

Quality and Outcomes Framework guidance for GMS contract 2009/10

Delivering investment in general practice

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Quality and Outcomes Framework guidance for GMS contract 2009/10

This guidance has been produced jointly by NHS Employers and the General Practitioners Committee and forms part of the contract changes for the General Medical Services Contract for 2009/10. It replaces all guidance issued in previous years.

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 – rationale and reporting/verification.

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 (for example 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 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.

All reporting should be possible through the use of GP clinical systems and practices can 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:

www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/qmas

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

www.paymodernisation.scot.nhs.uk/gms/quality/index.htm

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 suggested have an identifiable source in the clinical record.

PCOs may also wish to use these principles in the verification of other indicators.

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.

1.3 Logical Query Indicator Specification and the Dataset and Business Rules

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, Clinical Terms Version 3 and SNOMED) 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.

The Logical Query Indicator Specification and the Dataset and Business Rules are updated twice a year and can be downloaded from www.pcc.nhs.uk

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, for example 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, for example 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, for example 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, for example 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 coronary heart disease (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.

Exception reporting guidance can be found at the following location:
www.pcc.nhs.uk/uploads/QOF/october_06/qof212_exception_reporting_guidance_final.pdf

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 (SFE).

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	17	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 5mmol/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%

Cardiovascular disease – primary prevention

Indicator	Points	Payment stages
Initial diagnosis		
PP 1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.	8	40-70%
Ongoing management		
PP 2. The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5	40-70%

Heart failure

Indicator	Points	Payment stages
Records		
HF 1. The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF 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	6	40-90%
Ongoing management		
HF 3. The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contra-indication	10	40-80%

HF 4. 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 are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.	9	40-60%
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Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
Records		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA 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 5mmol/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%

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	18	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	40-70%

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 patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months	3	40-90%
DM 23. The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40-50%
DM 24. The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	8	40-70%
DM 25. The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	10	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 the previous 15 months is 5mmol/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 (COPD)

Indicator	Points	Payment stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 12. The percentage of all patients with COPD diagnosed after 1 April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	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 13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

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 stages
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		
PC 3. The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
Ongoing management		
PC 2. 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%
MH 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	6	25-50%
MH 7. 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		
DEM 1. The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM 2. 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
Records		
DEP 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	8	40-90%
DEP 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	25	40-90%
DEP 3. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care	20	40-90%

Chronic kidney disease (CKD)

Indicator	Points	Payment stages
Records		
CKD 1. 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		
CKD 2. 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		
CKD 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	11	40-70%
CKD 5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	9	40-80%
CKD 6. The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months	6	40-80%

Atrial fibrillation

Indicator	Points	Payment stages
Records		
AF 1. The practice can produce a register of patients with atrial fibrillation	5	
Initial diagnosis		
AF 4. The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis	10	40-90%
Ongoing management		
AF 3. The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	12	40-90%

Obesity

Indicator	Points	Payment stages
Records		
OB 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	8	

Learning disability

Indicator	Points	Payment stages
Records		
LD 1. The practice can produce a register of patients aged 18 and over with learning disabilities	4	

Smoking

Indicator	Points	Payment stages
Ongoing management		
SMOKING 3. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months	30	40-90%
SMOKING 4. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses 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	30	40-90%

Organisational domain

Records and information

	Indicator	Points
Records 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
Records 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
Records 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%	4
Records 11	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients	10
Records 13	There is a system to alert the out-of-hours service or duty doctor to patients dying at home	2
Records 15	The practice has up-to-date clinical summaries in at least 60% of patient records	25
Records 17	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients	5
Records 18	The practice has up-to-date clinical summaries in at least 80% of patient records	8
Records 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
Records 20	The practice has up-to-date clinical summaries in at least 70% of patient records	12
Records 21	Ethnic origin is recorded for 100% of new registrations	1
Records 23	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months (payment stages 40 – 90%)	11

Information for patients

	Indicator	Points
Information 4	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	1
Information 5	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2

Education and training

	Indicator	Points
Education 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	4
Education 5	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
Education 6	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
Education 7	<p>The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include:</p> <ul style="list-style-type: none"> • 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 <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)</p>	4
Education 8	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5

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

Practice management

	Indicator	Points
Management 1	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
Management 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	1
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	0.5
Management 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 with the PCO	3
Management 7	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> • a defined responsible person • clear recording • systematic pre-planned schedules • reporting of faults 	3
Management 9	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
Management 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	2

Medicines management

	Indicator	Points
Medicines 2	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
Medicines 3	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
Medicines 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)	3
Medicines 6	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
Medicines 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)	6
Medicines 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	4
Medicines 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%	7
Medicines 12	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%	8

Patient experience domain

Indicator	Points	Payment stages
<p>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</p>	33	
<p>PE 7 Patient experience of access (1) The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours)</p>	23.5	70-90%
<p>PE 8 Patient experience of access (2) The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.</p>	35	60-90%

Additional services

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

Cervical screening (CS)

	Indicator	Points
CS 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 five years (payment stages 40 – 80%)	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 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	2
CS 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	7

Child health surveillance (CHS)

	Indicator	Points
CHS 1	Child development checks are offered at intervals that are consistent with national guidelines and policy	6

Maternity services (MAT)

	Indicator	Points
MAT 1	Ante-natal care and screening are offered according to current local guidelines	6

Contraception (SH)

	Indicator	Points
SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months. (payment stages 40 – 90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (payment stages 40 – 90%)	3

Secondary prevention of 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	17	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 5mmol/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 most common 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 96.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/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 96.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/index.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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. 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.
- iii. 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.

Further Information: www.bhsoc.org/NICE_BHS_Guidelines.stm

A major overview of randomised trials showed that a reduction of 5-6 mm Hg in blood pressure sustained over five 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 Guidelines 93, 96, 97.

Further Information: www.sign.ac.uk/guidelines/fulltext/93-97/index.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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol.
- iii. 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 93, 96 and 97 recommend that patients who have 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol 5mmol/l or less.
- iii. 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 anticoagulant 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 96 and 97.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/index.html
www.sign.ac.uk/guidelines/fulltext/97/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:
 - i. 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.
 - ii. The presence of raised blood levels of markers of cardiac cell damage such as troponin.

Further information: www.nice.org.uk/Guidance/TA80
www.nice.org.uk/Guidance/TA90

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 Guideline 96 and 97.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/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 96.

Grade A Recommendation NICE Guideline A.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/index.html
www.escardio.org/guidelines-surveys/esc-guidelines/Pages/GuidelinesList.aspx

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.

Cardiovascular disease – primary prevention

Indicator	Points	Payment stages
Initial diagnosis		
PP 1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.	8	40-70%
Ongoing management		
PP 2. The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5	40-70%

Cardiovascular disease – primary prevention – rationale for inclusion of indicator set

CVD is the commonest cause of death in the UK, and importantly for patients, the major cause of premature death (before 65). Moreover, of greater significance for the NHS, CVD is now the commonest cause of disability (through stroke and heart failure particularly) and hospital admission. This results in CVD being the major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

Primary prevention (PP) works and evidence based interventions can dramatically reduce risk – in North Karelia which had the highest CVD rates in Europe 25 years ago, CVD mortality has reduced by 50% through rigid implementation of public health and individual patient interventions. An analysis of CHD trends in Ireland found that over a 15 year period, primary prevention achieved a two-fold larger reduction in CHD deaths than secondary prevention, with 68% of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in people without recognised CHD compared to 32% in CHD patients.¹

¹ Kabir Z., Bennett K., Shelley E., Unal B., Critchley J., Capewell S. Comparing primary prevention with secondary prevention to explain decreasing Coronary Heart Disease death rates in Ireland, 1985-2000. BMC Public Health 2007, 7:17

Primary prevention (PP) indicator 1

PP 1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment tool.

Primary prevention 1.1 Rationale

To deliver primary prevention of CVD requires that patients at risk are identified before disease has become established and that requires screening.

Current NICE Guidance (May 2008) recommends that the Framingham 1991² 10 year risk equations should be used to assess CVD risk. The variables required for this estimation are:

- Age
- Sex
- Systolic blood pressure (mean of previous two systolic readings)
- Total cholesterol
- HDL cholesterol
- Smoking status
- Presence of left ventricular hypertrophy.

Key to this assessment however, is that it should be an assessment of actual as opposed to estimated risk. The values used should have been recorded no longer than 6 months before the date of the risk assessment and prior to any treatment for hypertension.

This risk equation should not be used for people with:

- Coronary Heart Disease or angina
- Stroke or TIA
- Peripheral vascular disease
- Familial hypercholesterolemia
- Diabetes
- Chronic Kidney Disease where the patient has an eGFR value below 60.

Further information: *Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease*. Clinical Guideline 67. NICE: London 2008.

www.nice.org.uk/nicemedia/pdf/CG067NICEGuideline.pdf

2 NICE CG67, Appendix H (p.41) www.nice.org.uk/nicemedia/pdf/CG67FullGuidelineAppendixEFGHIJ.pdf
 Original ref: Anderson KM, Odell PM, Wilson PW et al. (1991) Cardiovascular disease risk profiles. American Heart Journal 121: 293-8. Risk profile only:
www.framinghamheartstudy.org/risk/coronary.html

It would be inappropriate to use the risk score for those patients already taking lipid lowering medication prior to a new diagnosis of hypertension.

The ASSIGN cardiovascular risk score was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham based risk scores for Scottish populations. (see www.assign-score.com) and continues to be developed. It is available through a web link to practices in Scotland and encompasses deprivation related risk due to post code.

Scottish practices should use the ASSIGN risk score or the Framingham 1991 10 year risk equations for the purposes of this indicator.

Primary prevention 1.2 Reporting and verification

The practices reports the number of patients with a new diagnosis of hypertension (excluding those with a pre-existing diagnosis of CHD, diabetes, stroke and/or TIA) in the preceding 1 April to 31 March and the percentage of these patients who have had a face to face CVD risk assessment within 3 months before and after the date of diagnosis using an agreed risk assessment tool.

Verification – PCOs may randomly select a number of case records of patients in which a risk assessment has been recorded as taking place to confirm that the key risk factors have been addressed and that biochemical and other clinical data used to inform the risk assessment are up-to-date.

Primary prevention (PP) Indicator 2

The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Primary prevention 2.1 Rationale

There is considerable evidence to support the positive impact of increasing physical activity, smoking cessation, reducing unsafe alcohol consumption, and improving diet on cardiovascular health.

Patients with hypertension are at increased risk of developing CVD and this risk can be reduced, not only by treating their hypertension, but by also reducing lifestyle risks.

Practices should refer to recognised guidance and advice on advising patients on lifestyle risk.

Further information:

Smoking Cessation: guidance and recent developments in smoking cessation in Smoking Cessation Update 2007 – (NHS Health Scotland and ASH Scotland).

www.healthscotland.com/documents/1762.aspx

Alcohol SIGN Guideline 74.

www.sign.ac.uk/guidelines/fulltext/74/index.html

Plan for Action on Alcohol Problems Update Scottish Government 2008.

www.scotland.gov.uk/Publications/2007/02/19150222/12

Diet and physical activity Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) Scottish Government 2008.

www.scotland.gov.uk/Publications/2008/06/20155902/10

Further information on the management of lifestyle factors can be found in *Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease*. Clinical Guideline 67. NICE: London 2008.

This advice should be reiterated on an annual basis.

Primary prevention (PP) 2.2 Reporting and verification

Practices should report the percentage of people diagnosed with hypertension on or after 1 April 2009 who have been given lifestyle advice in the previous 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

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

Heart failure

Indicator	Points	Payment stages
Records		
HF 1. The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF 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	6	40-90%
Ongoing management		
HF 3. The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contra-indication	10	40-80%
HF 4. 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 are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.	9	40-60%

Heart failure – rationale for inclusion of indicator set

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). This indicator set refers to all patients with heart failure unless specified otherwise.

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 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 investigated³ and this is expected to involve, as a minimum, specialist investigation (such as echocardiography or natriuretic 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 scintigraphy or angiography rather than echocardiography. Current guidance⁴ requires either echocardiography or specialist assessment for all patients with suspected heart failure, regardless of presumed aetiology.

Further information:

www.nice.org.uk/nicemedia/pdf/CG5NICEguideline.pdf

www.sign.ac.uk/guidelines/fulltext.95/index.html

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 Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), 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 ARBs is strong, however, this should only be after first attempting to initiate ACE inhibitors.⁵

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.

3 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

4 Remme et al. *Eur Heart J* 2001; 22: 1527-60

5 Pfeffer et al. *Lancet* 2003; 362: 759-766

Further information:

www.clinicalevidence.com/ceweb/conditions/cvd/0204/0204_113.jsp

www.sign.ac.uk/guidelines/fulltext/95/index.html

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.

Heart failure (HF) indicator 4

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 are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

Heart failure 4.1 Rationale

The evidence base for treating heart failure due to LVD with beta-blockers^{6,7} is at least as strong as the evidence base guiding the HF 3 indicator on ACE inhibitors (Level Ia), with a 34% reduction in major endpoints of beta-blockers on top of ACE inhibitors compared to placebo, and is a standard recommendation in all heart failure guidelines including NICE. The belief that beta-blockers are contra-indicated in heart failure was disproved, at least for the licensed beta-blockers, in the late 1990s and in some countries (especially Scandinavia) beta-blockers have never been contraindicated in heart failure. Furthermore, there are no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised people over 75 with significant benefits and no safety signal) and there are no contra-indication for use in people with COPD.

However, this strategy is more difficult in clinical practice than initiating ACE (more contra-indications, less tolerated, with a need for slower but more dose titration steps). Furthermore, there are negative trials of beta-blockers in heart failure⁸ and concerns over the effectiveness of atenolol in reducing vascular risk generally. Therefore the beta blocker used should be one licensed for heart failure, which is also in line with NICE recommendations. The only such agents in the UK are carvedilol, bisoprolol and nebivolol.

However, despite the evidence above, initiating beta-blockers in heart failure, or switching from one not licensed for heart failure, is more difficult because of the need to titrate from low doses and small increments over repeated visits. Patients also often suffer a temporary deterioration in symptoms with beta-blocker initiation which needs monitoring. The British National Formulary states that 'beta-blockers bisoprolol and

6 Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrandt P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J; MERIT-HF Study Group. Efficacy, safety and tolerability of metoprolol CR/XL in patients with diabetes and chronic heart failure: experiences from MERIT-HF. *Am Heart J*. 2005; 49 (1):159-67.

7 CIBIS-II Investigators and Committees. The Cardiac Insufficiency Bisoprolol Study II. *Lancet* 1999; 353: 9-13.

8 Anderson JL, Krause-Steinrauf H, Goldman S, Clemson BS, Domanski MJ, Hager WD, Murray DR, Mann DL, Massie BM, McNamara DM, Oren R, Rogers WJ; Beta-Blocker Evaluation of Survival Trial (BEST) Investigators. Failure of benefit and early hazard of bucindolol for Class IV heart failure. *J Card Fail*. 2003; 9 (4): 266-77

carvedilol are of value in any grade of stable heart failure and left-ventricular systolic dysfunction; nebivolol is licensed for stable mild to moderate heart failure. Beta-blocker treatment should be started by those experienced in the management of heart failure, at a very low dose and titrated very slowly over a period of weeks or months. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy'.⁹

Heart failure 4.2 Reporting and verification

The practice reports 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 are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

9 www.bnf.org/bnf/bnf/current/119651.htm (password protected site)

Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
Records		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA 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 5mmol/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, for example 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 13

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

Stroke 13.1 Rationale

The original indicator, stroke 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.

The NAO Report¹⁰ highlights that UK national guidelines recommend that all patients with suspected TIA should be assessed and investigated within seven days, but notes that only a third of people with TIA are seen in a clinic. The UK Guideline and the NAO concern reflect the evidence that there is a high early risk of stroke following TIA, and that there is insufficient recognition of the serious nature of this diagnosis.

This indicator refers to patients diagnosed with a stroke or a TIA from 1 April 2008. Practices should note that a referral should be considered for each new stroke or TIA unless specific agreement has been reached with a local specialist not to refer the patient. A new TIA in someone who has had previous TIAs should be treated as an urgent case.

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

¹⁰ Reducing brain damage: faster access to better stroke care. London; The Stationary Office 2005

Stroke 13.2 Reporting and verification

The practice should report those patients who have been referred for further investigation within one month of being added to the register in whom a new diagnosis of stroke or TIA has been made since 1 April 2008. 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with stroke or TIA diagnosed after 1 April 2008 to look at the proportion referred for further investigation.
- iii. 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.¹¹ The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in people with prior stroke or TIA.¹²

Grade A Recommendation RCP Stroke Guideline 2004.

Further Information: 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.

11 Collins et al. *Lancet* 1990; 335: 827-38

12 PROGRESS Collaborative Group, *Lancet* 2001; 358:1033-41

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.¹³ Subsequent sub-group analyses demonstrated that in patients with prior stroke or TIA, statin therapy reduced risk of subsequent vascular events.¹⁴ An economic analysis of this trial concluded that it was highly cost-effective to treat such patients.¹⁵

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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.

Stroke indicator 8

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.

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).

¹³ Heart Protection Study Collaborative Group, *Lancet* 2002; 360:7-22

¹⁴ Heart Protection Study Collaborative Group, *Lancet* 2004; 363:757-767

¹⁵ Heart Protection Study Collaborative Group, *Lancet* 2005; 365:1779-85

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 108.

Further information: www.sign.ac.uk/guidelines/fulltext/108/index.html

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: 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.'

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 108.

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.¹⁶ This is included in JCVI recommendations.

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.

16 Lavalley et al. *Stroke* 2002; 33: 513-518; Nichol et al. *NEJM* 2003; 348:1322-32

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	18	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	40-70%

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: 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 nine 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: 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 DM 12. For patients with chronic kidney disease, see CKD 4.

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 HbA1c or equivalent in the previous 15 months	3	40-90%
DM 23. The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40-50%
DM 24. The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	8	40-70%
DM 25. The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	10	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 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 the previous 15 months is 5mmol/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:

www.diabetes.org.uk/catalogue/reports.htm

And by SIGN – the Scottish Intercollegiate Guidelines Network.

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 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.

Diabetes 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 (usually overnight) 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.

Diabetes 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 for 04/05.

Diabetes (DM) indicator 2

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

Diabetes 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.

Diabetes 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 (DM) indicator 5

The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months.

Diabetes 5.1 Rationale

HbA1c 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 HbA1c measurement.

NICE Guidance for Type 2 diabetes 2008: www.nice.org.uk/Guidance/CG66

For the purposes of contract monitoring the indicator has been set at a minimal level assuming an HbA1c measurement at least annually.

There are proposals to modify the reporting of HbA1c during 2009-2010, so that results are also reported in mmol/mol. However laboratories will continue to report using the current percentage figure until April 2011. The QOF criteria for 2009-2010 are therefore based on the current arrangements to report HbA1c as a percentage figure.

Diabetes 5.2 Reporting and verification

The practice should report the percentage of diabetic patients who have had an HbA1c 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded HbA1c in last 15 months.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 23

The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

Diabetes 23.1 Rationale

The relationship between hyperglycaemia and cardiovascular risk is essentially linear, so for those with raised HbA1c levels, better glycaemic control should lead to reduced cardiac risk. For people with Type 1 diabetes, the finding of a 42% reduction in cardiovascular events in those treated intensively in the DCCT trial provides evidence for this (DCCT/EDICT, 2005). Similarly, 10 year follow-up data from the UKPDS trial showed significantly less cardiovascular disease in those patients with Type 2 diabetes who were intensively treated (Holman et al, 2008).

The three target levels for HbA1c (7%, 8% and 9%) are designed to provide an incentive to improve glycaemic control across the distribution of HbA1c values. The lower level may not be achievable for all patients, but the payment thresholds reflect this. Also practitioners should note that in the 2008 guidance for Type 2 diabetes NICE advises against pursuing highly intensive management to levels below 6.5%.

NICE Guidance for Type 2 diabetes 2008: www.nice.org.uk/Guidance/CG66

NICE identifies the following key priorities to help people with Type 2 diabetes achieve better glycaemic control:

- Offer structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care
- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition

- When setting a target glycated haemoglobin:
 - involve the person in decisions about their individual HbA1c target level, which may be above that of 6.5 % set for people with Type 2 diabetes in general
 - encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life
 - offer therapy (lifestyle and medication) to help achieve and maintain the HbA1c target level
 - inform a person with a higher HbA1c that any reduction in HbA1c towards the agreed target is advantageous to future health
 - avoid pursuing highly intensive management to levels of less than 6.5%
- Offer self-monitoring of plasma glucose to a person newly diagnosed with Type 2 diabetes only as an integral part of his or her self-management education. Discuss its purpose and agree how it should be interpreted and acted upon
- When starting insulin therapy, use a structured programme employing active insulin dose titration that encompasses: structured education, continuing telephone support, frequent self-monitoring, dose titration to target, dietary understanding, management of hypoglycaemia, management of acute changes in plasma glucose control, support from an appropriately trained and experienced healthcare professional
- References.¹⁷

Diabetes 23.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 7 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 7 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 7 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 24

The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

17 References: Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HA. 10-Year Follow-up of Intensive Glucose Control in Type 2 Diabetes. *The New England Journal of Medicine* 2008; 359(15):1577-1589. DCCT/EDIC Study Research Group. Intensive Diabetes Treatment and Cardiovascular Disease in Patients with Type 1 Diabetes. *The New England Journal of Medicine* 2005; 353(25):2643-2653

Diabetes 24.1 Rationale

See DM 23.1 above. Auditing the proportion of patients with an HbA1c below 8% is designed to provide an incentive to improve glycaemic control across the range of HbA1c values.

Diabetes 24.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 8 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 8 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 8 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 25

The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

Diabetes 25.1 Rationale

See DM 23.1 above. Auditing the proportion of patients with an HbA1c below 9% is designed to provide an incentive to improve glycaemic control amongst those with high levels of HbA1c who are at particular risk. The target level has been reduced in order to provide an incentive to improve the care of more people with high levels of HbA1c.

Diabetes 25.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 9 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with last recorded HbA1c 9 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 9 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.

Diabetes 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: 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.

In Scotland, the local Diabetic Retinopathy Screening (DRS) service provided under the auspices of the Scottish DRS Programme, is the only approved screening service for the purposes of this indicator (HDL 2006).

Diabetes 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.

Diabetes 9.1 Rationale

Patients with diabetes are at high risk of foot complications. Inspection for vasculopathy and neuropathy is needed to detect problems. These checks should be carried out at an annual review.

Patients with diabetes with foot problems are likely to benefit from referral to specialist diabetic podiatry services.

Foot risk stratification

Although absent pulses and neuropathy are risk factors for foot ulceration, there are other factors which are better predictors, e.g. previous ulceration. Also the presence of these conditions does not direct the clinician towards what to do practically. As a result foot risk stratification programmes have been introduced across Scotland and in many areas in England and Wales. Foot risk scores integrate a few of the best simple clinical predictors of foot ulceration (including pulses, neuropathy, previous ulceration and foot deformity), so that patients are categorized into high, moderate and low risk categories, which then directly relate to the care that is recommended for that patient.

Further information: NICE guidelines (2002). Type-2 diabetes. Prevention and management of foot problems. Section 6. Foot care management for people with diabetes: recommendations (p45).

www.nice.org.uk/nicemedia/pdf/CG10fullguideline.pdf

International Working Group for the Diabetic Foot: Guidelines on screening (2007).

www.iwgdf.org/index.php?option=com_content&task=view&id=39&Itemid=60

Diabetes Action Plan (Scottish Diabetes Framework). Scottish Executive 2006.

www.scotland.gov.uk/Resource/Doc/129328/0030795.pdf

SIGN guideline 55 (2001) Management of Diabetes.

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

These checks should be carried out at an annual review.

Diabetes 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.

Diabetes 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.

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

Diabetes 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.

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

Diabetes 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.

Diabetes 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: 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.

www.bhsoc.org/Latest_BHS_management_Guidelines.stm

NICE inherited guideline H.

www.nice.org.uk/page.aspx?o=38551

Diabetes 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).

Diabetes 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.

Urinary microalbuminuria has been identified as an independent risk factor for cardiovascular complications. Its presence is therefore a pointer to the need for more rigorous management of all cardiovascular risk factors. 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: www.sign.ac.uk/guidelines/fulltext/55/index.html
www.nice.org.uk/article.asp?a=27964

Health Technology Assessment Review 2005.

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.

Diabetes 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.

Diabetes 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.

Diabetes 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded eGFR or serum creatinine.
- iii. 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).

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

Diabetes 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.

Diabetes 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: 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.

Diabetes 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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.

- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol.
- iii. 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 5mmol/l or less.

Diabetes 17.1 Rationale

If total cholesterol is greater than 5.0mmol/l, statin therapy to reduce cholesterol should be initiated and titrated as necessary to reduce total cholesterol to less than 5mmol/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 the prescription of a statin should be considered for all diabetic patients over the age of 40, particularly if their cholesterol is greater than 5.0mmol/l. 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.¹⁸

Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction Haffner et al.¹⁹

SIGN Guideline 97: Risk estimation and the prevention of cardiovascular disease
www.sign.ac.uk/guidelines/fulltext/97/index.html

Diabetes 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:

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

18 *Lancet* 2003; 361:2005-2016

19 *NEJM* 1998; 339: 229-234

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.

Diabetes 18.1 Rationale

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

Diabetes 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 (COPD)

Indicator	Points	Payment stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 12. The percentage of all patients with COPD diagnosed after 1 April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	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 13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50-90%
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 post bronchodilator spirometry.

See COPD 12.1.

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 post bronchodilator 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 12

The percentage of all patients with COPD diagnosed after 1st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry.

COPD 12.1 Rationale

COPD is diagnosed if:

- the patient has an FeV1 of less than 80 per cent of predicted normal
- and has an FeV1/FVC ratio of less than 70 per cent
- and the patient has symptoms consistent with COPD.

Spirometry should be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400mcg salbutamol).

Prior to performing post-bronchodilator spirometry, patients do not need to stop any therapy, such as long acting bronchodilators or inhaled steroids.

All of these elements are required to make the diagnosis of COPD. Routine reversibility testing is not recommended in NICE, and the GOLD guidelines require post bronchodilator spirometry for diagnosis and grading. Failure to use post bronchodilator readings overestimated the prevalence of COPD by 25%.²⁰ This change will reduce workload in primary care and removes the conflict with evidence based guidelines.

Where doubt occurs as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. 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. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FeV1 of <80% of predicted normal as well as an appropriate medical history.

20 Johannessen et al. *Thorax* 2005; 60(10): 842-847

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

Further information: Global Strategy for the Diagnosis, Management and Prevention of COPD 2006.

www.goldcopd.org.

NICE Clinical Guideline 2004.

www.nice.org.uk/guidance/index.jsp?action=download&o=29303

www.thorax.bmj.com/content/vol59/suppl_1/

For the purposes of the QOF, post bronchodilator 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 12.2 Reporting and verification

Practices should report the percentage of patients diagnosed after 1 April 2008 who are on their COPD register, who have a record that the diagnosis has been confirmed by post bronchodilator spirometry.

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with COPD to look at the proportion with a record of post bronchodilator spirometry.
- iii. Inspection of a sample of records of patients for whom a record of post bronchodilator 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 www.thorax.bmj.com/content/vol59/suppl_1/

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. www.goldcopd.com/

Referral can be to a general physician, a respiratory physician or a GP with a special interest (GPwSI) 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with COPD to look at the proportion with spirometry results in the last two years.
- iii. 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 13

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.

COPD 13.1 Rationale

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management should be based on NICE guideline CG12 and international GOLD guidelines in terms of both drug and non-drug therapy.

In making assessments of the patient's condition as part of an annual review and when considering management changes it is essential that health care professionals are aware of:

- current lung function
- exacerbation history
- degree of breathlessness (MRC dyspnoea scale) and

A tool such as the Clinical COPD Questionnaire could be used to assess current health status.

Additionally 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. Where a patient is prescribed an inhaled therapy their technique should be assessed during any review.

The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available through the link below, under Diagnosing COPD, table 3.

www.thorax.bmj.com/content/vol59/suppl_1/

Further information on management of COPD:

www.thorax.bmj.com/content/vol59/suppl_1/

www.nice.org.uk/Guidance/CG12

www.goldcopd.com

www.ccq.nl

COPD 13.2 Reporting and verification

The practice should report the percentage of patients on the COPD register who have had a review of their COPD by a healthcare professional which included an assessment of breathlessness using the MRC dyspnoea score in the preceding 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 defined elements are recorded as having been addressed, if applicable.

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 appropriate clinical management can enable most people with epilepsy to lead a full and productive life. For the purposes of the QOF, epilepsy is defined as ‘recurrent unprovoked seizures.’

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 outside of primary care.

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 recognising that reported prevalence will be reduced as the register is limited to those receiving drug treatment.

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: 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 face to face review, where clinically appropriate. This guidance is due for review in 2008/9.

Further information: www.nice.org.uk/guidance/index.jsp?action=byID&o=10954

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 seizure 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 seizures 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 seizures as accurately as possible.

Leaflets for patients with epilepsy, including advice about medication, are available through Epilepsy Scotland on the link below:

www.epilepsyscotland.org.uk/information_section/healthpro/information_healthpro.html

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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with hypothyroidism to look at the proportion with recorded TSH/T4.
- iii. 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 stages
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. Better Cancer Care: An Action Plan.

www.scotland.gov.uk/Publications/2008/10/24140351/0

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		
PC 3. The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
Ongoing management		
PC 2. 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

Palliative care is the active total care of patients with life-limiting disease and their families by a multi-professional team. The first National End of Life Care (EOLC) Strategy was published in July 2008. It builds on work such as the NHS cancer plan 2000, NICE guidance 2004, NHS EOLC programme 2005 and was informed by the consultation including primary care in the Darzi end of life workstream.

In Scotland, "Living and Dying Well, a national action plan for palliative and end of life care in Scotland" 2008 places great emphasis on the role of primary care in providing palliative care for all patients with such needs, regardless of diagnosis. The action plan uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland.

www.scotland.gov.uk/Publications/2008/10/01091608/0

The way primary care teams provide palliative care in the last months of life has changed and developed extensively in recent years with:

- over 99% of practices now using a palliative care register since the introduction of this indicator set
- specific emphasis on the inclusion of patients with non-malignant disease and of all ages since April 2008
- patients and carers being offered more choice regarding their priorities and preferences for care including their preferred place of care in the last days of life. (Evidence shows that more patients achieve a home death if they have expressed a wish to do so.)
- increasing use of anticipatory prescribing to enable rapid control of symptoms if needed and a protocol or integrated care pathway for the final days of life

- identification of areas needing improvement by the National Audit Office e.g. un-necessary hospital admissions during the last months of life.²¹

The National EOLC Strategy and “Living and Dying Well” suggest that all practices should adopt a systematic approach to end of life care and work to develop measures and markers of good care. They recommend the Gold Standards Framework (GSF) and the associated After Death Analysis (ADA) as examples of good practice. Evidence suggests that over 60% of practices across the UK now use GSF to some degree to improve provision of palliative care by their primary care team.

The introduction of Gold Standard Framework (GSF) to primary care and its associated audit tool, the ADA are associated with a considerable degree of research and evaluation. GSF provides ideas and tools that help practices to focus on implementing high quality patient centred care.

www.goldstandardsframework.nhs.uk

Palliative care (PC) indicator 3

The practice has a complete register of all patients in need of palliative care/support, irrespective of age.

Palliative care 3.1 Rationale

About 1% of the population in the UK die each year (over half a million), an average of 20 deaths per GP per year. A quarter of all deaths are due to cancer, a third from organ failure, a third from frailty or dementia, and only one twelfth of patients have a sudden death. It should be possible therefore to predict the majority of deaths, however, this is difficult, with errors occurring, 30 per cent of the time. Two thirds of errors are based on over optimism and one third on over pessimism. However the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them and anticipating need.

Identifying patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. Therefore this QOF indicator set is focused on the maintenance of a register, (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient’s care have been assessed and future care can be co-ordinated and planned proactively.

A patient should be included on the register if any of the following apply:

1. their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask themselves ‘the surprise question’ – ‘Would I be surprised if this patient were still alive in 12 months?’).
2. they have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have 1 core and 1 disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of GSF website).
www.goldstandardsframework.nhs.uk

²¹ ‘In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month’ National Audit Office End of Life Care report November 2008)

3. they are entitled to a DS 1500 form. (The DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months.)

The register applies to all patients fulfilling the criteria regardless of age or diagnosis. The creation of a register will not in itself improve care but it enables the wider practice team to provide more appropriate and patient focussed care.

Palliative care 3.2 Reporting and verification

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

Verification – in the rare 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 QOF monitors occurrence of the multi-disciplinary meetings but it is up to the practice to ensure the meetings are effective. The aims of the meetings are to:

- ensure all aspects of the patients care have been considered (this should then be documented in the patients notes)
- improve communication within the team and with other organisations (e.g. care home, hospital, community nurse specialist) and particularly improve handover of information to out of hours services
- co-ordinate each patient's management plan ensuring the most appropriate member of the team takes any action, avoiding duplication
- ensure patients are sensitively enabled to express their preferences and priorities for care, including preferred place of care
- ensure that the information and support needs of carers are discussed, anticipated and addressed where ever reasonably possible.

Many practices find use of a checklist during the meeting to ensure all aspects of care are covered is useful e.g. SCR1 and 2 templates and assessment tools on the GSF website.

Scottish practices participating in the Palliative Care DES will have access to a reporting template which can be used and adapted for this purpose and available at annex D:

[www.sehd.scot.nhs.uk/pca/PCA2008\(M\)12.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)12.pdf)

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	40-90%
MH 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	6	25-50%
MH 7. 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 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 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.²² 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 (61% of people with schizophrenia and 46% of people with bipolar disorder smoke compared to 33% of the general population).

22 Marder et al. Am J Psychiatry 2004; 161: 1334-49

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.²³

People with schizophrenia appear to be at increased risk of impaired glucose tolerance and diabetes, and this is independent of treatment with the newer atypical antipsychotic drugs.²⁴

The NICE clinical guideline on schizophrenia (2002) recommended physical health checks for diabetes, blood pressure, lipids, and smoking (Good Practice Point). The NICE clinical guideline on bipolar disorder (2006) has recommended that people with bipolar disorder should have an annual physical health review, normally in primary care, to ensure that the following are assessed each year: lipid levels, including cholesterol in all patients over 40 even if there is no other indication of risk, plasma glucose levels, weight, smoking status, alcohol use, and blood pressure. See also the Disability Rights Commission Equal Treatment: Closing the Gap – One year on.

www.learningdisabilitiesuk.org.uk/docs/DRCrpt.pdf

Mental Health in Scotland: Improving the Physical Health and Well Being of those Experiencing Mental Illness.

Link to guidance document:

www.scotland.gov.uk/Publications/2008/11/28152218/0

A review of physical health will therefore normally include:

1. an enquiry about smoking, alcohol and drug use
2. a blood pressure check
3. a cholesterol check where clinically indicated
4. measurement of body mass index (BMI)
5. a check for the development of diabetes
6. cervical screening where appropriate
7. an enquiry about cough, sputum, and wheeze.

The accuracy of the record of medication prescribed by the General Practitioner and the Psychiatrist should also be checked at the same time.

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.

23 Seymour L. Not all in the mind: the physical health of mental health service users. *Mentality*, 2003

24 Bush and Holt, *British Journal of Psychiatry* 2004; 184 (suppl. 47); (s67-s71).

MH 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. 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.
- iii. 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 six 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 -1.0mmol/l (see the British National Formulary). If the range differs locally, the PCO will be required to allow for this.

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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients on lithium therapy to look at the proportion with recorded serum lithium in the therapeutic range.
- iii. 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 indicator reflects good professional practice and supported by national Clinical Guidelines:

www.nice.org.uk/guidance/index.jsp?action=byID&o=10916

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:

- i. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.
- ii. 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 Bulletin* 1993; 17(7): 409-411 and Office of the Deputy Prime Minister, *Mental health and social exclusion* (Social Exclusion Unit Report). London, ODPM, 2004).

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

iv. 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.²⁵

v. Early Warning Signs.

“Early warning signs” from the patient’s perspective that may indicate a possible relapse.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.

vi. 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: The Mental Health (Care and Treatment) (Scotland) Act 2003.

www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1

MH 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.

MH 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.²⁷ There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as

25 See Grove and Drurie. (Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK, 1999

26 See Birchwood et al. *Advances in Psychiatric Treatment* 2000; 6: 93-101 and Birchwood and Spencer. *Clinical Psychology Review* 2001; 21(8): 1211-26

27 Csernansky and Schuchart. *CNS Drugs* 2002; 16 (7): 473-484

“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.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, letter (only if there is no phone number recorded) 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.

28 Lester et al. BMJ. 2005; 330: 1122-28

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 originally 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 pre-requisite 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) but 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 Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008.

www.sign.ac.uk/pdf/qrg101.pdf

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.

See SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008.

www.sign.ac.uk/pdf/qrg101.pdf

“...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 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% or greater with a minimum change of at least 60l/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% 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% predicted, and a significant smoking history. Evidence would suggest that this should not usually be more than 15% 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.²⁹

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity.³⁰

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.

29 See Price et al. Clin Exp Allergy 2005; 35: 282-287.

30 Thomson et al. Eur Respir J 2004; 24: 822 – 833

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 SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008.

www.sign.ac.uk/pdf/qrg101.pdf

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?”

Guidelines suggest it should be abnormal in patients with mild to moderate asthma to have any nocturnal waking or activity limitation. Asthma symptoms may be expected on up to three days per week.

If asthma appears to be uncontrolled the following should be examined as part of the asthma review before increasing asthma therapy and treated appropriately:

- smoking behaviour as smoking interferes with asthma control
- poor inhaler technique
- inadequate adherence with regular preventative asthma therapy
- rhinitis.

There is increasing evidence for personalised asthma action plans in adults with persistent asthma. 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 especially during exacerbations. 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.

See SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008.

www.sign.ac.uk/pdf/qrg101.pdf

Summary of Asthma Review:

- assess symptoms (using RCP 3 questions)
- measure peak flow
- assess inhaler technique
- consider personalised asthma plan.

If asthma appears to be uncontrolled follow steps as outlined above. 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.

Verification – PCOs may randomly select a number of case records of patients in which the review has been recorded as taking place in order to confirm that the four elements have been addressed.

Dementia

Indicator	Points	Payment stages
Records		
DEM 1. The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM 2. 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 an insidious but ultimately 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 dementia.

The annual incidence of dementia of the Alzheimer type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal 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 an indicator of dementia especially when there is altered functioning in terms of activities of daily living.

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:

- i. An appropriate physical and mental health review for the patient.
- ii. 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.
- iii. If applicable, the impact of caring on the care-giver.
- iv. 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.³¹

The Audit Commission Report *Forget Me Not* 2002.

www.audit-commission.gov.uk/reports/AC-REPORT.asp?CatID=&ProdID=3DFEF403-038C-464f-8518-441477E92B15

The NSF for Older People.

www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066

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

31 Burt et al. *Psychol Bull* 1995; 117: 285-305

dementia.³² 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.³³

As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and nonstatutory 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.

SIGN Guideline 86 Managing patients with dementia.

www.sign.ac.uk/pdf/sign86.pdf

"Coping with Dementia – a Handbook for Carers" has been updated and widely distributed.

www.healthscotland.com/uploads/documents/7632-CopingWithDementia2008.pdf

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.

³² Eccles et al. *BMJ* 1998; 317: 802-808

³³ see Eccles et al. *BMJ* 1998; 317: 802-808

Depression

Indicator	Points	Payment stages
Records		
DEP 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	8	40-90%
DEP 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	25	40-90%
DEP 3. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care	20	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.³⁴ 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.³⁵ 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.

www.nice.org.uk/guidance/index.jsp?action=byID&o=10958

34 NICE Depression Guideline, December 2004

35 Murray CJL and Lopez AD. *The global burden of disease*. Boston, Mass: WHO and Harvard University Press, 1996

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.³⁶

The presence of depression in people with coronary heart disease is associated with reduced compliance with treatment, increased use of health resources, increased social isolation, and poorer outcomes.³⁷

A meta-analysis of 20 trials³⁸ 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. In other words, depression was an independent risk factor for mortality in people with CHD. There is Grade A evidence from two randomised controlled trials that SSRI antidepressant treatment in people with coronary heart disease is safe and effective in reducing depression, at least among those with a prior history of depression and more severe symptoms.³⁹ Patients treated with an SSRI were also found to have a 42% reduction in death or recurrent MI in a sub-group analysis of outcomes in a trial of cognitive behavioural therapy (CBT), although this was a post-hoc observation, and assignment to antidepressants was not randomised.⁴⁰

There is a 24% lifetime prevalence of co-morbid depression in individuals with diabetes mellitus⁴¹ 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.⁴² People with both diabetes and depression are less physically and socially active⁴³ and less likely to comply with diet and treatment than people with diabetes alone, leading to worse long term complications and higher mortality. It may also be that practitioners provide poorer care to patients with co-morbid depression and diabetes because depression impairs communication with patients.⁴⁴ There is good evidence from five randomised controlled trials that effective treatment with either antidepressants or CBT improves the outcome of depression in patients with diabetes.⁴⁵ While treatment has not been shown consistently to improve glycaemic control, psychological well-being has been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

36 Davies et al. *BMJ* 2004; 328: 939-943

37 Carney et al, *American Journal of Cardiology* 2003;92(11): 1277-81

38 Barth et al. *Psychosomatic Medicine* 2004; 66: 802-13

39 Glassman et al. *Journal of the American Medical Association* 2002; 288: 701-709; Taylor et al. *Archives of General Psychiatry* 2005; 62: 792-798

40 Lesperance et al. *Journal of the American Medical Association* 2007; 297: 367-379

41 Goldney et al. *Diabetes Care* 2004; 27(5): 1066-70

42 Anderson et al. *Diabetes Care* 2001; 24: 1069-78

43 Von Korf et al. *Psychosomatic Medicine* 2005; 67: 233-40

44 Piette et al. *American Journal of Managed Care* 2004; 10: 152-162

45 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; Katon et al. *Archives of General Psychiatry* 2004; 61: 1042-49; Williams et al. *Annals of Internal Medicine* 2004; 140: 1015-24

NICE guidance on Depression suggests that “screening should be undertaken in primary care ...for depression in high-risk groups” 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?”

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. This assessment should be informed by using a questionnaire measure of severity such as the PHQ-9, HADS, or BDI, as used for the DEP 2 indicator.⁴⁶

The specificity of screening has been shown to be improved by the addition of a third ‘help’ question asked of patients answering ‘yes’ to either of the first two questions: Is this something with which you would like help?⁴⁷ This third question has three possible responses: ‘no’, ‘yes, but not today’, or ‘yes’. A ‘no’ response to this third question makes major depression highly unlikely (negative predictive value NPV of 94%). It is important to stress therefore that a negative result to the two to three item screen can usually be taken to indicate that the patient doesn’t have depression.

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. These questions should be asked as part of a consultation and should not be posted to patients.

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 indicator applies to adults aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March. It does not include women with postnatal depression.

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

46 see also Whooley et al. *Journal of General Internal Medicine* 1997; 12 (7): 439-45

47 Arroll et al. *British Medical Journal* 2005; doi:10.1136/bmj.38607.464537.7c

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 but should be routinely considered for all patients with moderate or severe depression. The British Association of Psychopharmacology Guidelines state that antidepressants are a first-line treatment for moderate to severe major depression irrespective of environmental factors, and that antidepressants are not indicated for milder depression unless it has persisted for two years or more ('dysthymia').⁴⁸

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:

www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire⁴⁹

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://shop.gl-assessment.co.uk/home.php?cat=417&gclid=CPPr3fjJhpkCFQ6wQwodl2Krlw>

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.

Further Information: Zigmond AS, Snaith RP. *Acta Psychiatrica Scandinavica* 1983; 67: 361-70 and Wilkinson and Barczak. *Journal of the Royal College of General Practitioners* 1988; 38: 311-3.

48 Anderson et al. *Journal of Psycho-pharmacology* 2008; www.bap.org.uk/consensus/antidepressant.pdf

49 Further Information: Kroenke et al. *Journal of General Internal Medicine* 2001; 16: 606-13

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:

www.pearson-uk.com/product.aspx?n=1316&s=1322&cat=1426&skey=2646&gclid=Cluxq5CioZMCFQ6KMAodj16TrQ

Further Information: Arnau et al. *Health Psychology* 2001; 20(2): 112-9.

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.

Recent research has shown that the use of severity measures is valued by patients and that doctors' treatment and referral rates are related to the scores on the measures. Qualitative interviews with patients who had been assessed with the measures revealed that they saw them as evidence that GPs were carrying out a full assessment which helped them to receive treatment in line with the severity of their depression. The measures also helped some patients to understand how their different symptoms made sense when considered together as the syndrome of depression.⁵⁰

Prior to the introduction of the questionnaire measures into the QOF, an audit was carried out of the use of the Hospital Anxiety and Depression scale depression sub-scale (HAD-D) by volunteer GPs in Southampton.⁵¹ The likelihood of being prescribed an antidepressant increased significantly with severity on the HAD-D measure and was associated with improved targeting of antidepressant treatment when compared to a study carried out in the same area prior to the introduction of the HAD-D measure.⁵²

A more recent analysis of the use of the two most commonly used measures (the PHQ-9 and HAD-D) in 38 practices in three centres also found that rates of treatment and referral increased logically in line with higher scores. However, it was found that overall rates of treatment and referral were very similar for patients assessed with either measure, despite the fact that the PHQ-9 classified significantly more patients as moderately to severely depressed and in need of treatment, compared to the HAD-D. These results suggest practitioners do not decide on drug treatment or referral on the basis of the severity questionnaire scores alone.⁵³ They also suggest that the two most commonly used measures are inconsistent, the PHQ-9 rating more people above the recommended threshold for intervention than the HAD-D. This is consistent with other new evidence suggesting the thresholds for intervention for these instruments should be revised.

Recommended thresholds for intervention (revised)

A study in which the PHQ-9 and HAD-D were administered together to a single sample of patients also found that a greater proportion of the sample was classified as

50 Dowrick et al, *British Medical Journal*, in press

51 Kendrick. *British Journal of General Practice* 2006; 56: 796-797

52 Kendrick et al. *British Journal of General Practice* 2005; 55: 280-286

53 Kendrick et al, *British Medical Journal*, in press

depressed according to the PHQ-9 than according to the HAD-D.⁵⁴ Validation studies against more extensive 'gold standard' diagnostic assessments have suggested that the validity of the measures in terms of identifying major depressive disorder could be improved by using a more conservative cut-off score of 12 rather than 10 on the PHQ-9, and a less conservative cut-off of 10 rather than 11 on the HAD-D.⁵⁵ Changing the recommended threshold scores for intervention would therefore make these measures more valid against longer assessments, more consistent with each other, and more consistent with practitioners' clinical judgment.

The revised recommended thresholds for considering intervention are therefore:

- PHQ-9 score: 12
- HAD-D score: 10
- BDI-II score: 20.

It is, however, important to stress that symptom scores alone should not be used to determine the presence of depression which needs treatment.

It is also important for clinicians to consider family and previous history as well as the 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 at one point in time.

So decisions about treatment and referral should take into account:

- severity of symptoms (assessed clinically as well as with a measure)
- functional impairment (significant effects on work and daily activities)
- duration (watchful waiting for around eight weeks for mild symptoms)
- course (trajectory of scores, past history).

In addition, the PHQ-9 and the 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.

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. For the purposes of QOF measurement 'at the outset of treatment' is defined as within 28 days of the initial diagnosis.

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

Verification – PCOs may randomly select a number of case records of patients with a new diagnosis of depression to verify that their notes record an assessment of severity.

⁵⁴ Cameron et al, *British Journal of General Practice* 2008; 58:32-36

⁵⁵ Lowe et al, *Journal of Affective Disorders* 2004; 78:131-140; Gilbody et al, *British Journal of General Practice* 2007; 57:650-652

Depression (DEP) indicator 3

In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. (As described in the rationale for depression 2 above).

Depression 3.1 Rationale

The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived.⁵⁶

If treatment with antidepressants is initiated, then patients should be being followed up regularly for several months. Early cessation of treatment is associated with a greater risk of relapse, and the 2004 NICE guidelines on depression recommend initial treatment for six months after recovery. One study showed that only around one third or less of patients prescribed antidepressants were still receiving medication at 4-6 months.⁵⁷ Recent analysis of the GP Research Database for the years 1993 to 2005 has confirmed this finding: more than half of the patients treated with antidepressants for a new diagnosis of depression during those years received prescriptions for only one or two months of treatment and that pattern had not changed over the 13 year period.⁵⁸ If treatment is not started after the initial diagnosis then NICE guidance suggests patients should in any case be reassessed over one to two months, to see whether their symptoms have resolved or worsened to the point where treatment becomes advisable ('watchful waiting').

Recent research into the use of severity measures has shown that patients whose GPs used the measures for follow-up in addition to initial assessment valued having repeated scores to help monitor their progress and assess the effectiveness of treatment.⁵⁹ When asked, most of the GPs interviewed for the same study also believed that there was value in repeating the score as a way of monitoring patients' progress.

The PHQ-9 has been shown to be a responsive and reliable measure for gauging response to treatment in individual patient care.⁶⁰

Depression 3.2 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 5-12 weeks (inclusive) after the initial recording of the assessment of severity related to a new diagnosis of depression. New diagnoses are those which have been made between the preceding 1 April to 31 March. To be included in the numerator for this indicator a patient needs to have had both an initial and a subsequent severity assessment.

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

Verification – PCOs may randomly select a number of case records of patients with a new diagnosis of depression to verify that their notes record a follow-up assessment of severity 5-12 weeks after the initial assessment of severity.

56 Kates and Mach, *Canadian Journal of Psychiatry* 2007; 52(2): 77–85

57 Donoghue et al, *Acta Psychiatrica Scandinavica* 2000; 101: (suppl 403) 57-61

58 Kendrick et al, Society for Academic Primary Care Annual Scientific Meeting, London, July 2007

59 Dowrick et al, *British Medical Journal*, in press

60 Lowe et al, *Medical Care* 2004; 42: 1194-1201

Chronic kidney disease (CKD)

Indicator	Points	Payment stages
Records		
CKD 1. 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		
CKD 2. 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		
CKD 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	11	40-70%
CKD 5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	9	40-80%
CKD 6. The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months	6	40-80%

Chronic kidney disease – rationale for inclusion of indicator set

The international classification developed by the US National Kidney Foundation describes five stages of chronic kidney disease (CKD) using an estimated glomerular filtration rate (eGFR) to measure kidney function (table 1). 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. Several groups (NICE, SIGN, UK Consensus) have recommended splitting stage 3 into 3A and 3B (table 1). Stage four is a severe decrease in GFR with or without other evidence of kidney damage and stage five is established renal failure. The QOF indicator set refers to people with stage 3 to 5 CKD.

CKD is a long-term condition; the most recent population data from the National Health and Nutrition Examination Survey (NHANES 1999-2004) suggests that the age standardised prevalence of stage 3 to 5 CKD in the non-institutionalised American

population is approximately 6%.⁶¹ The prevalence in females was higher than in males (6.9 versus 4.9%). In the fully adjusted model, the prevalence of low GFR was strongly associated with diagnosed diabetes (OR, 1.54; 95% CI, 1.28-1.80) and hypertension (OR, 1.98; 95%CI, 1.73-2.67) as well as higher BMI (OR, 1.08; 95% CI, 1.02-1.15 per 5-unit increment of BMI).

In the UK the prevalence of CKD stage 3–5 was 8.5% and was higher in females, 10.6% in females versus 5.8% in males.⁶² The Association of Public Health Observatories has modelled the prevalence of CKD for England and Wales based on the results of the study by Stevens et al.

www.apho.org.uk/resource/item.aspx?RID=54378 and report a population prevalence of 8.9%.

The NHS Information Centre reports a prevalence of CKD for 2006/7 of 2.4% using QMAS returns www.ic.nhs.uk/webfiles/QOF/2006-07/QOF0607_Practice%20Prevalence.xls suggesting that, to date, CKD is under-reported in English GP practices.

Stage	GFR*	Description	Included in QOF
1	90+	Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease	No
2	60-89	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease	No
3	30-59	Moderately reduced kidney function Subdivided into 3A (45 to 59) and 3B (30 to 44)	Yes
4	15-29	Severely reduced kidney function	Yes
5	<15	Very severe, or established kidney failure	Yes

Table 1: Estimated glomerular filtration rate (eGFR) to measure kidney function

* All GFR values are normalized to an average surface area (size) of 1.73m2

Further Information: National Service Framework for Renal Services, February 2005.

www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm

This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m2 confirmed with at least two separate readings over a three month period).

CKD may be progressive; prevalence increase with age and female sex but progression increases with male sex, and South Asian and African Caribbean ethnicity. People of South Asian origin are particularly at risk of having both diabetes and CKD. 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 progression linked to hypertension.

61 Coresh et al *JAMA*. 2007;298(17):2038-2047

62 Stevens et al. *Kidney International* 2007; 72: 92-9

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. Where eGFR has persistently been recorded below 60 (<60) the CKD (stage 3) label should continue to apply, even if future management may lead to an improvement in eGFR.

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. The presence of proteinuria is a key risk multiplier at all stages of CKD and CKD is an independent risk factor for cardiovascular disease and a multiplier of other risk factors.⁶³

NICE guidance, early identification and management of Chronic Kidney Disease in adults in primary and secondary care was published in September 2008.

www.nice.org.uk/CG73

SIGN Guideline 103 Diagnosis and management of CKD in adults was published in June 2008.

www.sign.ac.uk/guidelines/fulltext/103.index.html

These indicators reflect both of the guidance documents:

- Albumin-creatinine ratio (ACR) is the preferred measure of proteinuria
- NICE suggests BP should be kept below 140 (systolic) and 90 (diastolic) with a target for systolic of between 120 and 139 mmHg. There is a tougher standard for diabetes. This compares with a BP audit standard of 145/85 in this guidance for 40 to 70% of the CKD population
- NICE recommends that the use of ACE inhibitors when there is hypertension and an ACR of ≥ 30 mg/mmol. However, when ACR ≥ 70 mg/mmol NICE recommends ACE inhibitors even in the absence of hypertension. As with BP there are stricter standards in diabetes
- NICE divides stage 3 into Stage 3a and 3b. They recommend testing for bone disease and anaemia in Stage 3b (eGFR 30 to 44), as well as stages 4 and 5
- NICE also recommends addition of the suffix (p) to denote significant proteinuria, defined as an ACR ≥ 30 mg/mmol (PCR ≥ 50 mg/mmol).

The QOF indicators are likely to converge with NICE guidance over coming years.

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 aged 18 years and over with a persistent estimated GFR or GFR of < 60 ml/min/1.73m² should be included in the register. From 2006, eGFR has been reported automatically when serum creatinine concentration is measured. Studies of

63 Wali and Henrich. *Cardiol Clin* 2005; 23(3): 343-62

general practice computerised medical records show that it is feasible to identify people with CKD⁶⁴ and that computer records are a valid source of data.⁶⁵

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.

Eating a protein containing meal can elevate creatinine; therefore it is recommended that patients do not eat meat in the 12 hours before their creatinine is measured and eGFR estimated.

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 rate of deterioration of their kidney function whether or not they have hypertension or diabetes.⁶⁶

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 2004⁶⁷: This suggests an "optimal" BP target in CKD of 130/80 mm Hg or 127/75 mm Hg if >1 g proteinuria. These targets in turn are derived from the Modification of Diet in Renal Disease study.⁶⁸

In practice, these targets are often hard to achieve and the indicator's 40% to 70% audit standard reflects this. The lower the blood pressure achieved the better for patient care; 140/85 mm Hg is used here as an audit standard for this indicator.

64 de Lusignan et al. Fam Pract 2005; 22(3): 234-41

65 Anandarajah et al. Nephrol Dial Transplant 2005; 20(10): 2089-96

66 Jafar et al. Ann Int Med 2003; 139: 244-52

67 Williams et al. J Human Hypertension 2004; 18: 139-185 (specific renal advice on pages 166-7).

68 Jafar et al. Ann Int Med 2003; 139: 244-52

www.nice.org.uk/Guidance/CG73

www.sign.ac.uk/guidelines/fulltext/103/index.html

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 mm Hg or less. This reading should have been in the previous 15 months.

Chronic kidney disease (CKD) indicator 5

The percentage of patients on the CKD register with hypertension and proteinuria 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 5.1 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.⁶⁹

The gold standard test for measuring proteinuria is a 24-hour urine collection; though problems with timing and completeness make this an impractical test to use in general practice. The alternatives are to test the albumin-creatinine ratio (ACR) or protein-creatinine ratio (PCR) in the urine or to use a stick test.

SIGN Guidance also recommends measuring proteinuria with ACR in patients with diabetes and TPCR in non-diabetic patients, reflecting the differing evidence base for these two patient populations whereas recent NICE guidance has suggested that the ACR should be used in all patients.

www.nice.org.uk/Guidance/CG73

www.sign.ac.uk/guidelines/fulltext/103/index.html

Thus, patients with non-diabetic stage 3 to 5 CKD should have an annual test of proteinuria ideally using ACR, or PCR according to local guidance. People with diabetes already have an annual micro-albuminuria test.

A systematic review has shown that investigation for infection of asymptomatic people with one "+" or more of is not indicated.⁷⁰ Practitioners should only go on to send off a mid-stream urine or perform another test to look for infection if there are symptoms.

It is not possible to derive a simple correction factor that allows the conversion of ACR values to PCR or 24 hour urinary protein excretion rates because the relative amounts of albumin and other proteins will vary depending on the clinical circumstances; however, the following table of approximate equivalents will allow clinicians unfamiliar with ACR values to see the approximate equivalent PCR and 24 hour urinary protein excretion rates (Table 2).

69 Kent et al JASN 2007;18:1959-1965. 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

70 Carter JL et al Nephrol Dial Transplant. 2006 Nov; 21(11):3031-7

Reference: www.nice.org.uk/Guidance/CG73

Albumin:creatinine ratio (mg/mmol)	Protein:creatinine ratio (mg/mmol)	24 hour urinary protein excretion (g/day)
30	50	0.5
70	100	1

Table 2: Approximate equivalent ACR, PCR and 24 hour urinary protein excretion

Chronic kidney disease 5.2 Reporting and verification

The practice reports the percentage of patients on its CKD register with hypertension and proteinuria 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.

Chronic kidney disease (CKD) indicator 6

The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (ACR) or protein: creatinine ratio (PCR) test recorded in the previous 15 months.

Chronic kidney disease 6.1 Rationale

Quantitative measurement of proteinuria will enable appropriate management of patients with CKD. There is good observational evidence linking proteinuria to adverse outcome.⁷¹

NICE recommends the use of ACE inhibitors when there is hypertension and an ACR of ≥ 30 mg/mmol. When ACR ≥ 70 mg/mmol NICE recommends ACE inhibitors are prescribed; even in the absence of hypertension.

SIGN recommends the use of ACE inhibitors and/or ARBs as agents of choice in patients with proteinuria >0.5 g/day (approximately equivalent to a PCR of >50 mg/mmol).

As with BP there are stricter standards for those with diabetes; ACR >2.5 mg/mmol in men and >3.5 mg/mmol in women – with or without hypertension.

www.nice.org.uk/Guidance/CG73

www.sign.ac.uk/guidelines/fulltext/103/index.html

Chronic kidney disease 6.2 Reporting and verification

The practice reports the percentage of patients on its CKD register who have an ACR or PCR test recorded in the previous 15 months.

71 Foster M. Arch Intern Med. 2007; 167(13):1386–92. Hallan S. Arch Intern Med. 2007; 167(22):2490–2496. Cirillo M. Arch Intern Med. 2008; 168(6):617–24. Brantsma A, J. Am Soc Nephrol. 2008; 19(9):1785-91

Atrial fibrillation

Indicator	Points	Payment stages
Records		
AF 1. The practice can produce a register of patients with atrial fibrillation	5	
Initial diagnosis		
AF 4. The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis	10	40-90%
Ongoing management		
AF 3. The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	12	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.⁷² 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.⁷³

www.sign.ac.uk/guidelines/fulltext/94/index.html

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.

⁷² Psaty et al. Circulation 1997; 96: 2455-61

⁷³ Wolf et al. Stroke 1991; 22: 983-88

Atrial fibrillation (AF) indicator 4

The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis.

AF 4.1 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 4.2 Reporting and verification

The practice reports those patients with atrial fibrillation diagnosed after 1 April 2008 who have had an ECG or been diagnosed by a specialist within 3 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 (AF) indicator 3

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

AF 3.1 Rationale

There is strong evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction)⁷⁴ and less so by aspirin (approximately 22 per cent risk reduction).⁷⁵ Warfarin in particular is under-used for stroke prevention in AF. A NICE costing report accompanying the recommendations for AF treatment in 2006⁷⁶ estimated that nationally 355,312 patients with AF should be on warfarin (i.e. all of those assessed as high risk, half of those at moderate risk, and none of those at low risk, using the NICE stroke risk stratification algorithm, and if not contraindicated), or an additional 165,946 patients who were not receiving this treatment – almost 50% of those estimated as requiring warfarin. Thus there is clearly a need to encourage the use of this treatment for AF patients at high risk of stroke. Furthermore, recent evidence from the BAFTA trial⁷⁷ and the ACTIVE-W⁷⁸ study suggests not only is warfarin much more effective than aspirin, but that it is not as unsafe – in terms of risk of serious haemorrhage – as previously thought (though it would be useful to ascertain if these findings are replicated elsewhere using an appropriate meta-analysis).

74 Atrial Fibrillation Investigators. Risk Factors for stroke and efficacy of antithrombotic therapy in atrial fibrillation: analysis of pooled data from five randomized clinical trials. *Arch Intern Med.* 1994; 154: 1949-1957.

75 Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *BMJ.* 2002 Jan 12;324(7329):71-86.

76 Atrial fibrillation. The management of atrial fibrillation costing report. NICE 2006.

77 Mant J, Hobbs FDR, Fletcher K, Roalfe A, Fitzmaurice D, Lip GYH, Murray E. Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 2007; 370: 493-503.

78 Healey JS, Hart RG, Pogue J, Pfeffer MA, Hohnloser SH, De Caterina R, Flaker G, Yusuf S, Connolly SJ. Risks and Benefits of Oral Anticoagulation Compared With Clopidogrel Plus Aspirin in Patients With Atrial Fibrillation According to Stroke Risk: The Atrial Fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE-W). *Stroke.* 2008; 39: 1482-1486.

Nevertheless, a significant proportion of AF patients – depending on the particular risk stratification scheme selected this can be the majority of people with AF – are not considered to be at high risk of stroke, though clearly this does not mean their risk of stroke is non-existent. Therefore, any treatment indicator (or set of indicators) should not focus solely on the high risk group, if that means the large group considered at moderate risk (or even those at low risk) are then excluded from their treatment being monitored. The NICE atrial fibrillation guidelines⁷⁹ suggest that for those at moderate risk, 'anticoagulation or antiplatelet therapy should be prescribed depending upon patient preference after discussion of risks and benefits'. This guidance therefore enables the clinician and patient to decide on the preferred regime, taking risks and benefits of both treatments (i.e. anticoagulant and antiplatelet therapy) into account, for all AF patients, whatever their category of stroke risk.

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 3.2 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.

⁷⁹ Atrial Fibrillation National Clinical Guideline for Management in Primary and Secondary Care. Royal College of Physicians 2006.

Obesity

Indicator	Points	Payment stages
Records		
OB 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	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 (forecasting obesity to 2010, Department of Health, 2006).

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4138630

Modelling future trends in obesity and their impact on health 2007.

www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/KeyInfo/Index.asp

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, 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 mellitus⁸⁰ and accelerated onset of cardiovascular disease.⁸¹ Obesity has therefore become a major health issue for the United Kingdom. The Foresight UK Tackling Obesities report 2007 estimated the cost to the UK of obesity to be £50b in 2050 at today's prices.

www.foresight.gov.uk/Obesity/Obesity.html

Healthy Eating, Active Living, the Scottish Government's action plan to improve diet, increase physical activity and tackle obesity was published in June 2008.

www.scotland.gov.uk/Publications/2008/06/20155902/0

NICE published clinical guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children in 2006 with amendments in July 2008.

www.nice.org.uk/Guidance/CG43

Tackling obesity is a high priority for government as set out in the 'Healthy Weight Healthy Lives' strategy and the current Change4Life campaign has a particular focus on at risk families.

www.dh.gov.uk/en/PublicHealth/Healthimprovement/Obesity/index.htm

80 Sullivan et al. *Diabetes Care* 2005; 28 (7): 1599-603

81 Gregg et al. *JAMA* 2005; 293 (15): 1868-74

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.

OB 1.2 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		
LD 1. The practice can produce a register of patients aged 18 and over 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 stay NHS beds for people with learning disabilities have closed, and virtually all people 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.

www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf

Revised guidance, 'Valuing People Now' is expected later this year. This will replace the 2001 policy document referenced above.

'The Same as You?' Scottish Executive (2000).

www.scotland.gov.uk/topics/health/care/VAUnit/Thesameasyou

NHS Health Scotland ; Health Needs Assessment Report: People with Learning Disabilities in Scotland (2004).

www.healthscotland.com/uploads/documents/LD_summary.pdf

Northern Ireland Strategy on Learning Disability www.rmhdni.gov.uk/

Learning Disability Strategy Section 7 Guidance on Service Principles and Service Responses, Welsh Assembly Government, 2004.

www.wales.nhs.uk/sites3/Documents/480/SP_response_guide-e.pdf

Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2008) www.iahpld.org.uk/

Learning disability (LD) indicator 1

The practice can produce a register of patients aged 18 and over 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", i.e. specific difficulties with learning, such as dyslexia.

For many people, there is little 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 specialist learning disability team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality Community Learning Disability Teams, working along with Primary Care Organisations, have provided expertise and data about and for people with learning disabilities. Practices should liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where employed by PCTs to assist in the construction of a primary care database.⁸²

Further information: www.bild.org.uk/05downloads.htm#bfs

Public Health Institute of Scotland's Autistic Spectrum Disorder: Needs Assessment Report (2001) www.scotland.gov.uk/Publications/2006/02/28094616/0

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.

⁸² see Martin and Martin. Journal of Learning Disabilities, 2000; 4(1): 37-48

Smoking

Indicator	Points	Payment stages
Ongoing management		
SMOKING 3. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months	30	40-90%
SMOKING 4. The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses 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	30	40-90%

Smoking indicator 3

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.

Smoking 3.1 Rationale

1. CHD. Smoking is known to be associated with an increased risk of coronary heart disease.

Reference SIGN Guideline 97; European Task Force European Society of Cardiology. Further Information:

www.sign.ac.uk/guidelines/fulltext/97/index.html

www.escardio.org/guidelines-surveys/esc-guidelines/pages/cvdprevention.aspx
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 108.

Further information: www.sign.ac.uk/pdf/sign108.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.

www.bhsoc.org/Latest_BHS_management_Guidelines.stm

Formal estimation of CHD risk should be undertaken. See new indicator set cardiovascular disease primary prevention.

The ASSIGN cardiovascular risk score was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham based risk scores for Scottish populations. (see www.assign-score.com) and continues to be developed. It is available through a web link to practices in Scotland and encompasses deprivation related risk due to post code.

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. There are a surprisingly small number of studies on smoking related to asthma. 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.⁸³
7. Chronic Kidney Disease. There is good evidence from observational studies that people with CKD are at increased cardiovascular risk and hence the rationale for including CKD here.
8. Schizophrenia, bipolar affective disorder or other psychoses. People with serious mental illness are far more likely to smoke than the general population (61% of people with schizophrenia and 46% 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.⁸⁴
9. 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 should be recorded every 15 months up to and including 25 years of age.
10. Ex-smokers. There are two ways in which a patient can be recorded as an ex-smoker. Firstly ex-smokers can be recorded as such in the previous 15 months.

It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to

⁸³ 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.

⁸⁴ Seymour L. Not all in the mind: the physical health of mental health service users. Mentality 2003

record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

Smoking 3.2 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.

For patients who smoke this recording should be made in the previous 15 months. Ex-smokers should be recorded as described above. Those who have never smoked should be recorded as such in the previous 15 months up to and including 25 years of age.

Smoking indicator 4

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar disorder or other psychoses 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.

Smoking 4.1 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 96/97.

Further Information: www.sign.ac.uk/guidelines/fulltext/96/index.html
www.sign.ac.uk/guidelines/fulltext/97/index.html

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking. Further guidance is available from the National Institute for Clinical Excellence.

www.nice.org.uk/guidance/index.jsp?action=byID&o=11452

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.

Further information on guidance and recent developments in Smoking Cessation Update 2007 NHS Health Scotland and ASH Scotland.

www.healthscotland.com/documents/1762.aspx

Smoking Indicator 4.2 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.

Section 3. 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 (QPA) has been approved for all Organisational Indicators in the Framework.

Records and information

	Indicator	Points
Records 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
Records 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
Records 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%	4
Records 11	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients	10
Records 13	There is a system to alert the out-of-hours service or duty doctor to patients dying at home	2
Records 15	The practice has up-to-date clinical summaries in at least 60% of patient records	25
Records 17	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients	5
Records 18	The practice has up-to-date clinical summaries in at least 80% of patient records	8
Records 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
Records 20	The practice has up-to-date clinical summaries in at least 70% of patient records	12
Records 21	Ethnic origin is recorded for 100% of new registrations	1
Records 23	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months (payment stages 40 – 90%)	11

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 (2008) 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% 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% 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 five 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.

Note: A logical query and dataset (business rule) is available to support this indicator.

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 (2008) 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 (2008) 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. Practices should adhere to the joint RCGP/GPC guidance on record keeping: www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/gp2gp/docs/good_practice_guidelines.pdf/view

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 this indicator based on their own experience and beliefs.

Note: A logical query and dataset (business rule) is available to support this indicator.

In Scotland, manual submission of achievement continues and is reviewed by the Scottish Government and Scottish General Practitioners Committee of the BMA annually. Please refer to PCO for current information.

Records indicator 17

The blood pressure of patients aged 45 and over is recorded in the previous five years for at least 80% of patients.

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 patient records.

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

Eighty per cent of newly registered patients have had their notes summarised within eight 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%) 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.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116839

National Resource Centre for Ethnic Minority Health and ISD ethnic monitoring toolkit.

www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

See also Gill et al. Health Care Needs Assessment: Black and Minority Ethnic groups.

www.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.

Scottish practices may wish to refer to the guidance for the 2008 Ethnicity DES which includes the codes to be used in the 2011 census and recommended Read Codes. This is available at [www.sehd.scot.nhs.uk/pca/PCA2008\(M\)12.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)12.pdf)

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.

Note: A logical query and dataset (business rule) is available to support this indicator.

Records indicator 23

The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months.

Payment stages: 40-90%.

Records 23.1 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. Current smokers should be recorded as such in the previous 27 months. Non-smokers should be recorded as such in the previous 27 months up to and including 25 years of age. New patients aged 26 years and over should be recorded as non-smokers at least once.

Records 23.2 Written evidence

There are two ways in which a patient can be recorded as an ex-smoker. Firstly ex-smokers can be recorded as such in the previous 27 months.

It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

A survey of written records or a computer search of patients aged over 15 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded. For current smokers this record should be in the previous 27 months. Ex-smokers should be recorded as described above. Those who have never smoked should be recorded as such in the previous 27 months up to and including 25 years of age. (Grade A)

Records 23.3 Assessment visit

A random sample of 20 notes or computerised records of patients aged over 15 years should be inspected, to confirm that smoking status is recorded as detailed above.

Records 23.4 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.

Note: A logical query and dataset (business rule) is available to support this indicator.

Information for patients

	Indicator	Points
Information 4	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	1
Information 5	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2

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*, 2008).

www.rcgp.org.uk/PDF/Good%20Medical%20Practice%20for%20General%20Practitioners%20%5B2008%5D.pdf

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 criterion.

Information indicator 5

The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

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 bupropion 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.

Education and training

	Indicator	Points
Education 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	4
Education 5	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
Education 6	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
Education 7	<p>The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include:</p> <ul style="list-style-type: none"> • 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 <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)</p>	4
Education 8	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5
Education 9	All practice-employed non-clinical team members have an annual appraisal	3
Education 10	The practice has undertaken a minimum of three significant event reviews within the last year	6

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, including GPs 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 www.resus.org.uk/pages/cpatpc.htm#contents

Resuscitation Guidelines 2005 (Resuscitation Council UK).

www.resus.org.uk/pages/guide.htm

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 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

3. 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.
4. 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.⁸⁵

SEA guidance for Primary Care Teams: NPSA/RCGP October 2008.

www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/

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.

⁸⁵ BMJ 1995; 311: 315-318

Practice management

	Indicator	Points
Management 1	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
Management 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	1
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	0.5
Management 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 with the PCO	3
Management 7	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> • a defined responsible person • clear recording • systematic pre-planned schedules • reporting of faults 	3
Management 9	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
Management 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	2

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 indicator 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 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 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 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 have a procedure for how carers are identified and a referral protocol to social services for assessment of carers support needs or to other local support such as carers centre.

A carer is defined as, someone who, without payment, provides help and support to a partner, 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.

www.carers.org/publications,185,GP.html

NHS Carer Information Strategies guidance – HDL22 (2006) (sections 3.3 and 3.10).

www.sehd.scot.nhs.uk/mels/HDL2006_22.pdf

Carers Scotland: Resource Pack for General Practice and Primary Care:

www.carerscotland.org/Information/Takingcareofyourself/Resourcepackforgeneralpracticeandprimarycare

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 www.eoc.org.uk/. Guidance can also be found on the ACAS web site on 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 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 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

	Indicator	Points
Medicines 2	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
Medicines 3	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
Medicines 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)	3
Medicines 6	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
Medicines 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)	6
Medicines 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	4
Medicines 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%	7
Medicines 12	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%	8

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 (2008) 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 (2008) 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 adviser and the practice have reached agreement on the action points.

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 adviser 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 years take a prescription medicine and 36% are taking four or more.⁸⁶ However, we also know that up to 50% 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% 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.

www.npc.co.uk/med_partnership/medication-review/room-for-review/downloads.html

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.

86 Medicines and Older People – Supplement to the National Service Framework for Older People, 2001

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.

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.

Patient experience domain

Indicator	Points	Payment stages
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	33	
PE 7 Patient experience of access (1) The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours)	23.5	70-90%
PE 8 Patient experience of access (2) The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.	35	60-90%

PE 1 Length of consultations

The length of routine booked appointments with the doctors in the practice is not less than ten 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 eight 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.

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.

PE 1.2 Written evidence

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. Practices should submit a statement to this effect. (Grade A)

For other practices, claiming against this indicator, 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.

PE 7 Patient experience of access (1)

The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours).

PE 7.1 Practice guidance

This indicator, alongside PE 8, encourages and incentivises practices to improve quick and convenient access to appointments with GPs and/or health professionals for their patients. Achievement of the indicator is dependent on the results of the national survey in each UK country. The arrangements for these differ in each country and further information is available below.

England

Achievement of the indicator is measured through the national patient experience survey titled the GP patient survey. The survey is conducted by a third party polling expert, Ipsos MORI, on behalf of the Department of Health. Ipsos MORI administer the GP patient survey to contractor's registered patients' and results are collated for each contractor.

The survey is administered each quarter through out the financial year. The assessment of achievement of the indicator is based on annual results. This is determined by aggregating the results data (numerators and denominators) for the questions relating to the indicator from each of the four quarterly surveys undertaken during the financial year.

Practices will want to encourage patients to respond to the survey by displaying the relevant communication materials provided by the Department of Health/Ipsos MORI. Some patients may not want to take part in the survey and practices will need to facilitate such requests in accordance with notified arrangements for patient opt outs.

A sliding scale will apply to payments between 70% and 90% in the same fashion as other thresholds in the clinical domain. Exception reporting does not apply.

Assessment visit (England only)

The results should be discussed and ways of improving patients' experience of access in the future. The Improvement Foundation provides a general source of advice to practices and PCTs over improving patient access.

www.improvementfoundation.org

Assessors' guidance (England only)

It may be useful to note if patient participation is encouraged by display of the appropriate communication materials.

Scotland

In Scotland, this indicator reflects the previous 48 hour access Directed Enhanced Service which was subject to a self declaration. From 2008/9, a national survey will be conducted annually in Scotland to assess practice achievement against this indicator and PE8 for advanced booking of appointments. The survey will be administered centrally by post to a sample of registered patients from each practice and the results collated for each practice. Information on the 2008/9 survey can be accessed at:

www.paymodernisation.scot.nhs.uk/gms/index.htm

www.scotland.gov.uk/Topics/Health/NHS-Scotland/Survey

Practices will be informed of their results by Boards and will not need to enter these onto their QMAS report.

Wales

Information for practices about the Welsh GP Patient Survey is available on the NHS Wales GMS website:

www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=34662

Northern Ireland

Information for practices about the Department of Health, Social Services and Public Safety GP Patient Survey is available on the DHSSPSNI website:

www.dhsspsni.gov.uk/index/hss/pc-primary-care.htm

PE 7.2 Written evidence

The appropriate national survey adopted in each UK country will deliver results to inform practices of their levels of achievement. The precise arrangements will vary in each UK country and again this will be notified in separate guidance.

England

In England, this will be a short report from the PCT. Practices in England will not be required to enter their achievement values from this report on QMAS. PCTs will do this on practices behalf. This is because reports will not be available until following the last day of the financial year and PCTs will therefore need to use the adjustment facility to ensure correct achievement payments are made to practices.

The precise arrangements are published on the GP patient survey pages of the Department of Health website:

www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatient/survey2007/index.htm

PE 8 Patient experience of access (2)

The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.

PE 8.1 Practice guidance

This indicator, alongside PE 7, encourages and incentivises practices to improve quick and convenient access to appointments with GPs and/or health professionals for their patients. Achievement of the indicator is dependent on the results of the national survey in each UK country. The arrangements for these differ in each country and further information is available below.

England

Achievement of the indicator is measured through the national patient experience survey titled the GP patient survey. The survey is conducted by a third party polling expert, Ipsos MORI, on behalf of the Department of Health. Ipsos MORI administer the GP patient survey to contractor's registered patients' and results are collated for each contractor.

The survey is administered each quarter through out the financial year. The assessment of achievement of the indicator is based on annual results. This is determined by aggregating the results data (numerators and denominators) for the questions relating to the indicator from each of the four quarterly surveys undertaken during the financial year.

Practices will want to encourage patients to respond to the survey by displaying the relevant communication materials provided by the Department of Health/Ipsos MORI. Some patients may not want to take part in the survey and practices will need to facilitate such requests in accordance with notified arrangements for patient opt outs.

A sliding scale will apply to payments between 60 and 90% in the same fashion as other thresholds in the clinical domain. Exception reporting does not apply.

Assessment visit (England only)

The results should be discussed and ways of improving patients' experience of access in the future. The Improvement Foundation provides a general source of advice to practices and PCTs over improving patient access.

www.improvementfoundation.org

Assessors' guidance (England only)

It may be useful to note if patient participation is encouraged by display of the appropriate communication materials.

Scotland

See PE7 above.

Wales

Information for practices about the Welsh GP Patient Survey is available on the NHS Wales GMS website:

www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=34662

Northern Ireland

Information for practices about the Department of Health, Social Services and Public Safety GP Patient Survey is available on the DHSSPSNI website:

www.dhsspsni.gov.uk/index/hss/pc-primary-care.htm

PE 8.2 Written evidence

The appropriate national survey adopted in each UK country will deliver results to inform practices of their levels of achievement. The precise arrangements will vary in each UK country and again this will be notified in separate guidance.

England

In England, this will be a short report from the PCT. Practices in England will not be required to enter their achievement values from this report on QMAS. PCTs will do this on practices behalf. This is because reports will not be available until following the last day of the financial year and PCTs will therefore need to use the adjustment facility to ensure correct achievement payments are made to practices.

The precise arrangements are published on the GP patient survey pages of the Department of Health website:

www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatient_survey2007/index.htm

Additional services

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

Cervical screening (CS)

	Indicator	Points
CS 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 five years (payment stages 40 – 80%)	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 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	2
CS 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	7

Child health surveillance (CHS)

	Indicator	Points
CHS 1	Child development checks are offered at intervals that are consistent with national guidelines and policy	6

Maternity services (MAT)

	Indicator	Points
MAT 1	Ante-natal care and screening are offered according to current local guidelines	6

Contraception (SH)

	Indicator	Points
SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months. (payment stages 40 – 90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (payment stages 40 – 90%)	3

Cervical screening (CS)

CS indicator 1

The percentage of patients aged from 25 to 64 (from 21 to 60 in Scotland, 20 to 64 in Wales and from 20 to 65 in Northern Ireland) whose notes record that a cervical smear has been performed in the last 5 years.

Standard 40 – 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%, 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.

Child health surveillance (CHS)

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 concern and that referrals are made as appropriate.⁸⁷

Health for All Children 4 (Hall 4): Guidance on Implementation in Scotland.

www.scotland.gov.uk/Publications/2005/04/15161325/13269

⁸⁷ See: Hall,D. and EllimanD.(2003) eds Health for all children (fourth ed) Oxford University Press Oxford

CHS 1.2 Written evidence

There should be a description of the child health surveillance programme and how concerns 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 concerns 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 concerns are followed up.

Maternity services (MAT)

MAT indicator 1

Ante-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.

Contraception (SH)

Around 80% of (prescribed) contraception in the UK is provided in general practice.

The vast majority of practices are providing the additional service for contraception and many are also providing enhanced services including long acting reversible contraception (LARC) methods. All practices providing any level of contraception need to be able to advise women about all methods to ensure they can make an informed choice. Clinical staff in practices which are not providing all methods also need enough knowledge of these to refer appropriately those women who have chosen a method which they do not supply. Practices also should be aware of local services and local referral pathways.

Ref Respect & Responsibility A Sexual Health Strategy for Scotland.

www.scotland.gov.uk/Resource/Doc/35596/0012575.pdf

NHS Quality Improvement Scotland Sexual Health Services – Standards March 2008.

www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MAR08.pdf

This indicator set seeks to increase the awareness of women seeking contraceptive advice in general practices of LARC methods and thus to increase the percentage of women using these methods.⁸⁸

SH indicator 1

The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.

SH 1.1 Rationale

General practices provide 80% of prescribed contraception in the UK. This register is applicable to all methods of contraception that have been prescribed by the practice:

- Emergency hormonal contraception
- Combined oral contraception
- Progestogen only oral contraception
- Contraceptive patch
- Contraceptive diaphragm
- Intrauterine device (IUD)
- Intrauterine system (IUS)
- Contraceptive implant.

Any woman who has been prescribed any method at least once in the last year (or the appropriate prescribing interval for method of choice) should be included on the register.

This indicator is prospective from 1 April 2009.

SH 1.2 Reporting and verification

The practice reports the number of women prescribed any method of contraception in the preceding 1 April to 31 March (or longer if appropriate for the method of choice).

SH indicator 2

The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months.

SH 2.1 Rationale

A woman's contraceptive needs can change over her reproductive lifespan. Women requiring contraception should be given detailed information about and offered a choice

⁸⁸ See also *J Fam Plann Reprod Health Care* 2008; 34(4): 000–000 "Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods" Anna Glasier, Jane Scorer, Alison Bigrigg.

of all methods, including LARC. This indicator seeks to encourage practices to review these needs on a regular basis and ensure that women are informed of advances in contraceptive choices.

All currently available long acting reversible contraception methods (LARC) are more cost-effective than the combined oral contraceptive even at one year of use. LARC methods include intrauterine devices, the intrauterine system, injectable contraceptives and implants. This is largely because their effectiveness is independent of patient compliance. Of the LARC methods, injectable contraceptives are the least cost effective. Increasing the uptake of LARC methods will reduce the number of unintended pregnancies. However, currently in the UK, about 8% of contraceptive users use LARC. Whilst international comparison is difficult, this percentage is very low.

Ref NICE guidance Long acting reversible contraceptives 2005.

www.nice.org.uk/Guidance/CG30

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources including the fpa, a UK-wide sexual health charity, which produces an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

www.fpa.org.uk/Information/Readourinformationbooklets/guide

Faculty of Sexual & Reproductive Healthcare guidelines on contraceptive methods are available at www.ffprhc.org.uk

SH 2.2 Reporting and verification

The practice reports the percentage of those women prescribed oral or transdermal contraception who have a record of having been given advice on LARC methods in the past 15 months.

Verification – Practices should be prepared to demonstrate how patients are given such advice, examples of leaflets and any specific practice protocols.

SH indicator 3

The percentage of women prescribed emergency hormonal contraception at least once in the last year by the practice, who have received information from the practice about long-acting reversible methods of contraception at the time of, or within one month of the prescription.

SH 3.1 Rationale

Women requiring emergency hormonal contraception should be given detailed information about and offered a choice of all methods, including LARC. It is often possible (and in many cases ideal practice) to commence an ongoing method of contraception at the same time as emergency hormonal contraception is given.

Some women seeking emergency contraception may be best served by being offered an emergency IUD. Emergency IUDs offer a slightly longer window period for action after unprotected intercourse than hormonal EC; they have a higher efficacy in prevention of pregnancy – and they provide excellent ongoing contraception if required.

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources however the fpa, a UK-wide sexual health charity, has an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

www.fpa.org.uk/Information/Readourinformationbooklets/guide

SH 3.2 Reporting and verification

Practices should report the percentage of those women prescribed emergency hormonal contraception who are recorded as having received advice on LARC methods at the time of, or within one month of the most recent script for emergency hormonal contraception.

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