patients with sustained systolic blood pressures of greater than or equal to 160 mmHg or sustained diastolic blood pressures of greater than or equal to 100 mmHg despite non-pharmacological measures.

Drug treatment is also indicated in patients with sustained systolic blood pressures of 140-159 mmHg or diastolic pressures of 90-99 mmHg if target organ damage is present or there is evidence of established cardiovascular disease or diabetes or the 10 year risk of CHD is raised.

Elevated blood pressure readings on three separate occasions are generally taken to confirm sustained high blood pressure.

British Hypertension Society Guidelines 2004

Further information:

http://www.bhsoc.org (see guidelines)

The routine surveillance of the patient population for hypertension is dealt with in the organisational indicators.

BP 1.2 Reporting and Verification

The practice reports the number of patients on its hypertension disease register and the number of patients on its hypertension register as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence with the reported prevalence.

Hypertension (BP) Indicator 4

The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months

BP 4.1 Rationale

The frequency of follow-up for treated patients after adequate blood pressure control is attained depends upon factors such as the severity of the hypertension, variability of blood pressure, complexity of the treatment regime, patient compliance and the need for non-pharmacological advice.

British Hypertension Society Guidelines 2004

Further information:

http://www.bhsoc.org

There is no specific recommendation in the British Hypertension Society Guidelines regarding frequency of follow-up in patients with hypertension. For the purposes of the contract it has been assumed that this will be undertaken at least six-monthly with the audit standard being set at nine months.

BP 4.2 Reporting and Verification

Practices should report the percentage of patients on their hypertension register who have had a blood pressure measurement recorded in the previous nine months.

Hypertension (BP) Indicator 5

The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less

BP 5.1 Rationale

For most patients a target of 140/85 is recommended. However, the British Hypertension Society suggests an audit standard of 150/90 which has been adopted for the QOF. For patients with diabetes mellitus, see DM12. For patients with chronic kidney disease, see CKD4.

BP 5.2 Reporting and Verification

Practices should report the percentage of patients on their hypertension register whose last recorded blood pressure is 150/90 or less. This blood pressure reading must have been measured in the previous nine months.

Diabetes Mellitus

Indicator	Points	Payment Stages
Records		
DM 19.The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
Ongoing Management		
DM 2.The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40-90%
DM 5. The percentage of patients with diabetes who have a record of HbA_{1c} or equivalent in the previous 15 months	3	40-90%
DM 20. The percentage of patients with diabetes in whom the last HbA_{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40-50%
DM 7. The percentage of patients with diabetes in whom the last HbA_{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	11	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40-90%
DM 9.The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	40-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40-60%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	40-90%
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months	3	40-90%
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	40-80%
DM 16. The percentage of patients with diabetes who	3	40-90%

have a record of total cholesterol in the previous 15 months		
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less	6	40-70%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40-85%

Diabetes - Rationale for Inclusion of Indicator Set

Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the general practitioner and members of the primary care team.

The indicators for diabetes are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK (see www.diabetes.org.uk/catalogue/reports.htm) and by SIGN - the Scottish Intercollegiate Guidelines Network (see www.sign.ac.uk/guidelines/published/index.html#Diabetes). The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes is available at http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en- this site also includes details of the evidence behind a range of recommendations. NICE has also published guidance on a number of aspects of diabetic control (www.nice.nhs.uk).

The indicators for diabetes are generally those which would be expected to be done, or checked in an annual review. There is no requirement on the GP practice to carry out all these items (e.g. retinal screening), but it is the practice's responsibility to ensure that they have been done.

Rather than including a substantial number of individual indicators, there has been discussion about whether a composite indicator such as "the percentage of diabetic patients who have had an annual check" would suffice. The view taken was that this would not make data collection any easier for GPs, since they would still have to satisfy their PCO at periodic visits that annual checks had included those items recommended in national guidance.

This set of indicators relates to both Type 1 and Type 2 diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.

Diabetes (DM) Indicator 19

The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes

DM 19.1 Rationale

It is not possible to undertake planned systematic care for patients with diabetes without a register which forms the basis of a recall system, and is needed in order to audit care.

The QOF does not specify how the diagnosis should be made, and a record of the diagnosis will, for the purposes of the QOF, be regarded as sufficient evidence of diabetes. However, in addition to the substantial number of undiagnosed patients with diabetes who exist, other patients are treated for diabetes when they do not in fact have the disease. Practices are therefore encouraged to adopt a systematic approach to the diagnosis of diabetes.

The World Health Organisation (WHO) 1999 criteria for the diagnosis of patients with diabetes mellitus are:

random glucose test: a glucose level above 11.1mmol/l taken at a random time on two occasions is a diagnosis of diabetes.

fasting glucose test: a glucose level above 7.0mmol/l measured without anything to eat and on two different days is also a diagnosis of diabetes.

glucose tolerance test: a blood glucose test is taken two hours after a glucose drink is given to the patient. A level above 11.1mmol/l is a diagnosis of diabetes, while a level below 7.8 is normal. However, if the level falls between these values the patient may have a decreased tolerance for glucose (known as impaired glucose tolerance or IGT).

Distinguishing Type 1 and Type 2 diabetes clinically may not always be easy in primary care. If this is unclear from the patients' paper or electronic records, the code for Type 1 diabetes should be used if the person is diagnosed with diabetes before the age of 30 or requires insulin within 1 year of diagnosis, and otherwise, the code for Type 2 should be used.

Separate coding of Type 1 and Type 2 diabetes allows the development of QOF

indicators that are more closely aligned to NICE guidance.

As the care of children with diabetes mellitus is generally under the control of specialists, the register should exclude those patients age 16 and under. Likewise, the indicators are not intended to apply to patients with gestational diabetes.

DM 19.2 Reporting and Verification

Practices should separately report the numbers of patients on their diabetic register (age 17 and over) with Type 1 and Type 2 diabetes and the number of patients on their diabetic register (age 17 and over) with Type 1 and Type 2 diabetes as a proportion of their total list size.

Practices should note that there has been a change to the acceptable read codes for this indicator to reflect the need for all patients to be recorded as having either Type 1 or Type 2 diabetes.

Verification – in order to ensure that patients with diabetes are not 'lost' due to the change in read codes, PCOs may wish to compare reported practice prevalence not only with national prevalence but with the practice prevalence

Diabetes (DM) Indicator 2

The percentage of patients with diabetes whose notes record BMI in the previous 15 months

for 04/05.

DM 2.1 Rationale

Weight control in overweight subjects with diabetes is associated with improved glycaemic control. There is little evidence to dictate the frequency of recording but it is general clinical practice that BMI is assessed at least annually.

DM 2.2 Reporting and Verification

Practices should report the percentage of patients on the diabetic register who have had a BMI recorded in the last 15 months.

Diabetes Indicator (DM) 5

The percentage of patients with diabetes who have a record of HbA_{1c} or equivalent in the previous 15 months

DM 5.1 Rationale

HbA_{1c} is a marker of long-term control of diabetes. Better control leads to fewer complications in both insulin dependent and non-insulin dependent patients with diabetes. There is no trial evidence to support the frequency of HbA_{1c} measurement.

Fructosamine may be used in some areas as an alternative to HbA_{1c} or, for example, in some patients with haemoglobinopathies.

In stable patients with diabetes, measurements should be made at six monthly intervals. Measurement should occur more frequently if control is poor or there has been a change in therapy.

Grade D Recommendation NICE Inherited Guideline G (2002)

For the purposes of contract monitoring the indicator has been set at a minimal level assuming an HbA_{1c} measurement at least annually.

DM 5.2 Reporting and Verification

The practice should report the percentage of diabetic patients who have had an HbA_{1c} or equivalent in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with diabetes to look at the proportion with recorded HbA_{1c} in last 15 months.
3 Inspection of a sample of records of patients for whom a record of HbA_{1c} is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 20

The percentage of patients with diabetes in whom the last HbA_{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months

DM 20.1 Rationale

For each individual a target HbA_{1c} should be set between 6.5 per cent and 7.5 per cent based on the risk of macrovascular and microvascular complications.

Grade B Recommendation NICE Inherited Guideline G (2002)

For the purposes of the QOF 7.5 (or equivalent) has been selected as an optimal level of control for the purposes of audit and reporting. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator. The fructosamine value is derived as follows:

Fructosamine = (HbA1C – 1.61)/0.017 = 346umol/l

The evidence for the targets for HbA_{1c} are based on the DCCT study in Type 1 diabetes, which found few microvascular complications in those with HbA_{1c} below 7.5 (N Engl J Med. 1993; 329 (14): 977-86). The authors of the NICE guidelines for Type 2 diabetes (2002) use this to argue for HbA_{1c} levels below 7.5 in Type 2 diabetics.

http://www.nice.org.uk/pdf/NICE_INHERITEG_guidelines.pdf

Although there is less direct evidence to support a specific threshold for risk of macrovascular disease in Type 2 diabetes, the 7.5 per cent threshold seems reasonable as a quality indicator for the purposes of QOF, and should play a role in shifting the overall distribution of blood glucose downwards in those with diabetes.

It is recognised that there may be variations in test availability and in normal ranges in different parts of the UK. If this is the case, the PCO may stipulate a different but equivalent range for this indicator, but it should be noted that the National Diabetes Support Team has advised that all laboratories should now report DCCT aligned results. This issue is discussed in the English NSF under Standards: Supplementary information: Clinical care of adults with diabetes: Monitoring blood glucose control.

http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en

DM 20.2 Reporting and Verification

The practice should report the percentage of patients on the diabetic register in which the last HbA_{1c} measurement was 7.5 or less. The test must have been carried out in the last 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA_{1c} 7.5 or less.
3 Inspection of a sample of records of patients for whom a record of HbA_{1c} 7.5 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 7

The percentage of patients with diabetes in whom the last HbA_{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months

DM 7.1 Rationale

Reaching optimal levels of control in diabetic patients is difficult. For this reason a second outcome indicator has been introduced to encourage working with patients with high HbA_{1c} to bring the level to 10 or less. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator (See 20.1 for calculation).

It is recognised that there may be variations in test availability and in normal ranges in different parts of the UK. If this is the case, the PCO may stipulate a different but equivalent range for this indicator.

DM 7.2 Reporting and Verification

The practice should report the percentage of patients on the diabetic register in which the last HbA_{1c} measurement was ten or less. The test must have been carried out in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with diabetes to look at the proportion with last recorded HbA_{1c} 10 or less.
3 Inspection of a sample of records of patients for whom a record of HbA_{1c} 10 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 21

The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months

DM 21.1 Rationale

Screening for diabetic retinal disease is effective at detecting unrecognised sight-threatening retinopathy. Systematic annual screening should be provided for all people with diabetes.

Grade B Recommendation SIGN 55

Further Information:

http://www.sign.ac.uk/guidelines/fulltext/55/index.html

In order to be effective, screening must be carried out by a skilled professional as part of a formal and systematic screening programme to detect

sight-threatening diabetic retinopathy. Practices should ensure that the screening received by patients meets national standards (where local services meet those standards) or PCO standards otherwise.

DM 21.2 Reporting and Verification

Practices should report the percentage of patients on the diabetic register who have had retinal screening performed in the last 15 months. To meet this indicator practices must now demonstrate that patients have received retinal screening to the required standard.

The PCO may ask for verification of attendance at an approved retinal screening service.

Diabetes (DM) Indicator 9

The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months

DM 9.1 Rationale

Patients with diabetes are at high risk of foot complications. Inspection for vasculopathy and neuropathy is needed to detect problems. Patients with diabetes with foot problems are likely to benefit from referral to specialist diabetic chiropody services. These checks should be carried out at an annual review.

DM 9.2 Reporting and Verification

Practices should report the percentage of patients on the diabetic register who have a record of the presence or absence of peripheral pulses in the last 15 months.

Diabetes (DM) Indicator 10

The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months

DM 10.1 Rationale

See DM 9.1

The measurement of foot sensation should be carried out as recommended in

the SIGN Guideline 55 on the Management of Diabetes. Foot sensation should be considered abnormal if monofilament and/or vibration sensation are impaired.

DM 10.2 Reporting and Verification

Practices should report the percentage of patients on the diabetic register with a record of neuropathy testing in the last 15 months.

Diabetes (DM) Indicator 11

The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months

DM 11.1 Rationale

Cardiovascular disease is the major cause of morbidity and mortality in people with diabetes, and coronary heart disease is the most common cause of death among people with Type 2 diabetes. Many people with Type 2 diabetes have an increased coronary event risk even if they do not have manifest cardiovascular disease.

Hypertension is associated with an increased risk of many complications of diabetes including cardiovascular disease. Blood pressure should be measured at least annually in patients with diabetes.

Grade D Recommendation NICE Inherited Guideline H

Further Information:

http://www.nice.org.uk/cat.asp?c=38551

DM 11.2 Reporting and Verification

Practices should report the percentage of patients on their diabetic register who have their blood pressure recorded in the previous 15 months.

Diabetes (DM) Indicator 12

The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less

DM 12.1 Rationale

Blood pressure lowering in people with diabetes reduces the risk of macrovascular and microvascular disease. Hypertension in people with diabetes should be treated aggressively with lifestyle modification and drug therapy.

Grade A Recommendation SIGN 55

The most commonly identified target level for blood pressure in patients with diabetes is 140/80. This is the level that health professionals should aim for. A slightly higher level (145/85) is used as the audit standard in common with other indicators.

Further Information:
http://www.sign.ac.uk/guidelines/fulltext/55/index.html

Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004 BHS IV

Journal of Human Hypertension 2004, 18(3), 139-185

http://www.bhsoc.org/Latest_BHS_management_Guidelines.htm

NICE inherited guideline H
http://www.nice.org.uk/page.aspx?o=38551

DM 12.2 Reporting and Verification

The practice should report the percentage of patients on the diabetic register in which the last blood pressure measurement was 145/85 or less. The pressure must have been measured in the previous 15 months.

Diabetes (DM) Indicator 13

The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)

DM 13.1 Rationale

Diabetic patients are at risk of developing nephropathy. Measurements of urinary albumin loss and serum creatinine are the best screening tests for

diabetic nephropathy. All patients with diabetes should have their urinary albumin concentration and serum creatinine measured at diagnosis and at regular intervals, usually annually.

Grade D Recommendation SIGN 55

Grade C Recommendation NICE Inherited Guideline F

Further Information:
http://www.sign.ac.uk/guidelines/fulltext/55/index.html

http://www.nice.org.uk/article.asp?a=27964

Diabetic nephropathy is defined by a raised urinary albumin excretion of greater than 300mg/day (indicating clinical proteinuria). Patients with proteinuria should be separately recorded after urinary tract infection has been excluded.

DM 13.2 Reporting and Verification

Practices should report the percentage of patients on the diabetic register who have a record of microalbuminuria testing in the last 15 months and the percentage of patients on the diabetic register who have proteinuria who have not therefore been tested for microalbuminuria.

Diabetes (DM) Indicator 22

The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months

DM 22.1 Rationale

See DM 13.1

Estimated glomerular filtration rate (eGFR), based on serum creatinine is reported as a better means to detect and monitor early renal disease and will be routinely reported data in 2006. This has therefore now been included in indicator 22. In the long term, eGFR should be easier for patients to understand, as log transformation is not required to assess change in renal function.

DM 22.2 Reporting and Verification

The practice should report the percentage of patients on the diabetic register who have a record of eGFR or serum creatinine in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with diabetes to look at the

proportion with recorded eGFR or serum creatinine.
3 Inspection of a sample of records of patients for whom a record of eGFR or serum creatinine is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 15

The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)

DM 15.1 Rationale

The progression of renal disease in patients with diabetes is slowed by treatment with ACE inhibitors, and trial evidence suggests that these are most effective when given in the maximum dose quoted in the British National Formulary (BNF). Although trial evidence is based largely on ACE inhibitors, it is believed that similar benefits occur from treatment with angiotensin II antagonists (A2) in patients who are intolerant of ACE inhibitors.

Patients with a diagnosis of microalbuminuria or proteinuria should be commenced on an ACE inhibitor or considered for angiotensin II antagonist therapy.

Grade A Recommendation SIGN 55

Further Information:

http://www.sign.ac.uk/guidelines/fulltext/55/index.html

DM 15.2 Reporting and Verification

Practices should report the number of patients with a prescription for ACE inhibitor or A2 antagonist in the last six months as a percentage of patients on the diabetic register who have microalbuminuria or proteinuria.

Diabetes (DM) Indicator 16

The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months

DM 16.1 Rationale

Vascular disease commonly complicates diabetes. Control of risk factors including serum cholesterol is associated with a reduction in vascular risk.

Grade C Recommendation SIGN Guideline 55

Further Information:

http://www.sign.ac.uk/guidelines/fulltext/55/section4.html

It is unclear from the literature how frequently this should be undertaken, but the English NSF recommends annually. In addition there is no indication as to at what age cholesterol above 5 should be treated. At this stage it is recommended that all patients with diabetes on the register (which is those seventeen and over) should have an annual cholesterol measurement.

DM 16.2 Reporting and Verification

Practices should report the percentage of patients on the diabetes register who have had a total cholesterol measured in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a Primary Care Organisation:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol.
3 Inspection of a sample of records of patients for whom a record of serum cholesterol is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 17

The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less

DM 17.1 Rationale

If total cholesterol is greater than 5.0 mmol/l, statin therapy to reduce cholesterol should be initiated and titrated as necessary to reduce total cholesterol to less than 5 mmol/l. There is ongoing debate concerning the intervention levels of serum cholesterol in diabetic patients who do not apparently have cardiovascular disease. Further National Guidance is awaited.

The age when a statin should be initiated is unclear. It is pragmatically suggested that all diabetic patients over the age of 40 with a cholesterol of

greater than 5mmol/l should be treated with a statin. Below the age of 40 a decision needs to be reached between the doctor and the patient and may involve assessment of other risk factors and the actual age of the patient.

Further Information:

Heart Protection Study Collaborative Group: MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial. Lancet 2003; 361:2005-2016.

Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction Haffner et al.. NEJM 1998; 339: 229-234.

DM 17.2 Reporting and Verification

Practices should report the percentage of patients on the diabetes register whose last measured cholesterol was 5mmol/l or less. The measurement should have been carried out in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol less than 5 mmol/l.
3 Inspection of a sample of records of patients for whom a record of serum cholesterol is less than 5 mmol/l is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 18

The percentage of patients with diabetes who have a record of influenza immunisation in the preceding 1 September to 31 March

DM 18.1 Rationale

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation.

DM 18.2 Reporting and Verification

The percentage of patients on the diabetic register who have had an influenza vaccination administered in the preceding 1 September to 31 March.

Chronic Obstructive Pulmonary Disease

Indicator	Points	Payment Stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 9. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	10	40-80%
Ongoing management		
COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-70%
COPD 11. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months	7	40-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

COPD - Rationale for Inclusion of Indicator Set

COPD is a common disabling condition with a high mortality. The most effective treatment is smoking cessation. Oxygen therapy has been shown to prolong life in the later stages of the disease and has also been shown to have a beneficial impact on exercise capacity and mental state. Some patients respond to inhaled steroids. Many patients respond symptomatically to inhaled beta agonists and anti-cholinergics. Pulmonary rehabilitation has been shown to produce an improvement in quality of life.

The majority of patients with COPD are managed by general practitioners and members of the primary healthcare team with onward referral to secondary care when required. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

COPD Indicator 1

The practice can produce a register of patients with COPD

COPD 1.1 Rationale

A register is a prerequisite for monitoring patients with COPD.

A diagnosis of COPD should be considered in any patient who has symptoms of persistent cough, sputum production, or dyspnoea and/or a history of exposure to risk factors for the disease. The diagnosis is confirmed by spirometry.

See COPD 9.1.

Where patients have a long-standing diagnosis of COPD and the clinical picture is clear, it would not be essential to confirm the diagnosis by spirometry in order to enter the patient onto the register. However, where there is doubt about the diagnosis practices may wish to carry out spirometry for confirmation.

COPD 1.2 Reporting and verification

The practice reports the number of patients on its COPD disease register and the number of patients on its COPD disease register as a proportion of total list size**.**

Where patients have co-existing COPD and asthma then they should be on both disease registers. Approximately 15 per cent of patients with COPD will also have asthma.

Verification - PCOs may compare the expected prevalence with the reported prevalence.

COPD Indicator 9

The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing

COPD 9.1 Rationale

COPD is diagnosed if:

the patient has an FEV1 of less than 70 per cent of predicted normal

and has an FEV1/FVC ratio of less than 70 per cent
and there is a less than 15 per cent response to a reversibility test.

All of these elements are required to make the diagnosis of COPD and to exclude co-existing asthma. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. However, where asthma is present, these patients should be managed as asthma patients as well as COPD patients.

While it is recognised that there may be an element of reversibility in patients with COPD, the definition centres on the lack of reversibility. Patients with

reversible airways obstruction should be included in the asthma disease register. Patients with coexisting asthma and COPD should be included on the register for both conditions.

The FEV1 is set at 70 per cent although the GOLD and BTS guidelines state 80 per cent. The rationale is that a significant number of patients with an FEV1 less than 80 per cent predicted may have minimal symptoms. The use of 70 per cent enables clinicians to concentrate on symptomatic COPD. Unlike asthma, airflow obstruction in COPD as measured by the FEV1 can never be returned to normal values.

Further information:
BTS COPD Guidelines 1997

http://www.brit-thoracic.org.uk/c2/uploads/bts_20copd_20guidelines.pdf

GOLD Guidelines September 2005

http://www.goldcopd.com/

NICE Clinical Guideline 2004
http://www.nice.org.uk/pdf/CG012_niceguideline.pdf

For the purposes of the QOF, spirometry undertaken between three months before and twelve months after a diagnosis of COPD being made would be considered as meeting the requirements of this indicator.

COPD 9.2 Reporting and Verification

Practices should report the percentage of patients who are on their COPD register who have a record that the diagnosis has been confirmed by spirometry including reversibility testing.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with COPD to look at the proportion with a record of spirometry.
3 Inspection of a sample of records of patients for whom a record of spirometry is claimed, to see if there is evidence of this in the medical records.

COPD Indicator 10

The percentage of patients with COPD with a record of FEV1 in the previous 15 months

COPD 10.1 Rationale

There is a gradual deterioration in lung function in patients with COPD. This deterioration accelerates with the passage of time. There are important interventions which can improve quality of life in patients with severe COPD. It is therefore important to monitor respiratory function in order to identify patients who might benefit from pulmonary rehabilitation or continuous oxygen therapy.

Current guidance states that there are no clear guidelines with regard to the optimum frequency of spirometry for patients with COPD and the time interval was pragmatically set at two years. However NICE Clinical Guideline 12 (February 2004), endorsed by the British Thoracic Society, now suggests that FEV1 and inhaler technique should be assessed at least annually for people with mild/moderate COPD (and in fact at least twice a year for people with severe COPD). The purpose of regular monitoring is to identify patients with increasing severity of disease who may benefit from referral for more intensive treatments/diagnostic review.

Further information:

Table 7 in http://www.nice.org.uk/pdf/CG012_niceguideline.pdf.

The QOF does not set specific criteria for the management of severe COPD. However practices should identify by symptoms and regular spirometry those patients who would benefit from long-term oxygen therapy and pulmonary rehabilitation.

These measures require specialist referral because of the need to measure arterial oxygen saturation to assess suitability for oxygen therapy, and the advisability of specialist review of patients prior to starting pulmonary rehabilitation.

The long-term administration of oxygen (>15 hours per day) to patients with chronic respiratory failure has been shown to increase survival and improve exercise capacity.

Grade A Evidence GOLD Guidelines

Further Information:

GOLD Guidelines September 2004

http://www.goldcopd.com/

Referral can be to a general physician, a respiratory physician or a GP with a special interest (GPSI) in respiratory disease. It is suggested that consideration for referral should be given in patients with FEV1 of less than 50 per cent predicted or in patients with disabling symptoms.

COPD 10.2 Reporting and Verification

Practices should report the percentage of patients on the COPD register who have had spirometry performed in the previous 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with COPD to look at the proportion with spirometry results in the last two years.
3 Inspection of a sample of records of patients with COPD for whom a record of spirometry is claimed, to see if there is evidence of this in the medical records.

COPD Indicator 11

The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 15 months

COPD 11.1 Rationale

All patients should be managed according to the BTS COPD guidelines. All symptomatic patients should be given a short-acting beta agonist and if still symptomatic a trial of regular use of an inhaled anti-cholinergic. Symptomatic patients should also be given a trial of inhaled steroids. Where there is no objective benefit inhaled steroids should not be continued. Exacerbations should generally be treated with a combination of antibiotics and oral steroids.

BTS COPD Guidelines 1997

Further information:

http://www.brit-thoracic.org.uk/c2/uploads/bts_20copd_20guidelines.pdf

There is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. See 10.1.

COPD 11.2 Reporting and Verification

The practice should report the percentage of patients on the COPD register in whom inhaler technique has been checked in the previous 15 months. Patients not on therapy which involves the use of inhalers should be exception-reported.

COPD Indicator 8

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

COPD 8.1 Rationale

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation.

COPD 8.2 Reporting and Verification

The percentage of patients on the COPD register who have had an influenza vaccination administered in the preceding 1 September to 31 March.

Epilepsy

Indicator	Points	Payment Stages
Records		
EPILEPSY 5. The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1	
Ongoing Management		
EPILEPSY 6. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	40-90%
EPILEPSY 7. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months	4	40-90%
EPILEPSY 8. The percentage of patients age 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months	6	40-70%

Epilepsy - Rationale for Inclusion of Indicator Set

Epilepsy is the most common serious neurological condition, affecting about 5 to 10 per 1000 of the population at any one time. Few epilepsies are preventable, but much of the handicap that results could be prevented by appropriate clinical management. For the purposes of the QOF, epilepsy is defined as 'more than one seizure.'

Epilepsy Indicator 5

The practice can produce a register of patients receiving drug treatment for epilepsy

Epilepsy 5.1 Rationale

The clinical indicators of epilepsy care cannot be checked unless the practice has a register of patients with epilepsy. The phrase 'receiving treatment' has been included in order to exclude the large number of patients who had epilepsy in the past, and may have been off treatment and fit-free for many years. Some patients may still be coded as 'epilepsy' or 'history of epilepsy' and will be picked up on computer searches. Patients who have a past history of epilepsy who are not on drug therapy should be excluded from the register. Drugs on repeat prescription will be picked up on search.

It is proposed that the disease register includes patients aged 18 and over as care for
younger patients is generally undertaken by specialists.

Epilepsy 5.2 Reporting and Verification

The practice reports the number of patients aged 18 and over on its epilepsy disease register and the number of patients aged 18 and over on its epilepsy disease register as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence with the reported prevalence.

Epilepsy Indicator 6

The percentage of patients aged 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months

Epilepsy 6.1 Rationale

It is recommended that the following information should be recorded routinely in patients' notes at each review:

- Seizure type and frequency, including date of last seizure
- Antiepileptic drug therapy and dosage
- Any adverse drug reactions arising from antiepileptic drug therapy
- Key indicators of the quality of care i.e. topics discussed and plans for future review

Grade C Recommendation SIGN 70 (2003)

Further information:

http://www.sign.ac.uk/guidelines/fulltext/70/index.html

NICE clinical guideline 20 (2004) suggests that 'all individuals with epilepsy should have a regular structured review …in adults this review should be carried out at least yearly by either a generalist or a specialist.' This guidance therefore supports the current epilepsy indicators which are in essence the component parts of an annual structured review.

Further information:
http://www.nice.org.uk/pdf/CG020NICEguideline.pdf

Clinical Standards Advisory Group. Services for Patients with Epilepsy. 2000. London. Department of Health.

Epilepsy 6.2 Reporting and Verification

Practices should report the percentage of patients on the epilepsy register who have a record of seizure frequency in the last 15 months.

Epilepsy Indicator 7

The percentage of patients aged 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months

Epilepsy 7.1 Rationale

See Epilepsy 6.1

The involvement of the patient and/or carer is included to stress the importance of a face to face medication review, where clinically appropriate.

Epilepsy 7.2 Reporting and Verification

Practices should report the percentage of patients on their epilepsy register who have had a medication review in the previous 15 months.

Epilepsy Indicator 8

The percentage of patients aged 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months

Epilepsy 8.1 Rationale

Seizure control gives some indication of how effective the management of epilepsy is.

However, it is recognised that fit control is often under the influence of factors outside the general practitioner's control. It is expected that exception-reporting in the epilepsy data set will be more common than in other chronic conditions (e.g. for patients with forms of brain injury which mean that their fits cannot be controlled, patients who find the side effects of medication intolerable etc).

The top level in this indicator has been deliberately kept at a lower level in order to encourage general practitioners to record the frequency of convulsions as accurately as possible.

Epilepsy 8.2 Reporting and Verification

Practices should report the percentage of patients with epilepsy who have been seizure free in the preceding 12 months, recorded in patients in the last 15 months.

Hypothyroid

Indicator	Points	Payment stages
Records		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
Ongoing Management		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	40-90%

Hypothyroidism - Rationale for Inclusion of Indicator Set

Hypothyroidism is a common, serious condition with an insidious onset. The mean incidence is 3.5 per 1000 in women, and 0.6 per 1000 in men. The probability of developing hypothyroidism increases with age and reaches 14 per 1000 in women aged between 75 and 80.

There is a clear consensus on how hypothyroidism should be treated**.**

Monitoring of hypothyroidism is almost entirely undertaken in primary care.

THYROID Indicator 1

The practice can produce a register of patients with hypothyroidism

Thyroid 1.1 Rationale

A register is a prerequisite for monitoring patients with hypothyroidism. Many patients will have been diagnosed at some time in the past and the details of the diagnostic criteria may not be available. For this reason the patient population should consist of those patients taking thyroxine with a recorded diagnosis of hypothyroidism. The most effective method for identifying the patient population would be a computer search for repeat prescribing of thyroxine with a subsequent check of the records to confirm the clinical diagnosis.

Thyroid 1.2 Reporting and Verification

The practice reports the number of patients on its hypothyroidism disease register and the number of patients on its hypothyroidism disease register as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence with the reported prevalence.

THYROID Indicator 2

The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months

Thyroid 2.1 Rationale

There is no clear evidence on the appropriate frequency of TSH/T4 measurement. However, the consensus group on thyroid disease recommended an annual check of TSH/T4 levels in all patients treated with thyroxine. In addition they recommend an annual check in patients previously treated with radio-iodine or partial thyroidectomy (Consensus statement for good practice and audit measures in the management of hypothyroidism and hyperthyroidism. BMJ 1996; 313: 539-544).

The practice should report the percentage of patients on its hypothyroid register who have had a TSH or T4 undertaken in the last 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients with hypothyroidism to look at the proportion with recorded TSH/T4.
3 Inspection of a sample of records of patients with hypothyroidism for whom a record of TSH/T4 is claimed, to see if there is evidence of this in the medical records.

Cancer

Indicator	Points	Payment stage
Records		
CANCER 1. The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'	5	
Ongoing Management		
CANCER 3. The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	40-90%

Cancer - Rationale for Inclusion of Indicator Set

Cancer is a clinical priority in all four countries. It is recognised that the principal active management of cancers occurs in the secondary care setting. General practitioners often have a key role in the referral and subsequently in providing a support role and in ensuring that care is appropriately co-ordinated. This indicator set is not evidence-based but does represent Good Professional Practice.

Cancer Indicator 1

The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'

Cancer 1.1 Rationale

A register is a prerequisite for ensuring follow-up of patients with cancer. The register can be developed prospectively as the intention is to ensure appropriate care and follow-up for patients with a diagnosis of cancer. For the purposes of the register all cancers should be included except non-melanomatous skin lesions.

Cancer 1.2 Reporting and Verification

The practice reports the number of patients added to its cancer register in the last twelve months and the number of patients added to its cancer register in the last twelve months as a proportion of total list size**.**

Verification - PCOs may compare the expected prevalence of new cases with the reported prevalence.

Cancer Indicator 3

The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring at 6 months after the practice has received confirmation of the diagnosis

Cancer 3.1 Rationale

Most general practitioners will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. A cancer review is an opportunity to cover the following issues:

- The patient's individual health and support needs (this will vary with e.g. the diagnosis, staging, age and pre-morbid health of the patient and their social support networks)
- The co-ordination of care between sectors.

Further information:

http://www.show.scot.nhs.uk/sehd/cancerinscotland/

Cancer 3.2 Reporting and Verification

The practice reports the number of patients with cancer diagnosed in the last 18 months with a review recorded in the six months after diagnosis.

Verification may involve randomly selecting a number of case records of patients in which the review has been recorded as taking place to confirm that the two components have been undertaken and recorded.

Palliative Care

Indicator	Points	Payment Stages
Records		
PC1: The practice has a complete register available of all patients in need of palliative care/support.	3	
Ongoing Management		
PC2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.	3	

Palliative Care- Rationale for Inclusion of Indicator Set

Primary palliative care is an area that is growing in significance and importance. Having made progress mainly in the area of cancer care, there is a developing impetus to improve end of life care (i.e. supportive care in the final year or so of life), for all patients with any end-stage illness, in the light of the changing demographic population profile (see *Palliative Care: The Solid Facts* and *Better Palliative Care for Older People*. http://www.euro.who.int/document/E82931.pdf
http://www.euro.who.int/document/E82933.pdf

There has been a recent National Cancer Research Institute (NCRI) strategic review http://www.ncri.org.uk/publications/index.cfm?NavSub=20 and there is considerable investment in this field which will produce further evidence over the coming years. In addition, the 'Gold Standards Framework' (GSF) www.goldstandardsframework.nhs.uk ,a widely implemented programme of care for palliative care patients, is now associated with a considerable degree of research and evaluation and is key to thinking through and implementing high quality patient centred care at the end of life for patients with both cancer and non cancer diagnoses. Its use is recommended in the NICE Guidance on Supportive and Palliative care (2004), by the Coronary Heart Disease Collaborative and in the NSF for renal services and also referred to in the NSFs for Long Term Conditions and Care of the Elderly.

It is important to remember that of the 530,000 deaths per annum in England, 25 per cent of people die from cancer, 19% die from heart disease and 14% from respiratory disease. From an individual GP perspective, you can expect approximately 20 deaths a year, of which 5 will be from cancer, 7 from organ failure, 1-2 will be sudden death and 6-7 from dementia, frailty and multiple co-morbidity.

The prognostication of likely disease progression is very difficult for both cancer and non cancer patients. Clinical prediction of survival is not an exact science with errors (defined as more than double as or less than half of actual survival), 30 per cent of the time. Two thirds of errors are based on over optimism and one third on over pessimism.

However there are considerable benefits in attempting to recognise the point at which an illness becomes advanced or end stage in order to mobilise best care for patients, and address the likely health and social care needs of patients and their families.

The disparity between preference for place of death and actual place of death is currently a matter of concern, with about 60 per cent of patients dying in hospital despite over 60 per cent preferring to die at home. With more proactive care in the community, more patients could be enabled to live well in their final months, and die where they choose. The GP's role is essential in this area, maintaining continuity of relationship during gradual

deterioration of the patient's condition, and delivering coordinated community care wherever the patient finally dies.

Therefore identifying patients in the advanced stage of their illness in need of palliative/ supportive care, assessing their needs and preferences and proactively planning their care, are three key steps in the provision of good end of life/ primary palliative care. This is why this new indicator set is focused on the maintenance of a register for patients, identified against certain criteria of prognosis and need, and on regular multidisciplinary planning meetings.

Palliative Care (PC) Indicator 1

The practice has a complete register of all patients in need of palliative care/support

Palliative Care 1.1 Rationale

Criteria for inclusion on the register are consistent with prognostic criteria for advanced disease described in the GSF and with the use of the DS 1500.

A patient should be included if:

2. Their death in the next 12 months can be reasonably predicted.

AND/OR

3. They have clinical indicators of need for palliative care that are prognostic clinical indicators of advanced or irreversible disease and include 1 core and 1 disease specific indicator in accordance with the GSF. http://www.goldstandardsframework.nhs.uk/content/developments/Suggested_Prognostic_Criteria_for_Advance_Disease.pdf

AND/OR

4. They are the subject of a DS 1500 form. (The DS 1500 form is designed to speed up the payment of the Disability Living Allowance, Attendance Allowance or Incapacity Benefit. It is usually issued when the patient is considered to be approaching the terminal stage of their illness. In Social Security law a patient is terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

The register is prospective from 1 April 06 and applies to adults over the age of 18 years.

The creation of a register will also enable the wider practice team to provide more appropriate and patient focussed care e.g. reception staff will be aware of the need to prioritise communications from relatives to clinical staff if the patient in question is on the register.

Palliative Care 1.2 Reporting and Verification

The practice reports the number of patients on its palliative care register.

Verification – in the case of a nil register at year end, if a practice can demonstrate that it had a register in year then it will be eligible for payment.

Palliative Care Indicator 2

The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed

Palliative Care 2.1 Rationale

The aims of the case review meetings are to:

- Improve the flow of information (particularly out of hours and between different teams)
- Ensure that each patient has a management plan as defined by the practice team and that decisions are acted upon by the most appropriate member of the team
- Ensure that the management plan includes preference for place of care
- Ensure that the support needs of carers are discussed and addressed where ever reasonably possible.

Palliative Care 2.2 Reporting and Verification

The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.

Mental Health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
Ongoing management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	2	40-70%
MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%
MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40-90%

Mental Health - Rationale for Inclusion of Indicator Set

There are relatively few indicators of the quality of mental health care in relation to the importance of these conditions. This reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to general practitioners. The indicators included in the QOF can therefore only be regarded as providing a partial view on the quality of mental health care.

For many patients with mental health problems, the most important indicators relate to the inter-personal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options. Within the 'patient experience' section of the quality framework, there exists the opportunity to focus patient surveys on particular groups of patients. This would be one way in which a practice could look in more detail at the quality of care experienced by people with mental health problems.

Mental health problems are also included in some of the organisational indicators. These include the need for a system to identify and follow up patients who do not attend where the practice has taken on a responsibility for administering regular neuroleptic injections, significant event audits which focus specifically on mental health problems, and methods of addressing the needs of carers.

This indicator set now focuses on patients with serious mental illness and there are new indicator sets that focus on people with depression and dementia.

Mental Health (MH) Indicator 8

The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses

MH 8.1 Rationale

The register now includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses rather than a generic phrase that is open to variations in interpretation. This brings mental health in line with other areas of the QOF.

The notion of agreeing to regular follow up has also been removed to acknowledge the variation in interpretation of this clause and to bring the indicator in line with the rest of the QOF.

MH 8.2 Reporting and Verification

The practice reports the number of patients on its mental health disease register and the number of patients on its mental health disease register as a proportion of total list size**.**

Verification - PCOs may enquire as to how the practice identifies patients for inclusion on the register.

Mental Health (MH) Indicator 9

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status

MH 9.1 Rationale

Patients with serious mental health problems are at considerably increased risk of physical ill-health than the general population (Marder et al. Am J Psychiatry 2004; 161: 1334-49). It is therefore good practice for a member of the practice team to review each patient's physical health on an annual basis.

Health promotion and health prevention advice is particularly important for people with serious mental illness however there is good evidence that they are much less likely than other members of the general population to be offered, for example, blood pressure checks and cholesterol checks if they have concurrent coronary heart disease, and cervical screening. People with serious mental illness are also far more likely to smoke than the general population (61per cent of people with schizophrenia and 46 per cent of people with bipolar disorder smoke compared to 33% of the general population). Premature death and smoking-related diseases, such as respiratory disorders and heart disease, are, however, more common among people with serious mental illness who smoke, than in the general population of smokers (Seymour L. Not all in the mind: the physical health of mental health service users. Mentality, 2003). See also the Social Exclusion Unit Report *Mental Health and Social Exclusion* (2004) for further details:

http://www.socialexclusion.gov.uk/downloaddoc.asp?id=134.

A review of physical health will therefore normally (and at appropriate intervals) include:

1. Issues relating to alcohol or drug use.
2. Smoking and blood pressure (including history suggestive of arrythmias – Hennessy et al. *BMJ* 2002; 325: 1070).
3. Cholesterol checks where clinically indicated.
4. BMI.
5. An assessment of the risk of diabetes from olanzepine and risperidone (Koro et al. BMJ 2002; 325: 243).
6. Cervical screening where appropriate.

See also Disability Rights Commission *Equal Treatment: Closing the Gap. Interim report of a formal investigation into Health inequalities*.
http://www.drc-gb.org/documents/interim_report_final.doc

The accuracy of medication prescribed by the general practitioner can also be checked at the same time.

There is more guidance on regular reviews of patients with mental health problems in *A practical guide to the National Service Framework for Mental Health*. This is published by the National Primary Care Research and Development Centre and can be downloaded from www.npcrdc.man.ac.uk.

MH 9.3 Reporting and Verification

The practice should report the percentage of patients on the mental health register who have been reviewed in the previous 15 months.

Verification may involve randomly selecting a number of case records of patients in which the review has been recorded as taking place to confirm that the components have been undertaken and recorded.

Mental Health (MH) Indicator 4

The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months

4.1: Rationale

The number of points and indicators for Lithium have been reduced in recognition of the relatively small number of people this indicator applies to and the importance of the intermediate outcome of the lithium level being within the therapeutic range.

It is important to check thyroid and renal function on an annual basis since there is a much higher than normal incidence of hypercalcaemia and hypothyroidism in patients on lithium, and of abnormal renal function tests. Overt hypothyroidism has been found in between 8 per cent and 15 per cent of people on lithium.

See www.jr2.ox.ac.uk/bandolier/band74/b74-6.html).

MH 4.2 Reporting and Verification

MH 4.2.1 Practices should report the percentage of patients on lithium therapy with a record of TSH in the last 15 months.

MH 4.2.2 Practices should report the percentage of patients on lithium therapy with a record of serum creatinine in the last 15 months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients on lithium therapy to look at the proportion with recorded TSH and creatinine in the last 15 months.
3 Inspection of a sample of records of patients on lithium therapy for whom a record of TSH and creatinine is claimed, to see if there is evidence of this in the medical records.

Mental Health (MH) Indicator 5

The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months

MH 5.1 Rationale

Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs e.g. thiazide diuretics or NSAIDs which may reduce lithium excretion. However, there is no definitive evidence on the frequency of lithium level checks. Most practitioners would monitor lithium levels when stable every three to six months. Where a practice is prescribing, it has responsibility for checking that routine blood tests have been done (not necessarily by the practice) and for following up patients who default where responsibility has been accepted for administering treatment.

The therapeutic range for patients on lithium therapy is normally 0.4 -1.0 mmol/l

(see the British National Formulary). If the range differs locally, the PCO will be required to allow for this.

See:
http://www.nhslothian.scot.nhs.uk/primarycarelibrary/2_ClinicalPractice/2_Guidelines/Guidelines/Lithium.pdf)

MH 5.2 Reporting and Verification

Practices should report the percentage of patients on lithium whose last serum lithium level is in the therapeutic range. The level should have been undertaken in the previous six months.

In verifying that this information has been correctly recorded, a number of approaches could be taken by a PCO:

1 Inspection of the output from a computer search that has been used to provide information on this indicator.
2 Inspection of a sample of records of patients on lithium therapy to look at the proportion with recorded serum lithium in the therapeutic range.
3 Inspection of a sample of records of patients on lithium therapy for whom a record of serum lithium in the therapeutic range is claimed, to see if there is evidence of this in the medical records.

Mental Health (MH) Indicator 6

The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate

MH 6.1: Rationale

This new indicator reflects good professional practice and supported by national Clinical Guidelines http://www.nice.org.uk/pdf/CG1fullguideline.pdf

Patients on the mental health register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. This consultation may include the views of their relatives or carers where appropriate.

Up to one half of people who have a serious mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.

When constructing the primary care record research supports the inclusion of the following information:

1. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.

2. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement.

People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services (See Ford et al.Psychiatric Bulletin1993; 17(7): 409-411 and Office of the Deputy Prime Minister Mental health and social exclusion (Social Exclusion Unit Report). London, ODPM, 2004).

3. Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received.

4. Occupational status.
In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (ONS Labour Force Survey, Autumn 2003)People with mental health problems also earn only two-thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities amongst users of mental health services with up to 90 per cent wishing to go into or back to work (See Grove and Drurie. (Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK,1999).

5. Early Warning Signs.
"Early warning signs" from the patient's perspective that may indicate a possible relapse (See Birchwood et al. Advances in Psychiatric Treatment 2000; 6: 93-101 and Birchwood and Spencer. Clinical Psychology Review 2001; 21(8): 1211-26). Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the person thinks may have acted as triggers.

6. The patient's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and wishes around medication.

A care plan should be accurate, easily understood, reviewed as part of the annual review and discussed with the patient, their family and/or carers.

If a patient is treated under the care programme approach (CPA), then they should have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of the QOF.

Further Information:
Mental Health (Care and Treatment) Act 2003
http://www.scotland.gov.uk/Publications/2003/11/18547/29201

Mental Health 6.2 Reporting and Verification

The practice reports the percentage of patients on the mental health register who have a comprehensive care plan recorded.

Mental Health (MH) Indicator 7

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for the annual review who are identified and followed up by the practice team within 14 days of

non attendance

MF 7.1: Rationale

Poor compliance with medication is well recognised, and it is estimated that around 50 per cent of people with schizophrenia do not always take their medication regularly. This may lead to relapse, hospitalisation and poorer outcome (Csernansky and Schuchart. CNS Drugs 2002; 16 (7): 473-484). There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as “irrationality,” as part of having a serious mental illness, rather than recognising that not turning up for an appointment may be a sign of relapse (Lester et al. BMJ. 2005; 330: 1122-28).

This indicator requires proactive intervention from the practice to contact the patient and enquire about their health status. This may be through telephone contact or visit where appropriate. If the person is in contact with secondary care, it will be appropriate to contact their key worker to discuss any concerns. Evidence will be required as to how this contact has been made.

MH 7.2: Reporting and Verification

Practices report the percentage of patients who did not attend their annual review who have been followed up within 14 days of their non-attendance.

Asthma

Indicator	Points	Payment stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months	4	
Initial Management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40-80%
Ongoing management		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Asthma - Rationale for Inclusion of Indicator Set

Asthma is a common condition which responds well to appropriate management and which is principally managed in primary care.

This indicator set was informed by the British Thoracic Society/ SIGN guidelines which were published in early 2003. In keeping with the other indicators, not all areas of management are included in the indicator set in an attempt to keep the data collection within manageable proportions.

Asthma Indicator 1

The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months

Asthma 1.1 Rationale

Proactive structured review as opposed to opportunistic or unscheduled review is associated with reduced exacerbation rates and days lost from normal activity. A register of patients who require follow up is a prerequisite for structured asthma care.

The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most people, the diagnosis can be corroborated by suggestive changes in lung

function tests.

One of the main difficulties in asthma is the variable and intermittent nature of asthma. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV1) which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma must be in doubt.

A proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400mls or more on FEV1 – but do not return to over 80 per cent predicted and have a significant smoking history. From 1 April 2006 these patients should be recorded on both the asthma and COPD registers.

Children

A definitive diagnosis of asthma can be difficult to obtain in young children. Asthma should be suspected in any child with wheezing, ideally heard by a health professional on auscultation and distinguished from upper airway noises.

In schoolchildren, bronchodilator responsiveness, PEF variability or tests of bronchial hyperactivity may be used to confirm the diagnosis, with the same reservations as above.

The diagnosis of asthma in children should be based on:

- the presence of key features and careful consideration of alternative diagnoses
- assessing the response to trials of treatment and ongoing assessment
- repeated reassessment of the child, questioning the diagnosis if management is ineffective.

Grade D recommendation: SIGN/BTS British Guideline on the Management of Asthma

It is well recognised that asthma is a variable condition and many patients will have periods when they have minimal symptoms. It is inappropriate to attempt to monitor symptom-free patients on no therapy or very occasional therapy.

This produces a significant challenge for the QOF. It is important that resources in primary care are targeted to patients with greatest need - in this instance patients who will benefit from asthma review rather than insistence that all patients with a diagnostic label of asthma are reviewed on a regular basis.

For this reason it is proposed that the asthma register should be constructed

annually by searching for patients with a history of asthma, excluding those who have had no prescription for asthma-related drugs in the last 12 months. This indicator has been constructed in this way as most GP clinical computer systems will be able to identify the defined patient list.

Asthma 1.2 Reporting and Verification

Asthma 1.2.1 Practices should report the number of patients with active asthma (i.e. a diagnosis of asthma, excluding those who have had no prescription issued for an asthma-related drug in the previous 12 months), and the number of patients with active asthma (i.e. diagnosis of asthma, excluding those who have had no prescription issued for an asthma-related drug in the previous 12 months) as a proportion of their practice list size.

Asthma 1.2.2 Practices should be able to report the number of patients with inactive asthma (i.e. those who have a diagnosis of asthma who have had no asthma-related drug issued in the previous 12 months) and the number of patients with inactive asthma (i.e. those who have a diagnosis of asthma who have had no asthma-related drug issued in the previous 12 months) as a proportion of their practice list size.

Verification - PCOs may compare the expected prevalence with the reported prevalence.

Asthma Indicator 8

The percentage of patients aged eight and over, diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility

Asthma 8.1 Rationale

Accurate diagnosis is fundamental in order to avoid untreated symptoms as a result of under-diagnosis, and inappropriate treatment as a result of over-diagnosis. Both scenarios have implications both to the health of the patient, and the cost of providing healthcare.
National and international guidelines emphasise the importance of demonstrating variable lung function in order to confirm the diagnosis of asthma. “Variability of PEF and FEV1, either spontaneously over time or in response to therapy is a characteristic feature of asthma.” [The British Thoracic Society / Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. Thorax 2003; 58 (S1): i1-i94. 2004 update http://www.brit-thoracic.org.uk and http://www.sign.ac.uk] “…measurements of airflow limitation, its reversibility and its variability are considered critical in establishing a clear diagnosis of asthma” [Global Strategy for Asthma Management and Prevention. www.ginasthma.org]. One peak flow measurement (as required by the Asthma 2 indicator in the 2004/5 QOF) provides no information about variability and therefore can neither confirm, nor refute, the diagnosis.

Objective measurement of variability either spontaneously over time or in response to therapy is thus fundamental to the diagnosis of asthma, and may be conveniently achieved in primary care with serial peak flow measurements. Significant variability in peak flow is defined as a change of 20 per cent or greater with a minimum change of at least 60 l/min ideally for three days in a week for two weeks seen over a period of time and may be

demonstrated by monitoring diurnal variation, demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks inhaled steroids, two weeks oral steroids) or a reduction after exercise or when the patient next meets his/her trigger. Spirometry (>15 per cent and 200ml change in FEV1) may still be used to confirm variability, though the limitation imposed by a surgery-based measurement means that changes over time may be missed.

It is important to recognise that while repeated normal readings in a symptomatic patient cast doubt on a diagnosis of asthma, the natural variation of the disease means that many patients with asthma will not necessarily have significant variability at any given time. Confirmation of the diagnosis may therefore require further recordings e.g. during a subsequent exacerbation. In circumstances of persisting doubt then more specialist assessment is required which may include hyper-responsiveness testing and consideration of alternative diagnoses.

It is of note that a proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400mls or more on FEV1 – but do not return to over 80 per cent predicted, and a significant smoking history. Evidence would suggest that this should not usually be more than 15 per cent of the overall COPD population.

Asthma 8.2 Reporting and Verification

The practice should report the percentage of patients aged eight or over diagnosed as having asthma after 1 April 2006 with measures of variability or reversibility.

Asthma Indicator 3

The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months

Asthma 3.1 Rationale

Many young people start to smoke at an early age. It is therefore justifiable to ask about smoking on an annual basis in this age group.

The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. Clin Exp Allergy 2005; 35: 282-287.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity (Thomson et al. Eur Respir J 2004; 24: 822 – 833).

Asthma 3.2 Reporting and Verification

Practices should report the percentage of patients on the asthma register between the ages of 14 and 19 where smoking status has been recorded in the

previous 15 months.

Asthma Indicator 6

The percentage of patients with asthma who have had an asthma review in the previous 15 months

Asthma 6.1 Rationale

Structured care has been shown to produce benefits for patients with asthma. The recording of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. SIGN/BTS proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

National and international guidelines recommend the use of standard questions for the monitoring of asthma. “Proactive structured review, as opposed to opportunistic or unscheduled review, is associated with reduced exacerbation rate and days lost from normal activity. See The British Thoracic Society / Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. Thorax 2003; 58 (S1): i1-i94. 2004 update http://www.brit-thoracic.org.uk and http://www.sign.ac.uk.

The QOF suggests the utilisation of the RCP three questions as an effective way of assessing symptoms:

"In the last month
- Have you had difficulty sleeping because of your asthma symptoms (including cough)?
- Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
- Has your asthma interfered with your usual activities e.g. housework, work/school etc?"

Although there is good evidence on the use of personalised asthma plans in secondary care, there is very limited evidence in primary care. Practices may wish to follow the advice of the BTS/SIGN guideline and offer a personalised asthma action plan to patients.

Peak flow is a valuable guide to the status of a patient’s asthma. However, it is much more useful if there is a record of patients’ best peak flow, i.e. their peak flow when they are well. Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients over the age of 18 there need be no particular time limit on when the best peak flow was measured although in view of the reduction of peak flow with age it is recommended that the measurement be within the preceding five years. For patients aged 18 and under the peak flow will be changing; therefore it is recommended that the best peak flow should be re-assessed annually.

Inhaler technique should be reviewed regularly. National and international

guidelines emphasise the importance of assessing ability to use inhalers before prescribing, and regularly reviewing technique, especially if control is inadequate. “Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique.” “Reassess inhaler technique as part of structured clinical review.” The British Thoracic Society / Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. Thorax 2003; 58 (S1): i1-i94. 2004 update http://www.brit-thoracic.org.uk and http://www.sign.ac.uk

Summary of Asthma Review:

- Assess symptoms (using RCP 3 questions)
- Measure peak flow
- Assess inhaler technique
- Consider personalised asthma plan.

It is recognised that a significant number of patients with asthma do not regularly attend for review. For this reason the percentage achievement for the asthma indicators has been set at a lower level compared to process indicators in some other chronic disease areas.

Asthma 6.2 Reporting and Verification

Practices should report the percentage of patients on their asthma register who have had an asthma review in the previous 15 months.

Dementia

Indicator	Points	Payment Stages
Records		
DEM1: The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25-60%

Dementia- Rationale for Inclusion of Indicator Set

Dementia is a syndrome characterised by catastrophic, progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at 80 years of age. The annual incidence of vascular dementia is 1.2/100 overall person years at risk, and is the same in all age groups. Alzheimer 's disease accounts for 50-75 per cent of cases of dementiaThe annual incidence of senile dementia of the Alzheimer type rises to 34.3/100 person years at risk in the 90 year age group; the incidence is higher in women than in men. Other types of dementia such as Lewy Body dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is not a good indicator of dementia; altered functioning is a more important symptom.

Dementia (DEM) Indicator 1

The practice can produce a register of patients diagnosed with dementia

Dementia 1.1 Rationale

A register is a pre-requisite for the organisation of good primary care for a particular patient group. There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when patients are referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.

Dementia 1.2 Reporting and Verification

The practice reports the number of patients with dementia on its register and the number of people with dementia as a proportion of its list size.

Dementia (DEM) Indicator 2

The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months

Dementia 2.1 Rationale

The face to face review should focus on support needs of the patient and their carer. In particular the review should address four key issues:

1. An appropriate physical and mental health review for the patient
2. If applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs
3. If applicable, the impact of caring on the care giver
4. Communication and co-ordination arrangements with secondary care (if applicable).

A series of well-designed cohort and case control studies have demonstrated that people with Alzheimer-type dementia do not complain of common physical symptoms, but experience them to the same degree as the general population. Patient assessments should therefore include the assessment of any behavioural changes caused by;

- concurrent physical conditions (e.g. joint pain or intercurrent infections)
- new appearance of features intrinsic to the disorder (e.g. wandering) and delusions or hallucinations due to the dementia or as a result of caring behaviour (e.g. being dressed by a carer)

Depression should also be considered since it is more common in people with dementia than those without (Burt et al. Psychol Bull 1995; 117: 285-305).

The Audit Commission Report Forget Me Not 2002. http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/3DFEF403-038C-464f-8518-441477E92B15/forgetupdate.pdf

and the NSF for Older People http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wg3bg0 both recommend that patients and carers should be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia (Eccles et al. BMJ 1998; 317: 802-808). As the illness progresses, needs may change and the review may focus more on issues such as respite care.

There is good evidence from well-designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions, they should contact the carer's own GP for further support and treatment (see Eccles et al. BMJ 1998; 317: 802-808).

As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process.

Dementia 2.2 Reporting and Verification

The practice reports the percentage of patients with dementia on its register who have had their care reviewed in the previous 15 months.

Verification – PCOs may randomly select a number of case records of patients in which the review has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.

Depression

Indicator	Points	Payment Stages
Diagnosis and initial management		
DEP1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40-90%
DEP2: In those patients with a new diagnosis of depression, recorded between the preceeding1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40-90%

Depression- Rationale for Inclusion of the Indicator Set

Depression is common and disabling. The estimated point prevalence for major depression among 16-65 year olds in the UK is 21/1000 (males 17, females 25). Mixed anxiety and depression is prevalent in a further 10 per cent of adult patients attending general practices (NICE Depression Guideline, December 2004). It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after cardiovascular disease in terms of the world's disabling diseases (Murray CJL and Lopez AD. The global burden of disease. Boston, Mass: WHO and Harvard University Press, 1996). Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2000, 109.7 million lost working days and 2615 deaths were attributable to depression. The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.

Further information:
Depression. Management of depression in Primary and Secondary Care. Clinical Guideline 23. NICE, London 2004.
http://www.nice.org.uk/pdf/CG023NICEguideline.pdf

Depression (DEP) indicator 1

The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions

Depression 1.1 Rationale

Depression is more common in people with coronary heart disease and presence of depression is associated with poorer outcomes. Up to 33 per cent of patients develop depression after a myocardial infarction (Davies et al. BMJ 2004; 328: 939-943). A recent meta-analysis of 20 trials found that depressive symptoms and clinical depression in people with CHD increased mortality for all follow up periods even after adjustment for other risk factors (Barth et al. Psychosomatic Medicine 2004; 66: 802-13).

There is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus (Goldney et al. Diabetes Care 2004; 27(5): 1066-70), a prevalence rate three times higher than the general population. A recent meta-analysis of 42 studies found that depression is clinically relevant in nearly

one in three patients with diabetes (Anderson et al. Diabetes Care 2001; 24: 1069-78). There is also some trial based evidence to suggest that treatment of depression may improve glycaemic control (Lustman et al. Psychosomatic Medicine 1997; 59: 241-50; Lustman et al. Annals of Internal Medicine 1998; 129: 613-621; Lustman et al. Diabetes Care 2000; 23: 618-23

).Psychological well-being has also been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

NICE guidance on Depression suggests that "screening should be undertaken in primary care …for depression in high-risk groups" (Grade C) and that "screening for depression should include the use of at least two questions concerning mood and interest:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?

and

- During the last month, have you often been bothered by having little interest or pleasure in doing things?"

(NICE Grade B).

A "yes" answer to either question is considered a positive test. A "no" response to both questions makes depression highly unlikely. These two brief questions could be asked as part of a diabetes or coronary heart disease review and patients who answer "yes" to either questions could be referred to the GP for further assessment of other symptoms such as tiredness, guilt, poor concentration, change in sleep pattern and appetite and suicidal ideation to confirm a diagnosis of depression (see also Whooley et al. Journal of General Internal Medicine 1997; 12 (7): 439-45 and Arroll et al. BMJ 2003; 327: 1144-6).

Depression 1.2 Reporting and Verification

Practices report the percentage of patients on their diabetes and CHD registers whose records show that they have been screened for depression using the two standard questions. This screening will have been recorded in the previous 15 months.

Verification – PCOs may randomly select a number of case records of patients in whom screening has been undertaken to ensure that the two standard questions are being used.

Depression (DEP) Indicator 2

In those patients with a new diagnosis of depression recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care

Depression 2.1 Rationale

This is a prospective indicator and applies to adults aged 18 years and over with a new diagnosis of depression after 1 April 06. It does not include women with postnatal depression.

GP global assessment of severity does not accord closely with more structured assessment of symptoms (Kendrick et al. British Journal of General Practice 2005; 55: 280-286). Assessment of severity is essential to decide on appropriate interventions and improve the quality of care.

A measure of severity at the outset of treatment enables a discussion with the patient about relevant treatment interventions and options, guided by the stepped care model of depression described in NICE guidance. The guidance states, for example, that antidepressants are not recommended for the initial treatment of mild depression (Grade C

evidence) but should be routinely considered for all patients with moderate or severe depression (Grade B evidence). The British Association of Psychopharmacology Guidelines state that antidepressants are a first-line treatment for major depression irrespective of environmental factors (grade A evidence) and that antidepressants are not indicated for acute milder depressions (grade B evidence) (Anderson et al. Journal of Psycho-pharmacology 2000; 14: 3-20).

Not all severity assessment measures map directly onto NICE guidance, which uses ICD-10 symptoms in defining mild, moderate, severe and severe depression with psychotic symptoms. However, the underlying principle of all three suggested measures is that a higher score indicates greater severity requiring different types of treatment. It is, however, also important for clinicians to consider family and previous history as well as degree of associated disability and patient preference in making an assessment of the need for treatment, rather than relying completely on a single symptom count. In addition, the Patient Health Questionnaire (PHQ-9) and the Beck Depression Inventory Second Edition (BDI-II) have not been validated in terms of their cultural sensitivity and it is important to bear this in mind if using them with black and minority ethnic populations.

The three suggested severity measures validated for use in a primary care setting are the Patient Health Questionnaire (PHQ-9), the Beck Depression Inventory Second Edition (BDI-II) and the Hospital Anxiety and Depression Scale (HADS). It is advisable for a practice to choose one of these three measures and become familiar with its questions and scoring systems.

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a nine question self-report measure of severity that takes approximately three minutes to complete. It uses DSM-IV criteria and scores are categorised as minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19) and severe depression (20-27).
It was developed and validated in the US and can be downloaded free of charge from: http://www.depressionprimarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/

For further information, see:
Kroenke et al. Journal of General Internal Medicine 2001;16: 606-13.

Hospital Anxiety and Depression Scale (HADS)

Despite its name, the HADS has been validated for use in community and primary care settings. It is self administered and takes up to five minutes to complete. The Anxiety and Depression scales both comprise seven questions rated from a score of 0 to 3 depending on the severity of the problem described in each question. The two sub-scales can also be aggregated to provide an overall anxiety and depression score. The anxiety and depression scores are categorised as normal (0-7), mild (8-10), moderate (11-14) and severe (15-21).

The HADS allows you to establish the severity of both anxiety and depression simultaneously, whilst giving a separate score for each since the two subscales, anxiety and depression are independent measures. The HADS can be ordered from:

http://www.nfer-nenelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1125

The HADS depression subscale (HAD-D) has 90 per cent sensitivity and 86 per cent specificity for depression compared to the gold standard of a structured diagnostic interview.

For further information, see:
Zigmond AS,.Snaith RP. Acta Psych Scand 1983 ;67: 361-70 and Wilkinson and Barczak. J R Coll Gen Pract 1988; 38: 311-3.

Beck Depression Inventory Second Edition (BDI-II)

The BDI-II is a 21 item self report instrument that uses DSM-IV criteria. It takes approximately five minutes to fill in. A total score of 0-13 is considered minimal range, 14-19 is mild, 20-28 is moderate, and 29-63 is severe. The instruments and manuals can be ordered on line from:

http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=112&page_id=9707008&query=beck%2A&hiword=beck%2A+

For further information, see:
Arnau et al. Health Psychology 2001; 20(2): 112-9.

Depression 2.3 Reporting and Verification

Practices report the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity at the outset of treatment. New diagnoses are those which have been made between the preceding 1 April to 31 March.

Practice also report in each patient record which of the three assessment tools they used.

Chronic Kidney Disease

Indicator	Points	Payment stages
Records		
CKD1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial Management		
CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40-90%
Ongoing Management		
CKD3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40-70%
CKD4: The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	4	40-80%

Chronic Kidney Disease- Rationale for Inclusion of Indicator Set

Chronic Kidney Disease is a long-term condition present in 10 per cent of the population (Coresh J. J Am Soc Nephrol 2005; 16(1): 180-8). The International Classification developed by the US National Kidney Foundation describes five stages of chronic kidney disease using an estimated glomerular filtration rate (eGFR) to measure kidney function. People with CKD stages three to five have, by definition, less than 60 per cent of their kidney function. Stage three is a moderate decrease in GFR with or without other evidence of kidney damage, stage four is a severe decrease in GFR with or without other evidence of kidney damage and stage five is established renal failure.

This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m^2 for over 3 months). Five percent of the population have stage 3 to 5 CKD (Webb et al. Am J Kidney Disease 2004: 43 (5): 25-35).

CKD may be progressive and its prevalence increases with age, male sex, and South Asian and African Caribbean ethnicity. People of South Asian origin are particularly at risk of CKD-linked diabetes. Diabetes is more common in this community than in the population overall. People of African and African Caribbean origin have an increased risk of CKD linked to hypertension.

Further Information:
National Service Framework for Renal Services, February 2005
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4101902&chk=6Tjqb8

Only a minority of people with stage one or two CKD go on to develop more advanced disease and symptoms do not usually appear until stage four. However, early identification of CKD is important as it allows appropriate measures to be taken not only to slow or prevent the progression to more serious CKD but also to combat the major risk of illness or death due to cardiovascular disease. CKD is an independent risk factor for cardiovascular disease and a multiplier of other risk factors (Wali and Henrich. Cardiol Clin 2005; 23(3): 343-62).

Chronic Kidney Disease (CKD) Indicator 1

The practice can produce a register of patients aged 18 years and over with chronic kidney disease (US National Kidney Foundation: Stage 3 to 5 CKD)

Chronic Kidney Disease 1.1: Rationale

Patients aged18 years and over with a last estimated GFR or GFR of <60ml/min/1.73m^2 should be included in the register. From 2006, eGFR will be included with creatinine testing. Studies of general practice computerised medical records show that it is feasible to identify people with CKD (de Lusignan et al. Fam Pract 2005; 22(3): 234-41) and that computer records are a valid source of data (Anandarajah et al. Nephrol Dial Transplant 2005; 20(10): 2089-96).

The compilation of a register of people with CKD will enable appropriate advice, treatment and support for the patient to preserve kidney function and to reduce the risk of cardiovascular disease.

Chronic Kidney Disease 1.2: Reporting and Verification

The practice reports the number of patients on its CKD register and the number of patients with CKD as a proportion of total list size.

Chronic Kidney Disease (CKD) Indicator 2

The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months

Chronic Kidney Disease 2.1: Rationale

Studies show that reducing blood pressure in people with CKD reduces the deterioration of their kidney function whether or not they have hypertension or diabetes. (Jafar et al. Ann Int Med 2003; 139: 244-52).

Chronic Kidney Disease 2.2: Reporting and Verification

Practices report the percentage of patients on its CKD register who have had a blood pressure measurement recorded in the previous 15 months.

Chronic Kidney Disease (CKD) Indicator 3

The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less

Chronic Kidney Disease 3.1: Rationale

Studies have shown that in people over 65 years and in people with diabetes, normal blood pressure is hard to achieve but is important (Anderson et al. American Journal of Kidney Disease 2005; 45(6): 994-1001).

See also the latest British Hypertension Society guidelines 2004: Williams et al. J Hum HT 2004; 18: 139-185 (specific renal advice on pages 166-7). This suggests an “optimal” BP target in CKD of 130/80 or 127/75 if >1 g proteinuria. These targets in turn are derived from the Modification of Diet in Renal Disease study, (Klahr et al. NEJM 1994; 330: 877-884; Peterson et al. Ann Int Med 1995; 123: 754-762).

In practice, these targets are often hard to achieve. The lower the blood pressure achieved the better for patient care; 140/85 is taken as a pragmatic starting point for a new quality indicator.

Chronic Kidney Disease 3.2: Reporting and Verification

The practice reports the percentage of patients on its CKD register whose last recorded blood pressure measurement is 140/85 or less. This reading should have been in the previous 15 months.

Chronic Kidney Disease (CKD) Indicator 4

The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)

Chronic Kidney Disease 4.1: Rationale

ACE inhibitors and ARBs are generally more effective than other anti-hypertensives in minimising deterioration in kidney function and this effect is most marked where there is significant proteinuria. Such treatment is both clinically and cost effective (Jafar et al. Ann Int Med 2003; 139(4): 244-52).

See also: Lewis et al. NEJM 1993; 329:1456-1462; Brenner et al. NEJM 2001; 345:861-869; Ruggenenti et al. Lancet 1999; 354: 359-364).

Chronic Kidney Disease 4.2: Reporting and Verification

The practice reports the percentage of patients on its CKD register with hypertension whose records show they have been prescribed an angiotensin converting enzyme inhibitor (ACE-I) or an angiotensin receptor blocker (ARB) in the previous six months.

Atrial Fibrillation

Indicator	Points	Payment Stages
Records		
AF1: The practice can produce a register of patients with atrial fibrillation.	5	
Initial diagnosis		
AF2: The percentage of patients with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis.	10	40-90%
Ongoing management		
AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy.	15	40-90%

Atrial Fibrillation- Rationale for Inclusion of Indicator Set

Atrial fibrillation is common, and an important cause of morbidity and mortality. The age specific prevalence of atrial fibrillation is rising, presumably due to improved survival of people with coronary heart disease (the commonest underlying cause of AF (Psaty et al. Circulation 1997; 96: 2455-61). One percent of a typical practice population will be in AF; 5 per cent of over 65s, and 9 per cent of over 75s. Atrial fibrillation is associated with a five fold increase in risk of stroke (Wolf et al. Stroke 1991; 22: 983-88).

Atrial Fibrillation (AF) Indicator 1
The practice can produce a register of patients with atrial fibrillation

AF 1.1: Rationale

This is good professional practice and is consistent with other clinical domains within the QOF as a building block for further evidence based interventions. A register makes it possible to call and recall patients effectively to provide systematic care and to audit care. A register should include all people with an initial event; paroxysmal; persistent and permanent AF.

AF 1.2: Reporting and Verification

The practice reports the number of patients on its AF register and the number of patients with AF as a proportion of total list size.

Atrial Fibrillation Indicator 2

The percentage of patients with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis

AF 2.1: Rationale

AF is historically too often inaccurately coded. Patients with an irregular pulse have been given an AF code even though the accuracy of AF diagnosed in this way is only approximately 30 per cent. The introduction of this indicator will enable the compilation of a more accurate register and help to ensure that treatments are targeted more appropriately. The act of referral for a specialist opinion (e.g. cardiology out patient or ECG technician report) is insufficient to achieve this indicator.

AF 2.2: Reporting and Verification

The practice reports those patients with atrial fibrillation diagnosed after 1 April 2006 who have had an ECG or been diagnosed by a specialist within 12 months of being added to the register. The practice may also report patients who have been diagnosed or had an ECG up to three months before being added to the register.

Atrial Fibrillation Indicator 3

The percentage of patients with atrial fibrillation who are currently treated with anti-coagulant drug therapy or an anti-platelet drug therapy

There is strong evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction) (Arch Intern Med 1994; 154: 1449-57) and less so by aspirin (approximately 22 per cent risk reduction) (Antithrombotic trialists' collaboration BMJ 2002; 324: 71-86). Warfarin carries a higher risk of serious haemorrhage than aspirin, and these risks are higher in older people (Van Walraven et al. JAMA 2002; 288: 2441-8). Therefore for some older people in AF, it is unclear whether warfarin or aspirin should be the preferred therapy. This guidance enables the clinician and patient to decide on the preferred regime taking risks and benefits of both treatments into account.
NICE Grade A evidence.

Anti-coagulation or anti-platelet therapy would not necessarily be indicated if the episode of AF was an isolated event that was not expected to re-occur (e.g. one off AF with a self-limiting cause).

For the purposes of the QOF, acceptable anti-coagulation agents are warfarin and phenindione, acceptable anti-platelet agents are aspirin, clopidogrel and dipyridamole.

AF 2.3 Reporting and Verification

Practices report the percentage of patients with AF whose records show they have been prescribed anti-coagulant or anti-platelet drug therapy in the previous six months.

Obesity

Indicator	Points	Payment Stages
Records		
OB1: The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.	8	

Rationale for Inclusion of Indicator Set

The prevalence of obesity in the United Kingdom is at least 21 per cent in men and 23.5 per cent in women and looks set to continue to rise (Health Surveys England, 2002, The Stationery Office, 2003; Scottish Health Survey, 2003). There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes. In addition to the obvious associated disease burden such as inactivity, degenerative joint disease, lower employment and mood disorders (Russell et al. BMJ 2005; 330: 1354), obesity is also a major contributory factor for some of the commonest causes of death and disability in developed economies, most notably greater rates of diabetes mellitus (Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603) and accelerated onset of cardiovascular disease (Gregg et al. JAMA 2005; 20; 293 (15): 1868-74). Obesity has therefore become a major health issue for the United Kingdom.

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

OB 1.1 Rationale

This register is prospective. It is envisaged that it will include, all people whose body mass index (BMI) has been recorded in the practice as part of routine care. It is expected that this data will inform public health measures.

OB1.2 Reporting and Verification

Practices should report the number of patients on its obesity register and the number of patients with obesity as a proportion of total list size.

Learning Disabilities

Indicator	Points	Payment Stages
Records		
The practice can produce a register of patients with learning disabilities	4	

Rationale for Inclusion of Indicator Set

People with learning disabilities are amongst the most vulnerable and socially excluded in our society. It is estimated that there are approximately 20 /1,000 people with mild learning disabilities and 3-4/1,000 people with severe and profound learning disabilities in the UK. Over the past three decades, almost all the long term stay hospitals for patients with learning disabilities have closed, and virtually all patients with learning disabilities are now living in the community and depend on GPs for their primary health care needs.

Further information:
Valuing People: a new strategy for learning disability in the 21st century. London, Department of Health, 2001.
http://www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf

'The Same as You?' Scottish Executive (2001)
http://www.scotland.gov.uk/topics/health/care/VAUnit/Thesameasyou

Northern Ireland Strategy on Learning Disability
http://www.rmhldni.gov.uk/learning_disability.asp

Learning Disability Strategy Section 7 Guidance on Service Principles and Service Responses, Welsh Assembly Government, 2004
http://www.wales.gov.uk/subisocialpolicy/content/guidance/sp-response-guide-e.pdf

Learning Disability (LD) Indicator 1

The practice can produce a register of patients with learning disabilities

LD 1.1 Rationale

The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike (See Treat Me Right, Mencap, 2004; www.mencap.org.uk).

Learning disability is defined in Valuing People (and 'The Same as You') as the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with:
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood (18 years), with a lasting effect on development.

The definition encompasses people with a broad range of disabilities. It includes adult with autism who also have learning disabilities, but not people with a higher level autistic spectrum disorder who may be of average or above average intelligence. The presence of an Intelligence Quotient below 70, should not, in isolation, be used in deciding whether someone has a learning disability.

The definition does not include all those people who have a "learning difficulty".

For most people, there is no difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multidisciplinary team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality learning disability teams have expanded and these, working along with Primary Care Organisations, have provided expertise and data about and for people with learning disabilities. Some hold 'Special Needs Registers' increasingly re-named 'Learning Disability Databases'. Learning Disabilities nurses from the community learning disability team are thus likely to know the names of patients and the practice with whom they are registered and may also be able to assist in the construction of a primary care database (see Martin and Martin. Journal of Learning Disabilities, 2000; 4(1): 37-48).

Further information:
http://www.bild.org.uk/factsheets/what_is_learning_disability.htm

The creation of a full register of patients aged 18 years and over with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

LD1.2 Reporting and Verification

Practices report the number of patients aged 18 years and over on its learning disability register and the number of patients with learning disabilities as a proportion of total list size.

3.Smoking Indicators

Indicator	Points	Payment Stages
Ongoing management		
Smoking 1: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis	33	40-90%
Smoking 2: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months	35	40-90%

(2) Smoking Indicator 1
The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis

(3)

(4)

(5) Smoking 1.1- Rationale

1. CHD
Smoking is known to be associated with an increased risk of coronary heart disease.

Reference SIGN Guideline 41; European Task Force European Society of Cardiology
Further Information:
http://www.sign.ac.uk/guidelines/fulltext/41/index.html
http://www.escardio.org/knowledge/guidelines/CVD_Prevention_in_Clinical_Practice.htm

2. Stroke/TIA
There are few randomised clinical trials of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated.
Grade C Recommendation SIGN 13
Further information:
http://www.sign.ac.uk/pdf/sign13.pdf

3. Hypertension
The British Hypertension Society recommends that all patients with hypertension should have a thorough history and physical examination and a smoking history is taken.

British Hypertension Society Guidelines 2004
Further information: Journal of Human Hypertension 2004; 18(3): 139 –185.
http://www.bhsoc.org/Latest_BHS_management_Guidelines.htm

Formal estimation of CHD risk using a recognised chart e.g. Joint British Societies Recommendations should be undertaken.
Risk calculators are available at: http://www.hyp.ac.uk/bhs/resources/guidelines.htm

4. Diabetes
The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.

5. COPD
Smoking cessation is the single most effective - and cost-effective - intervention to reduce the risk of developing COPD and stop its progression.
Grade A Evidence GOLD Guidelines
Further Information:
GOLD Guidelines www.goldcopd.com/

6. Asthma
The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. New grade A evidence suggests that smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome. See Tomlinson et al. Thorax 2005; 60: 282-7. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. Clin Exp Allergy 2005; 35: 282-287.

7. Non-smokers
It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients need only be recorded once since diagnosis.

(6) Smoking 1.2 Reporting and Verification

Practices report the percentage of patients on any or any combination of the named registers in whom smoking status has been recorded in the previous 15 months.

(a) Smoking Indicator 2

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months

(7) Smoking 2.1 Rationale
Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of individual and group smoking cessation advice, and assistance reinforced on multiple occasions - initially during cardiac rehabilitation and reinforced by primary care teams - gave the highest success rates.

Reference Grade B recommendation SIGN Guidelines 41/51
Further Information:
http://www.sign.ac.uk/guidelines/fulltext/51/index.html
http://www.sign.ac.uk/guidelines/fulltext/41/index.html

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or buproprion in patients who have indicated a wish to quit smoking. Further guidance is available from the National Institute for Clinical Excellence.

Further Information:
http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf

In a significant number of PCOs across the UK specialist smoking cessation clinics are now available. Referral to such clinics, where they are available, can be discussed with patients. This should also be recorded as giving smoking cessation advice.

The recording of advice given does not necessarily reflect the quality of the intervention. It is therefore proposed that only smoking advice should be part of the reporting framework. Clinicians may choose to record advice given in relation to other modifiable risk factors.

4.Smoking Indicator 2.2 Reporting and Verification

Practices should report the percentage of patients on any or any combination of the named registers who smoke who have a record of having been offered smoking cessation advice in the previous 15 months.

Organisational Domain

1. Format

Organisational indicators are split into five domains:

Records and information about patients (A)
Information for patients (B)
Education and training (C)
Practice management (D)
Medicines management (E)

For each indicator (x) four descriptions are given unless it is reported electronically:

X.1 Practice guidance

This section contains a number of things, dependent on the indicator, including:

justification for the indicator
a more detailed description of the indicator
references which practices may find useful
some helpful guidance on how practices may go about meeting the requirements of the indicator.

X.2 Written evidence

This specifies the written evidence which a practice would be expected to produce for an assessment visit. The evidence generally should be available in the practice and need not be submitted in advance. However, some written evidence will be required in advance and this is indicated in the document. In some instances no written evidence will be required but may be requested if there is an appeal.

In summary, written evidence is categorised as follows:

Grade A – to be submitted in advance of a visit.

Grade B – to be available in the practice at the visit.

Grade C – optional or used in the event of an appeal.

X.3 Assessment visit

This section describes how a visiting assessment team will verify the written evidence.

X.4 Assessors' guidance

This section contains more detailed guidance for assessors to use during practice assessment visits. This guidance has been produced to ensure that practices are being judged to the same standard across the UK.

2. Equivalence – Other Schemes

It is recognised that a number of schemes are currently in place across the UK to encourage practice development. Other practice-based accreditation schemes may apply to the National Reference Group to be recommended as equivalent to appropriate aspects of the organisational indicators of the QOF.

These schemes must involve the practice in meeting indicators considered by the Reference Group to be equivalent to a relevant indicator in the Framework. Any scheme which is to be considered must include as part of its process a visit to the practice.

The RCGP Quality Practice Award has been approved for all Organisational Indicators in the Framework. Version 7 of QPA to be published in August 2003 and has been modified to meet the requirements of the Framework in relation to the organisational framework.

Records and Information

Records 3 1 point	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours
Records 8 1 point	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded
Records 9 4 points	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%
Records 11 10 points	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients
Records 13 2 points	There is a system to alert the out-of-hours service or duty doctor to patients dying at home
Records 15 25 points	The practice has up-to-date clinical summaries in at least 60% of patient records
Records 17 5 points	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients
Records 18 8 points	The practice has up-to-date clinical summaries in at least 80% of patient records
Records 19 7 points	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice
Records 20 12 points	The practice has up-to-date clinical summaries in at least 70% of patient records
Records 21 1 point	Ethnic origin is recorded for 100% of new registrations
Records 22 11 points	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once (payment stages 40 – 90%)

Records Indicator 3

The practice has a system for transferring and acting on information about patients seen by other doctors out of hours

Records 3.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states that the excellent GP "can demonstrate an effective system for transferring and acting on information from other doctors about patients". Out-of-hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

If the practice undertakes its own out-of-hours cover, there needs to be a system to ensure that out-of-hours contacts are entered in the patient's clinical

record.

If out-of-hours cover is provided by another organisation, for example a co-operative, deputising service, PCO provided service or shared rota there needs to be a system for

transferring information to the practice
transferring that information into the clinical record
identifying and actioning any required follow-up.

Records 3.2 Written evidence

There must be a written procedure for the transfer of information. (Grade B)

Records 3.3 Assessment visit

Inspection of the procedure for the transfer of information may be carried out on an assessment visit.

Records 3.4 Assessors' guidance

Receptionists and doctors will be questioned on the system for the transfer of information.

Records Indicator 8

There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded

Records 8.1 Practice guidance

It is important that a clinician avoids prescribing a drug to which the patient is known to be allergic. Not all patients can recall this information and hence records of allergies are important.

All prescribing clinicians should know where such information is recorded. Ideally the place where this information is recorded should be limited to one place and not more than two places.

Records 8.2 Written evidence

There should be a statement as to where drug allergies are recorded. (Grade C)

Records 8.3 Assessment visit

The practice should be able to demonstrate where drug allergies are recorded.

Records 8.4 Assessors' guidance

The place where drug allergies are recorded can be on the computer or in the paper records. This information should be easily available to the prescribing clinician at the time of consultation.

Records Indicator 9

For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)
Minimum Standard 80%

Records 9.1 Practice guidance

When reviewing medication, it is important to know why a drug was started. This information in the past has often been difficult to identify in GP records, particularly if a patient has been on a medication for a long time or has transferred between practices. It is proposed that this information needs to be recorded clearly in the clinical records.

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

Records 9.2 Written evidence

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80 per cent of repeat medications commenced after 1 April 2004. (Grade A)

Records 9.3 Assessment visit

The records should be inspected.

Records 9.4 Assessors' guidance

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of twenty patients for whom repeat medication has

been started since that date should be surveyed. If the standard is not achieved then a further twenty clinical records should be surveyed and the cumulative total should be used. The minimum standard is that 80 per cent of the indications for repeat medication drugs can be identified.

Records Indicator 11

The blood pressure of patients aged 45 and over is recorded in the previous 5 years for at least 65% of patients

Records 11.1 Practice guidance

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 and over has been pragmatically chosen as the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is proposed as Records Indicator 17 but a higher standard must be achieved.

Records 11.2 Written evidence

A survey of the records of patients aged 45 and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in the previous 5 years. (Grade A)

Records 11.3 Assessment visit

A random sample of 20 notes or computerised records of patients aged 45 and over should be inspected, to confirm that blood pressure has been recorded in the previous 5 years.

Records 11.4 Assessors' guidance

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

Records Indicator 13

There is a system to alert the out-of-hours service or duty doctor to patients dying at home

Records 13.1 Practice guidance

Good Medical Practice (2001) states that when off duty the doctor ensures there are arrangements which "include effective hand-over procedures and clear communication between doctors". It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out-of-hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out-of-hours period. If a practice does its own on call duties then a system should ensure that all doctors in the practice are aware of these patients. A single-handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice e.g. on holiday.

Records 13.2 Written evidence

The system for alerting the out-of-hours service or duty doctor to patients dying at home should be described. (Grade C)

Records 13.3 Assessment visit

The doctors in the practice should be questioned on the system that is in place.

Records 13.4 Assessors' guidance

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill and/or dying at home and what information was passed to the out-of-hours service or duty doctor.

Records Indicator 15

The practice has up-to-date clinical summaries in at least 60% of patient records

Records 15.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states “Important information in records should be easily accessible, for example, as part of a summary”.

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in the summary. All significant past and continuing problems should be included.

If a computer is used the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data.

Similar indicators are proposed as Records 18 and Records 20 but higher standards must be achieved.

Records 15.2 Written evidence

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date. (Grade A)

Records 15.3 Assessment visit

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

Records 15.4 Assessors’ guidance

The practice’s own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess

Records Indicator 17

The blood pressure of patients aged 45 and over is recorded in the previous 5 years for at least 80% of patients

this indicator based on their own experience and beliefs.

Records 17.1 Practice guidance

See Records 11.1.

Records 17.2 Written evidence

See Records 11.2. (Grade A)

Records 17.3 Assessment visit

See Records 11.3.

Records 17.4 Assessors' guidance

See Records 11.4.

Records Indicator 18

The practice has up-to-date clinical summaries in at least 80% of

Records 18.1 Practice guidance

See Records 15.1.

Records 18.2 Written evidence

See Records 15.2. (Grade A)

Records 18.3 Assessment visit

See Records 15.3.

Records 18.4 Assessors' guidance

See Records 15.4.

Records Indicator 19

80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice

Records 19.1 Practice guidance

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

Records 19.2 Written evidence

A survey should be carried out of the records of newly registered patients whose notes have been received between 8 and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively a computer print-out should be examined, showing the patients registered where the records have been received between 8 and 26 weeks previously, to confirm whether the computer record contains a clinical summary. (Grade A)

Records 19.3 Assessment visit

A sample of 20 records of patients whose records were sent to the practice between 9 and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

Records 19.4 Assessors' guidance

A list of patients registered in the past 12 months and whose records have been forwarded between 9 and 26 weeks ago to the practice will be obtained from the PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least 10 per cent) from the practice survey a further 20 records will be checked if appropriate.

Records Indicator 20:
The practice has up-to-date clinical summaries in at least 70% of patient records

Records 20.1 Practice Guidance

See Records 15.1.

Records 20.2 Written evidence

See Records 15.2. (Grade A)

Records 20.3 Assessment Visit

See Records 15.3.

Records 20.4 Assessors Guidance

See Records 15.4.

Records Indicator 21:
Ethnic origin is recorded for 100% of new registrations

Records 21.1 Practice guidance

The UK is an increasingly ethnically diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.

The experience of the UK census now means that there are nationally used ethnic categories that have been thoroughly tested and that are known to be acceptable to the majority of the population.

Further information:

A practical guide to ethnic monitoring in the NHS and Social care. London, Department of Health, 2005.
http://www.dh.gov.uk/PublicationsAndStatistics/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116839&chk=xfG3pr

National Resource Centre for Ethnic Minority Health and ISD ethnic monitoring toolkit
http://www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

See also Gill et al. Health Care Needs Assessment: Black and Minority Ethnic groups.
http://hcna.radcliffe-oxford.com/bemgframe.htm

It should be noted that the census codes enable the patient to refuse to divulge their ethnicity and therefore this will not affect the practice's ability to achieve 100 per cent on this indicator.

Records 21.2 Written evidence

A survey of written records or a computer search of new registrations should be carried out to determine the percentage where ethnicity is recorded. (Grade A)

Records 21.3 Assessment Visit

A random sample of notes or computerised records of new registrations should be inspected, to confirm that ethnicity is recorded.

Records 21.4 Assessors' guidance

The practice's own survey is verified by inspecting a number of new patient registration records at the visit.

Records Indicator 22
The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once.

Payment stages: 40-90%

Records 22.1 Practice Guidance

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record. Dependent upon how practices record smoking status, the survey can be undertaken by computer search or a survey of the written records.

Records 22.2 Written evidence

A survey of written records or a computer search of patients aged from 15 to 75 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded at least once. (Grade A)

Records 22.3 Assessment Visit

A random sample of 20 notes or computerised records of patients aged from 15 to 75 should be inspected, to confirm that smoking status is recorded at least once.

Records 22.4 Assessors' guidance

The practice's own survey is verified by inspecting 20 patient records at the visit. If the result differs from the practice survey then a further 20 patient records should be checked.

Information for Patients

	Indicator
Information 3 1 point	The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day
Information 4 1 point	If a patient is removed from a practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient
Information 5 2 points	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
Information 7 1.5 points	Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO

Information Indicator 3

The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day

Information 3.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states that the excellent GP "has a system for receiving or returning phone calls from patients" and that the unacceptable GP "provides no opportunity for patients to talk to a doctor or a nurse on the phone".

Some practices have specific times to speak to a clinician and others make arrangements for the clinician to phone the patient back.

It is useful for this information to be advertised to patients e.g. through the practice leaflet, notices in the practice, slips given to patients when being asked to phone back for a result, the tear-off side of a prescription, the practice newsletter etc.

Information 3.2 Written evidence

The practice has a written policy on telephone availability (Grade A)

Information 3.3 Assessment visit

The assessors should seek out evidence on when the practice team is available

to answer telephone calls by checking practice leaflets, observing the office and asking reception and clinical staff.

The receptionists should be able to respond positively to a request by a patient to speak to a clinician on the telephone. The assessors should confirm with reception staff the information they give patients who require to speak to a GP or practice-employed nurse. Patients do not require to speak to a clinician immediately unless it is an emergency, but at least one clinician in the practice should be available every working day. The assessors should confirm with staff how patients are informed of the policy and check the stated sources, e.g. practice leaflet, notices at the reception desk or in the waiting area, etc.

Information Indicator 4

If a patient is removed from the practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient

Information 4.1 Practice guidance

It is good practice to explain to a patient the reasons for being removed from the list. This is the recommendation of both the BMA and the RCGP. Normally, this will be based on a perceived breakdown in the doctor/patient relationship but it will often be useful to give a fuller explanation than simply stating this. The letter should not normally be a standard letter of removal but tailored to the individual situation. The reason for removal should not be solely that a patient has made a complaint against the practice (see Good Medical Practice for General Practitioners, 2002).

Many patients will not be aware of the procedure for registration with another practice and will not be aware that the Primary Care Organisation can assist them. They should be given relevant guidance and contact details.

In exceptional circumstances, it will be felt that a written explanation of the reasons for removal from the list will further inflame a difficult situation, potentially endangering the safety of practice team members. In these circumstances, the omission of a written explanation will be justified. It may be useful to discuss this issue and include guidance in the practice's policy.

Information 4.2 Written evidence

There should be a written policy on removing patients from the list. (Grade B)

Information 4.3 Assessment visit

The written policy statement should be inspected or the practice team should be questioned on the policy.

Information 4.4 Assessors' guidance

The practice should submit a written policy. It may also be useful to check with team members that the policy is consistently used. Patients should normally be given a written

reason for their removal and the letter should contain both the elements in the

Information Indicator 5

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

criterion.

Information 5.1 Practice guidance

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or buproprion in patients who have indicated a wish to quit smoking.

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

Information 5.2 Written evidence

There should be a practice protocol concerning smoking cessation. (Grade A)

Information 5.3 Assessment visit

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

Information 5.4 Assessors' guidance

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

Information Indicator 7

Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO

Information 7.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states "patients appreciate being able to contact the surgery throughout the working day". To satisfy this indicator, reception staff will have to be available face to face and on the telephone for the stated hours, spread through Monday to Friday. This indicator may be difficult and inappropriate to satisfy in some single-handed and remote and rural practices. In these circumstances, the level of receptionist cover should be agreed with the PCO. The practice should have written confirmation that this level of cover has been agreed.

There should be a written summary of the times when telephone/face to face access to receptionists is available. (Grade A)

Information 7.3 Assessment visit

Reception staff should be questioned concerning the arrangements for access to receptionists.

Information 7.4 Assessors' guidance

Assessors should confirm with reception staff that their hours of work as a team cover the hours of telephone and face to face availability as stated in the summary. In single-handed or remote and rural practices where it is not appropriate or possible to provide this amount of cover, the practice should have available written confirmation from the PCO of the agreed level of coverage.

Education and Training

Education 1 **4 points**	There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months
Education 4 **3 points**	All new staff receive induction training
Education 5 **3 points**	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
Education 6 **3 points**	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
Education 7 **4 points**	The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include: • Any death occurring in the practice premises • New cancer diagnoses • Deaths where terminal care has taken place at home • Any suicides • Admissions under the Mental Health Act • Child protection cases • Medication errors • A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different (near miss)
Education 8 **5 points**	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal
Education 9 **3 points**	All practice-employed non-clinical team members have an annual appraisal
Education 10 **6 points**	The practice has undertaken a minimum of three significant event reviews within the last year

Education Indicator 1

There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months

Education 1.1 Practice guidance

The primary care team members deal with cardio-pulmonary collapse relatively rarely, but require up-to-date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices

offer training on a more frequent basis.

This training may be available from a variety of providers including your local Accident and Emergency Department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Further information:
Cardiopulmonary Resuscitation Guidance for Clinical Practice and Training in Primary Care (2001)
http://www.resus.org.uk/pages/cpatpc.htm#contents

Education 1.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 1.3 Assessment visit

Staff should be questioned on the date of their last BLS training**.**

Education 1.4 Assessors' guidance

Assessors should confirm by checking the BLS attendance list that practice-employed clinical staff have attended.

Education Indicator 4

All new staff receive induction training

Education 4.1 Practice guidance

The use of a structured induction programme will help new staff fit more quickly into the practice and support them in becoming effective team members. It is useful to establish a programme of induction for a post, but to remember that it may need to be used flexibly, for example when an employee:

- is returning to work after a long absence
- has not worked before
- has a disability
- is from an ethnic minority group.

A programme could include:

- going through terms and conditions of employment
- meeting other members of the practice team, possibly including shadowing
- clarifying areas of responsibility and accountability
- practice codes and/or standards and regulations including Health and

Safety/special hazards, uniforms, arrangements for working overtime, time in lieu etc
- familiarisation with protocols and procedures including employment procedures e.g. sickness absence policy
- training in the responsibilities of the post.

This list is not exhaustive.

Clear recording of the areas covered in the programme and regular reviews of progress will help establish the standard of performance which is expected and help the manager and new member of staff to identify any areas for future development.

Education 4.2 Written evidence

If a new member of staff has commenced after 1 April 2003, a copy of the induction programme which has been implemented should be available. (Grade B)

Education 4.3 Assessment visit

The induction programme should be inspected.

Education 4.4 Assessors' guidance

It may be useful to speak to the newest member of staff as well as inspecting the induction programme itself if he or she has commenced in post after 1 April 2003.

Education Indicator 5

There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months

Education 5.1 Practice guidance

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

Education 5.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 5.3 Assessment visit

Staff should be questioned on the date of their last BLS training**.**

Education 5.4 Assessors' guidance

Confirmation that practice non-clinical staff have attended training should be obtained by checking the BLS attendance list.

Education Indicator 6

The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team

Education 6.1 Practice guidance

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (Education 7 and Education 10).

Education 6.2 Written evidence

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

Education 6.3 Assessment visit

The issue of learning from complaints should be discussed with staff and doctors.

Education 6.4 Assessors' guidance

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

Education Indicator 7

The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include:

- **Any death occurring in the practice premises**
- **New cancer diagnoses**
- **Deaths where terminal care has taken place at home**
- **Any suicides**
- **Any patient admitted under the Mental Health Act**
- **Child Protection Cases**
- **Medication errors**
- **A significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)**

Education 7.1 Practice guidance

Detail of methodology on significant event analysis is given in Education 10.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, e.g. patient suicide, then this should be stated in the evidence.

Education 7.2 Written evidence

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 7.3 Assessment visit

The reviews should be discussed.

Education 7.4 Assessors' guidance

The practice should report on its analyses in a form consistent with either of the two methods described in Education 2.

Education Indicator 8

All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal

Education 8.1 Practice Guidance

The production of a personal learning plan should be one of the outcomes of the appraisal system and the points allocated to this indicator have been increased to reflect this. The plan should record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

Education 8.2 Written evidence

The staff appraisal system should be described. (Grade C)

Education 8.3 Assessment visit

A discussion should be held with practice-employed nursing staff about their personal learning plans and the appraisal system.

Education 8.4 Assessors' guidance

Personal learning plans and the appraisal system should be discussed with practice-employed nursing staff and the person responsible for managing the appraisal system.

Education Indicator 9

All practice-employed non-clinical team members have an annual appraisal

Education 9.1 Practice guidance

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

Education 9.2 Written evidence

The staff appraisal system should be described. (Grade C)

Education 9.3 Assessment visit

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

Education 9.4 Assessors' guidance

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

Education Indicator 10

The practice has undertaken a minimum of three significant event reviews within the last year

Education 10.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1 A multidisciplinary meeting to explain the concept.
2 Consideration of events which should be important to the practice but need not imply criticism of the practice or of individuals. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper (see reference at end of this section). Some of the examples from this are below.

Preventative care:	Measles Unplanned pregnancy Non-accidental injury Squint diagnosed by an ophthalmologist
Acute care:	Sudden unexpected death Death occurring on the practice premises Suicide or suicide attempt

	All new cancer diagnoses Myocardial Infarction Terminal care death at home Section under Mental Health Act
Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

1 Mechanism for identification of events.
A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.

2 Significant events meetings.
These are generally multidisciplinary but need not be so and need to be sensitively chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This could be:

- celebration of excellent care
- no change
- audit required
- immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- **Description of event**. This should be brief and can be in note form.
- **Learning outcome.** This should describe the aspects which were of high

standard and those which could be improved. Where appropriate it should include why the event occurred.

- **Action plan**. The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

Reference:
Royal College of General Practitioners. Significant Event Auditing: Occasional Paper 70. London: RCGP,
1995.

A description of significant event audit is also available in: Robinson et al. How To Do It: Use facilitated case discussions for significant event auditing. BMJ 1995; 311: 315-318.

Education 10.2 Written Evidence

Each case report should consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 10.3 Assessment Visit

The reviews should be discussed.

Education 10.4 Assessors Guidance

The practice should report their analyses in a form consistent with either of the two following methods:

A. Statement of the problem or event, learning outcome and action plan **OR**
B. What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, if possible, all team members who were stakeholders in the event in the case discussion.

Practice Management

D. Practice Management	
Management 1 **1 point**	Individual healthcare professionals have access to information on local procedures relating to Child Protection
Management 2 **1 point**	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
Management 3 **0.5 points**	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
Management 4 **1 point**	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
Management 5 **3 points**	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
Management 6 **2 points**	Person specifications and job descriptions are produced for all advertised vacancies
Management 7 **3 points**	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: • A defined responsible person • Clear recording • Systematic pre-planned schedules • Reporting of faults
Management 8 **1 point**	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
Management 9 **3 points**	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
Management 10 **2 points**	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Management Indicator 1

Individual healthcare professionals have access to information on local procedures relating to Child Protection

Management 1.1 Practice guidance

Awareness of the existence of local Child Protection procedures is mandatory and all healthcare professionals should be able to access a copy.

Management 1.2 Written evidence

There should be a description of how local procedures are accessed. (Grade C)

Management 1.3 Assessment visit

Access to local procedures should be demonstrated.

Management 1.4 Assessors' guidance

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

Management Indicator 2

There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used

Management 2.1 Practice guidance

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

Management 2.2 Written evidence

There should be written policy regarding:

backing up data and verification, including the frequency of that back-up
storage on and off site
authorisation to load programmes. (Grade A)

Management 2.3 Assessment visit

The back-up and loading arrangements should be demonstrated.

Management 2.4 Assessors' guidance

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

Management 3

The Hepatitis B status of all doctors and relevant practice employed staff is recorded and immunisation recommended if required in accordance with national guidance

Management 3.1 Practice guidance

Useful guidance on Hepatitis B risks and immunisation is contained in the UK Health Departments' publication "Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses - recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis" (www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf).

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 1994 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The Health Department guidance "Protecting health care workers and patients from Hepatitis B" and the 1996 and 2004 addenda (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose Hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90 per cent of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen Hepatitis B immunisation policy in the general practice staff (non medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in “Immunisation against Infectious Disease” (see Annex 1 in the above website).

In relation to confidentiality, the BMA Website offers the following guidance:
“It is extremely important that hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care. Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information”.

Management 3.2 Written evidence

There should be evidence that the Hepatitis B status of all staff is known. (Grade C)

Management 3.3 Assessment visit

Questioning should take place on the system to check Hepatitis B status.

Management 3.4 Assessors’ guidance

It should be confirmed that evidence is available that the Hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

Management Indicator 4

The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care

Management 4.1 Practice guidance

The Health Departments in each Country will issue guidance relating to

instrument sterilisation on which the General Practitioners Committee will be consulted.

Management 4.2 Written evidence

There must be a policy for instrument sterilisation.

Management 4.3 Assessment visit

The sterilisation arrangements should be inspected.

Management 4.4 Assessors' guidance

Sterilisation arrangements should be in line with national guidance.

Management Indicator 5

The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO

Management 5.1 Practice guidance

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

Management 5.2 Written evidence

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

Management 5.3 Assessment visit

The practice leaflet and appointment book should be checked.

Management 5.4 Assessors' guidance

The assessor should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide

evidence that the PCO has agreed the range on offer.

Management Indicator 6

Person specifications and job descriptions are produced for all advertised vacancies

Management 6.1 Practice guidance

Production of a person specification and job description at the time of identifying a vacancy not only ensures that the practice maximises its chances of employing the right person for the job, but protects the practice against the risk of being in breach of the following acts: the Sex Discrimination Act, Equal Pay Act, Disability Discrimination Act and Race Relations Act. The government is currently working on draft legislation covering discrimination on the grounds of sexual orientation, religion and age. It is also good practice not to discriminate on these grounds during the recruitment process.

Useful guidance on how to recruit without discrimination can be found on the following web sites:

- The Equal Opportunities Commission Code of Practice – Sex Discrimination at http://www.eoc.org.uk . If unsuccessful candidates for a post were to claim that they had been discriminated against on the grounds of sex, then they could take their complaint to an employment tribunal. The tribunal would take into account whether the Code of Practice was relevant to the circumstances of the case and, if so, failure by the practice to follow the code would be taken into consideration in its determination. The ACAS website also gives guidance on equal opportunities (http://www.acas.org.uk).
- The Disability Discrimination Act: Code of Practice for the elimination of discrimination in the field of employment against disabled persons or persons who have had a disability. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the selection process, terms and conditions of service and 'reasonable adjustments'. See http://www.disability.gov.uk/ and http://www.drc-gb.org/. Practice applies to employers with 15 or more employees. This threshold excluding small firms will be reviewed. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the selection process, terms and conditions of service and "reasonable adjustments."
- The Commission for Race Equality: Employment Code of Practice at: http://www.cre.gov.uk/. The Code of Practice covers advertising, selection/short listing, uniforms, language and other areas.

Practices in Northern Ireland should also be aware of their responsibilities under Section 75 of the Equality Legislation. For further information see http://www.dhsspsni.gov.uk/equality/index.asp.

Management 6.2 Written evidence

The person specification and job description of the last person employed after 1 April 2003 should be available. (Grade B)

Management 6.3 Assessment visit

The assessment should involve questioning on the person specification and job description of the last person employed after 1 April 2003.

Management 6.4 Assessors' guidance

The assessors should check that the practice's approach to recruitment has included production of a person specification and job description relevant to the actual vacancy. Discussion could include the process used for drawing up the person specification e.g. who was involved and the opportunity for reviewing the job description. The practice could demonstrate understanding of how the production of the specification and job description demonstrates good employment practice.

Management Indicator 7

The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:

- **A defined responsible person**
- **Clear recording**
- **Systematic pre-planned schedules**
- **Reporting of faults**

Management 7.1 Practice guidance

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on www.hse.gov.uk**.** The website provides a free booklet "Five steps to risk assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between

inspections and maintenance. For example, a printer may be inspected and maintained by a “competent” person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website, others may also be relevant to the individual practice’s circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

Management 7.2 Written evidence

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

Management 7.3 Assessment visit

Assessors should undertake a review of equipment requiring maintenance, and the log of inspection and maintenance.

Management 7.4 Assessors’ guidance

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule.

The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (e.g. printer) up to larger items such as a steriliser or defibrillator.

Management Indicator 8

The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation, etc.)

Management 8.1 Practice guidance

The practice should have a policy which clearly defines the levels of financial responsibility in the practice. This will include a description of the activities which are carried out by the practice manager (e.g. payroll), other staff (e.g. petty cash) and partners (e.g. calculation of drawings) and will make clear the extent of responsibility. For example, the senior receptionist may be responsible for managing the petty cash on a day-to-day basis and may produce a monthly statement for the practice manager along with handing over cash for banking. The practice manager may then be responsible for checking this and for recording and banking the cash. The practice manager may have overall responsibility for ensuring the management of the petty cash.

The line of accountability for finance in the practice should also be clearly defined. For example, a particular partner may be identified as being responsible on behalf of the partnership for financial management. This responsibility may be delegated to the practice manager, who may have responsibility for day to day bookkeeping, banking and other record-keeping, reconciling the bank statements and preparing regular financial statements for the finance partner. The finance partner will then be responsible to the partnership as a whole.

A fraud prevention policy may cover the following areas:

- a defined partner is responsible with the practice manager for business and finance affairs
- bank accounts are only operable with at least two signatories. The number of non-partners who are signatories should be restricted
- the same individual should where ever possible not be both payee and authorising signatory
- the practice should avoid undue reliance on one member of staff for financial and business controls
- staff are never paid in cash for work undertaken
- there is a written procedure for the removal of cash from petty cash
- all income and expenditure are recorded and reconciled with the bank statement
- purchases of equipment etc are only made with the prior approval of a partner – a level of expenditure may be agreed and set above which approval should be sought
- all transfers between accounts are properly authorised and can be

substantiated
- all cheques signed should be accompanied by appropriate documentation e.g. invoice
- the practice should ensure where possible that one individual does not place an order, authorise the invoice and sign the cheque.

Management 8.2 Written evidence

The policy is provided. (Grade A)

Management 8.3 Assessment visit

Questioning is carried out on the steps taken to prevent fraud.

Management 8.4 Assessors' guidance

The practice's fraud prevention policy is discussed with the practice manager and the partner(s) with financial responsibility.

Management Indicator 9

The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment

Management 9.1 Practice guidance

The practice should produce a procedure for how carers are identified and a referral protocol to social services for assessment of carers with specific needs.

A carer is defined as, 'someone who, without payment, provides help and support to a relative, friend or neighbour, who could not manage to stay at home without their help due to age, sickness, addiction or disability'.

The practice should remember to include any young carers who are particularly vulnerable.

Further information:
'Focus on Carers and the NHS-identifying and supporting hidden carers. Good Practice Guide'
http://www.carers.org/data/files/carersnhs-11.pdf

BMA Guidance on Working with Carers
http://www.bma.org.uk/ap.nsf/Content/Carers

Management 9.2 Written evidence

The protocol is available. (Grade A)

Management 9.3 Assessment visit

The policy is discussed.

Management 9.4 Assessors' guidance

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

Management Indicator 10

There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Management 10.1 Practice guidance

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the Disciplinary and Grievance Procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers on http://www.eoc.org.uk/. Guidance can also be found on the ACAS web site on http://www.acas.org.uk. The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies.
- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at http://www.ihm.org.uk.
- IHM Diversity Group recommendations for Recruitment and Selection.
- Sickness Absence: ACAS as above, including their booklet entitled "Absence and Labour Turnover".
- BMA guidance on managing absence at http://www.bma.org.uk.

Management 10.2 Written evidence

Employment policies should be recorded. (Grade B). Policies should be

consistent with current legislation and indicate a date when the policy has been reviewed.

Management 10.3 Assessment visit

The procedures manual should be inspected.

Management 10.4 Assessors' guidance

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

Medicines Management

	E. Medicines Management
Medicines 2 **2 points**	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis
Medicines 3 **2 points**	There is a system for checking the expiry dates of emergency drugs on at least an annual basis
Medicines 4 **3 points**	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)
Medicines 6 **4 points**	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing
Medicines 7 **4 points**	Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend
Medicines 8 **6 points**	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)
Medicines 10 **4 points**	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change
Medicines 11 **7 points**	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%
Medicines 12 **8 points**	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%

Medicines Indicator 2

The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis

Medicines 2.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states that the excellent doctor “has up-to-date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

Medicines 2.2 Written evidence

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

Medicines 2.3 Assessment visit

The appropriate equipment and drugs are inspected.

Medicines 2.4 Assessors' guidance

The dates of emergency drugs should be checked.

Medicines Indicator 3

There is a system for checking the expiry dates of emergency drugs on at least an annual basis

Medicines 3.1 Practice guidance

Good Medical Practice for General Practitioners (2002) states that the unacceptable GP "has drugs which are out of date" and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors' bags.

Medicines 3.2 Written evidence

The system is described. (Grade C)

Medicines 3.3 Assessment visit

A random sample of doctors' bags and other emergency drugs is checked.

Medicines 3.4 Assessors' guidance

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

Medicines Indicator 4

The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)

Medicines 4.1 Practice guidance

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (Medicines Indicator 8).

Medicines 4.2 Written evidence

The practice leaflet or policy is available. (Grade A). The receptionists are questioned on the policy.

Medicines 4.4 Assessors' guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines Indicator 6

The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing

Medicines 6.1 Practice guidance

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.
Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

Medicines 6.3 Assessment visit

The actions should be discussed.

Medicines 6.4 Assessors' guidance

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

Medicines Indicator 7

Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend

Medicines 7.1 Practice guidance

The consequences of patient default from this system are serious. It is therefore important that the practice's follow-up system is efficient and reliable. However, because of the relatively low number of patients in this group, a simple manual system will often be effective. If the practice has the opportunity for involving a CPN in the patient follow-up system, this can contribute

significantly.

Medicines 7.2 Written evidence

The system should be described. (Grade C)

Medicines 7.3 Assessment visit

The assessors should question the practice team on whether they have patients on injectable neuroleptic medication and ask them to demonstrate the system for identifying and following up those who do not attend. Additionally the practice should be able to demonstrate that they are delivering this service to at least one patient during the QOF year in order to be eligible for the points.

Medicines 7.4 Assessors' guidance

If the patient receives his or her injections from a hospital team that is responsible for this care, then the practice does not need to include those patients who receive their injection in this way in their system. This for example would apply in relation to a CPN who reports to the mental health team rather than to the practice.

Medicines Indicator 8

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)

Medicines 8.1 Practice guidance

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (Medicines Indicator 4).

Medicines 8.2 Written evidence

The practice leaflet or policy is available. (Grade A) The receptionists are questioned on the policy.

Medicines 8.4 Assessors' guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines Indicator 10

The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change

Medicines 10.1 Practice guidance

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

If the PCO prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Medicines 10.2 Written evidence

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing advisor that he or she has been unable to visit within the relevant year.

Medicines 10.3 Assessment visit

Actions and improvements should be discussed.

Medicines 10.4 Assessors' guidance

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

Medicines Indicator 11

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

Standard 80%

Medicines 11.1 Practice guidance

Medication is by far the most common form of medical intervention. Four out of five people over 75 take a prescription medicine and 36 per cent are taking four or more (Medicines and Older People – Supplement to the National Service Framework for Older People, 2001). However, we also know that up to 50 per

cent of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5-17 per cent of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the Briefing Paper http://www.medicines-partnership.org/medication-review/room-for-review/downloads.

The underlying principles of any medication review, whether using the patient's full notes or face to face are:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
4. Any changes resulting from the review are agreed with the patient.
5. The review is documented in the patient's notes.
6. The impact of any change is monitored.

Medicines DO NOT include dressings and emollients but would include topical preparations with an active ingredient such as steroid creams and ointments and hormone preparations.

Medicines 11.2 Written Information

A survey of medication review should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on four or more medications.

Medicines 11.3 Assessment Visit

Inspection of records should be carried out.

Medicines 11.4 Assessors' guidance

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

Medicines Indicator 12

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines.
Standard 80%

Medicines 12.1 Practice Guidance

See Medicines 11.1

Medicines 12.2 Written Information

See Medicines 11.2

Medicines 12.3 Assessment Visit

See Medicines 11.3

Medicines 12.4 Assessors' Guidance

See Medicines 11.4

5.Patient Experience

PE Patient Experience
PE 1 Length of Consultations **33 points** The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.
PE 2 Patient Surveys (1) **25 points** The practice will have undertaken an approved patient survey each year
PE 5 Patient Surveys (2) **20 points** The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that: 1. Summarises the findings of the survey. 2. Summarises the findings of the previous year's survey. 3. Reports on the activities undertaken in the past year to address patient experience issues.
PE 6 Patient Surveys (3) **30 points** The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that: 1. Sets priorities for the next 2 years. 2. Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative). 3. Describes the plans for achieving the priorities, including indicating the lead person in the practice. 4. Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

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

PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things that are crucial parts of general practice, yet cannot easily be measured – e.g. listening to patients, taking time, involving patients in decisions, explaining treatments, in addition to providing high quality care for the many conditions not specifically included in the QOF.

Practices can claim this payment if their normal booking interval is 10 minutes or more. 'Normal' means that three quarters or more of their appointments should be 10 minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

Practices with appointment systems

For practices where three quarters of patients are seen in booked appointments of 10 minutes or more, and surgery sessions are not normally interrupted by 'extras', the contract requirement is met. Extras seen at the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at 10 minute intervals, but six extras are routinely added in, then the average time for patients will be 120/18 = 6.7 minutes, and these slots would not meet the 10 minute requirement. Practices will generally find it easier to decide whether they meet the 'three quarters' requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are 10 minutes or more in length should be three quarters of the total.

6.

7.Practices without appointment systems or with mixed systems

Some practices do not run an appointment system. In this case, or where some surgeries are regularly 'open', practices should measure the actual time of consultations in two separate sample weeks during each year. It is not necessary to do this if fewer than a

quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of 10 minutes or more, as the 'three quarters' requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face to face time has been 8 minutes in three quarters of consultations (equivalent to the face to face time in a 10 minute booked slot), and 5 minutes in the remainder.

Unusual systems

Practices organise consulting in a wide variety of different ways. This Guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

8.

9.PE 1.2 Written evidence

If submitting on length of consultation, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

PE 1.3 Assessment visit

If the practice operates an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year.

If the practice has submitted a survey of consultation length, this should be reviewed.

PE 1.4 Assessors' guidance

The assessors may need to look at a number of sample days to confirm that 75 per cent of consultations have been booked at least at 10 minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the doctors and reception staff on how and when this was carried out.

PE2 Patient Surveys (1)

The practice will have undertaken an approved patient survey each year

PE 2.1 Practice guidance

A practice will meet the contract requirement if it has carried out a survey of patient views in the previous year, using one of two currently approved instruments (GPAQ – the General Practice Assessment Questionnaire, and IPQ – the Improving Practice Questionnaire). It is possible that other instruments will be added to the approved list following submission to and approval by the National Panel.

GPAQ is a shortened version of GPAS which has been developed for the new contract. GPAQ is available with full instructions at www.gpaq.info/s.co.uk

IPQ is available at http://projects.ex.ac.uk/cfep/ipq.htm

Practices have a choice of how to administer their survey. IPQ and GPAQ can both be administered by giving them to patients attending the surgery, and filled in after consultations with the GP. In addition, GPAQ is available in a version designed to be administered by post. In some cases, if practices consent, a PCO may take responsibility for carrying out a postal survey of all practices in its area.

One advantage of administering questionnaires in the surgery is that they can relate to an individual GP, who will then also be able to use the results in his or her revalidation folder. Surveys carried out by post do not generally relate to a named doctor, except in single-handed practices.

If surveys are carried out in the surgery, these should be conducted on consecutive patients. If carried out by post, adult patients should be randomly sampled.

The number of points allocated to this indicator has been decreased in recognition of the need to move towards the practice team actively addressing issues raised from a patient perspective.

A minimum of 25 completed questionnaires per 1000 Contractor Registered Population should be obtained in the survey. In order to obtain this return, practices may need to administer a considerably higher number.

PE 2.2 Written evidence

Practices should provide evidence that the survey has been undertaken including the date and methodology (Grade A).

PE5 Patient Surveys (2)

The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:
1. Summarises the findings of the survey.
2. Summarises the findings of the previous year's survey.
3. Reports on the activities undertaken in the past year to address patient experience issues.

PE 5.1 Practice guidance

The practice will undertake one of the surveys detailed in PE 2.

The practice should examine and summarise the results of the survey from the current and previous year and consider the areas where changes could be made to improve the services and quality of care for patients. This should include a comparison of numerical scores in the relevant survey areas and a review of patient comments. They should then report on the activities they have chosen to undertake to address these issues in their action plan.

The practice need not provide the results of the surveys but should provide an overview of their analysis of the surveys and any subsequent proposals for change. Some proposals for change may have resource consequences which need to be discussed with the PCO. This could take the form of a report from a team meeting.

PE 5.2 Written evidence

A report of the action plan from the practice should be available (Grade A).

PE 6 Patient Surveys (3)

The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:

1. Sets priorities for the next 2 years.
2. Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative).
3. Describes the plans for achieving the priorities, including indicating the lead person in the practice.
4. Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

PE 6.1 Practice guidance

Practices should have undertaken a recommended patient survey and have discussed it as a team. (See PE 2 and PE 3.) and produced an action with priorities as described above. A lead person for patient experience should be identified in each practice.

Subsequently the team should share the contents of the action plan with the most appropriate person or persons which may be a PCO approved patient representative. If the practice has a patient participation group then this group may be used.

If no patient group exists, one could be convened using one or more of the following methods:

- an advertisement placed in the waiting room at least two weeks before the meeting
- a random sample of patients who are written to and invited by the practice at least three weeks in advance of the meeting
- an advertisement in the practice newsletter if the practice has one
- a leaflet handed out by reception staff or a notice on the side of prescriptions.

Practices may wish to convene a focus group with particular service needs e.g. mothers with young children, the elderly, patients whose first language is not English, patients with mental health problems etc, with which to share the results of the surveys and action plan.

PE 6.2 Written evidence

Practices should submit a copy of their action plan, with evidence that some change has been achieved e.g. through patient report or by demonstrating a positive change in the patient survey (Grade A).

Additional Services

For practices providing additional services the following organisational markers will apply.

Additional	Cervical Screening (CS)
CS 1 **11 points**	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 40 – 80%
CS 5 **2 points**	The practice has a system for informing all women of the results of cervical smears
CS 6 **2 points**	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years
CS 7 **7 points**	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/ recall, exception reporting and the regular monitoring of inadequate smear rates
Additional	**Child Health Surveillance (CHS)**
CHS 1 **6 points**	Child development checks are offered at intervals that are consistent with national guidelines and policy
Additional	**Maternity Services (MAT)**
MAT 1 **6 points**	Ante-natal care and screening are offered according to current local guidelines
Additional	**Contraceptive Services (CON)**
CON 1 **1 point**	The team has a written policy for responding to requests for emergency contraception
CON 2 **1 point**	The team has a policy for providing pre-conceptual advice

CS Indicator 1

The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last 5 years Standard 25 – 80%

CS 1.1 Practice guidance

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged from 25 to 64 (from 21 to 60 in Scotland, from 20 to 64 in Wales and from 20 to 65 in Northern Ireland) who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 40 and 80 per cent, in a similar fashion to the clinical indicators.

Exception reporting (as detailed in the clinical section) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

CS 1.2 Written evidence

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had an a cervical smear performed in the last 5 years. (Grade A). In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

CS 1.3 Assessment visit

The print-out should be inspected.

CS 1.4 Assessors' guidance

The assessors should enquire on how patients who are exception-reported are identified and recorded.

CS Indicator 5

The practice has a system for informing all women of the results of cervical smears

CS 5.1 Practice guidance

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outwith the practice.

CS 5.2 Written evidence

There should be a description of system and example of letters sent to patients (Grade C).

CS 5.3 Assessment visit

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

CS 5.4 Assessors' guidance

A letter sent to the patient containing and explaining the result is ideal.

CS Indicator 6

The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years

CS 6.1 Practice guidance

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear-takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

CS 6.2 Written evidence

An audit of inadequate smears should be recorded. (Grade A)

CS 6.3 Assessment visit

A discussion with smear-takers should take place, dealing with the audit and any educational needs which arose and how these were met.

CS 6.4 Assessors' guidance

All the elements for an audit stated in the practice guidance need to be present.

CS Indicator 7

The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates

CS 7.1 Practice Guidance

If a robust system for the management of cervical screening is not in place then

this is an area of great risk for general practice. The policy may have been drawn up outwith the practice and should be in line with national guidance.

CS 7.2 Written Evidence
There should be a written policy covering the issues outlined above (Grade A).

CS 7.3 Assessment Visit
The policy should be discussed with relevant staff and the practice should demonstrate how the systems operate.

CS 7.4 Assessors Guidance
It may be necessary to ask the practice to demonstrate how its policy operates.

CHS Indicator 1

Child development checks are offered at intervals that are consistent with national guidelines and policy

CHS 1.1 Practice guidance

The child health surveillance programme should be based on national guidelines. It is important that the practice has a system to ensure follow-up of any identified problem and that referrals are made as appropriate.

CHS 1.2 Written evidence

There should be a description of the child health surveillance programme and how problems are followed up. (Grade C)

CHS 1.3 Assessment visit

The practice team is asked for details of child health surveillance in the practice and how problems are followed up.

CHS 1.4 Assessors' guidance

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure problems are followed up.

MAT Indicator 1

Anti-natal care and screening are offered according to current local guidelines

MAT 1.1 Practice guidance

Most local areas have produced guidelines, which should be adopted within the

practice.

MAT 1.2 Written evidence

There should be written guidelines on ante-natal care and screening. (Grade A)

MAT 1.3 Assessment visit

The assessment should involve a description of ante-natal care, using the illustration of one case.

MAT 1.4 Assessors' guidance

The case should show that the guidance is known and is being used.

CON Indicator 1

The team has a written policy for responding to requests for emergency contraception

CON 1.1 Practice guidance

The purpose of the policy is to ensure requests for emergency contraception are appropriately handled so that it can be offered within the effective time. Receptionists as well as clinicians will need to be aware of and act on the policy.

CON 1.2 Written evidence

There should be a written policy on responding to requests for emergency contraception. (Grade A)

CON 1.3 Assessment visit

The policy should be discussed.

CON 1.4 Assessors' guidance

The policy must allow emergency contraception to be given within the effective time.

CON Indicator 2

The team has a policy for providing pre-conceptual advice

CON 2.1 Practice guidance

The policy should cover such areas as smoking, alcohol, diet, prophylactic folic acid, rubella status, any genetically inherited condition, substance abuse and any pre-existing medical condition.

CON 2.2 Written evidence

There should be a written policy for providing pre-conceptual advice. (Grade A)

CON 2.3 Assessment visit

The policy should be discussed.

CON 2.4 Assessors' guidance

All the elements contained in the practice guidance (2.1) should be present in the policy. ".