QUALITY AND OUTCOMES FRAMEWORK (QOF)
GUIDANCE FOR NHS BOARDS AND GP PRACTICES
2015/16
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Section 1: Introduction

The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

QOF was introduced as part of the new GMS contract in 2004.

From May 2006, evidence was provided by an 'expert panel', coordinated by a consortium of academic bodies, including the Universities of Birmingham and Manchester, which informed negotiations between NHS Employers, on behalf of the four UK health departments and the General Practitioners Committee (GPC) of the British Medical Association (BMA) on what changes should be made to the QOF each year.

The National Institute for Health and Clinical Excellence (NICE) became responsible for managing an independent and transparent approach to developing the QOF clinical and health improvement indicators from April 2009.

Changes to QOF are agreed as part of wider changes to the General Medical Services (GMS) contract. Since 2013 changes to the GMS contract in Scotland are negotiated annually by the Primary Care Division of the Scottish Government (SG) and the Scottish General Practitioners Committee (SGPC) of the British Medical Association (BMA).

This document includes a copy of the summary of indicators for the 2015/16 QOF as set out in Annex E of the General Medical Services (GMS) Statement of Financial Entitlements Directions (SFE) 2014/15 for Scotland and provides additional guidance on the indicators in Scotland. It replaces all guidance issued in previous years. Annex E to the SFE 2014/15 (Scotland) forms part of the GMS contract for 2015/16.

This guidance applies to Scotland only in line with the GMS Contract Agreement in Scotland for 2015/16.

NICE operates an online facility which allows stakeholders to comment on current QOF indicators. Comments inform the review of existing QOF indicators against set criteria which include:

- evidence of unintended consequences;
- significant changes to the evidence base;
- changes in current practice.

These comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be considered during negotiations between the Scottish Government and Scottish
General Practitioners Committee of the BMA (SGPC) on potential changes to QOF in Scotland. The online facility is available on the NICE website.¹

The focus for new indicators is provided by NICE Quality Standards. Interested individuals/organisations are encouraged to register with NICE as a stakeholder in the development of individual quality standards. Once registered, stakeholders are able to comment on the content of quality standards during their development. The comments facility and full details of quality standards in development are available on the NICE website.²

The term NHS Board is used throughout the guidance, as the structure responsible for primary care in Scotland.

Principles

The following principles relating to the QOF have been agreed by the negotiating parties:

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 is 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 e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

General information on indicators

SG and SGPC have agreed minimal changes (summarised at section ten) to QOF this year to support a period of stability during which consideration can be given to the appropriateness of more fundamental changes to the contract in Scotland. These minimal changes are seen as necessary to address developments in the evidence base and/or patient safety issues only. The term ‘based on NICE menu ID XX’ is used to refer to NICE indicators amended by negotiations. GPs will use their professional judgement and will continue to treat patients in accordance with best clinical practice guidelines. The resources released from a small number of indicator

¹ NICE website. QOF. [www.nice.org.uk/aboutnice/qof/qof.jsp](http://www.nice.org.uk/aboutnice/qof/qof.jsp)
² NICE website. Quality standards. [www.nice.org.uk/ourguidance/niceguidancebytype/clinicalguidelines/shregistration/shregistration.jsp](http://www.nice.org.uk/ourguidance/niceguidancebytype/clinicalguidelines/shregistration/shregistration.jsp)
retirements have been redirected to address other clinical areas as indicated in the summary in section 10.

Indicators across all domains were renumbered from April 2013. In the guidance they are prefixed by an abbreviation of the category to which they belong, for example coronary heart disease (CHD) indicator number one becomes CHD001. The addition of zeros indicates the change from previous years numbering.

For Indicators that apply to **Scotland only**, and differ from the rest of the UK, will have (S) after the indicator number, so for CHD indicator number one above, CHD001 becomes CHD001(S).

Indicators that have been developed through the NICE process are identified by the reference 'NICE [YEAR] menu ID: NMXX' for information.

For the purposes of calculating achievement payments, contractor achievement against QOF indicators is measured:

- on the last day of the relevant financial year (31 March); or

- in the case where the contract terminates mid-year, on the last day on which the contract subsists. For example, for payments relating to the financial year 1 April 2015 to 31 March 2016 unless the contract terminates mid-year, achievement is measured on 31 March 2016. If the contract ends on 30 June 2015, achievement is measured on 30 June 2015.

- Excluding QS004(S), which is based on the practice list size as of 1st April 2015

Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods are defined by reference to the last day of the financial year to which the achievement payments relate – for example:

- Indicator CHD002(S) – “The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less”, the phrase “in the preceding 15 months” means in the 15 month period ending on 31 March in the financial year to which the achievement payments relate;

- Indicator HYP006(S) – “The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 12 months) is 150/90 mmHg or less”, the phrase “in the preceding 12 months” means in the twelve month period ending on 31 March in the financial year to which the achievement payments relate;

- Indicator CS002(S) – “The percentage of women (aged 20 or over and under the age of 60) whose notes record that a cervical screening test has been performed in the preceding 5 years” the phrase “in the preceding 5 years” means in the five year period ending on 31st March in the financial year to which the achievement payments relate;

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NICE menu of indicators. [www.nice.org.uk/aboutnice/qof/indicators.jsp](http://www.nice.org.uk/aboutnice/qof/indicators.jsp)
• Indicator CHD007(S) – “The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March” the phrase “in the preceding 1 August to 31 March” means the eight month period ending on 31 March in the financial year to which the achievement payments relate.

For clarity, the following points apply to any indicators in which age or date ranges are referenced:

• Where an indicator refers to patients diagnosed after a specified date (and does not specify a period within which the care described in the indicator is to be carried out), the indicator is looking for any record of the care described at any time on or after the diagnosis date (provided that the diagnosis date is on or after the specified date) up to and including the date that the achievement is measured. This type of indicator is called a “cumulative” indicator. AST002 is an example: “The percentage of patients aged 8 years or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before and any time after diagnosis”. This indicator is looking for any record of the specified care at any time on or after the diagnosis date (provided that the diagnosis date is on or after 1 April 2006), up to and including the date that the achievement is measured;

• Patients are considered to be 'currently treated' with a specified medicine if they have had a prescription for that medicine within the preceding six months ending on the last day of the financial year to which the achievement payments relate.

Annex E to the SFE 2014/15 (Scotland) sets out the rules that apply to measuring achievement for contracts that end before the end of the financial year.

**Disease registers (denominators)**

An important feature of the QOF was the establishment of disease registers. These were lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator.

Although the points associated with the creation and maintenance of disease registers have been retired from 2014-15 (i.e. transferred from QOF to core) practices are advised to continue to appropriately read code all of the relevant diagnoses and provide clinically appropriate lifestyle advice at the time of diagnosis.

It will be important that GP Practices continue to create and maintain appropriate patient lists (denominators), as they will need them to ensure that a) good clinical care can continue to be delivered b) there is a basis for the calculation of achievement for those dependent indicators that remain within the relevant disease area and c) there is no apparent reduction in prevalence, which will continue to be reviewed on an annual basis and reflected in the final practice QOF payment.
Clinical areas previously transferred to core

Where whole clinical areas have been transferred to core from 1\textsuperscript{st} April 2014 e.g. Hypothyroidism, Epilepsy, Learning Disability and Obesity it is still expected that practices will continue to provide all appropriate clinical care. This is also true for areas without any indicator areas such as Child Health Surveillance and Maternity Services.

Verification

Annex E to the SFE 2014/15 (Scotland) sets out the requirements in relation to verification. The contractor is required to ensure that it is able to provide any information that the NHS Board may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled and the contractor is required to make that information available to the NHS Board on request. In verifying that an indicator has been achieved and information correctly recorded, the NHS Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.

For indicators where achievement is not extracted automatically from GP clinical systems the guidance outlines the evidence which the NHS Board may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested by the NHS Board for payment verification purposes.

QOF Business Rules

In April 2010, the NHS Health and Social Care Information Centre (HSCIC) took over the development of the Business Rules from NHS Employers and NHS Connecting for Health (CfH).

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

It has been agreed that Scotland will use the UK business rules where possible and appropriate. A number of the agreed clinical indicators are different between Scotland and England, and where necessary these indicators have amendments to the indicator descriptions, points allocated and thresholds to reflect the different
priorities in Scotland. Any amendments to the Business Rules for use in Scotland will be agreed with SGPC. A copy of the current version of the full Business Rules can be found at:

http://www.hscic.gov.uk/qofbrv32

**Exception reporting**

Exception reporting applies to those indicators in any domain of the QOF where the achievement is determined by the percentage of patients receiving the specified level of care.

Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group. Patients who are on the disease register or in the target group for the clinical area concerned, but not included in an indicator denominator for definitional reasons are called “exclusions”.

“Exceptions” relate to registered patients who are on the relevant disease register or in the target group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted and they have not received the care specified in the indicator wording. If the patient has been excepted but subsequently the care has been provided within the relevant time period the patient will be included in both the denominator and the numerator (i.e. achievement will always take precedence over an exception).

**Exception reporting criteria**

Patients may be excepted if they meet the following criteria for exception reporting:

A. patients who have been recorded as refusing to attend for review who have been invited on at least three occasions during the financial year to which achievement payments relate (except in the case of indicator CS002(S), where the patient should have received the nationally agreed invitations from the recall system during the period of time specified in the indicator during which achievement is to be measured (i.e. the preceding 5 years ending 31 March in the financial year to which achievement payments relate).

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

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

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

E. patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, 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 patient record following a discussion with the patient.

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

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

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

In addition, contractors may exception report patients from single indicators if they meet criteria in C to I, for example a patient who has heart failure (HF) due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin converting enzyme inhibitors (ACE-inhibitors/ACE-I) and angiotensin receptor blocker (ARB) could be exception reported from HF004(S). This would result in the patient being removed from the denominator for that indicator only.

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

Additional guidance on exception reporting can be found in section eight of this document and in Annex E of the SFE 2014/15 (Scotland).
Section 2: Summary of all indicators

Section 2.1: Clinical domain

Section 2.1 applies to all contractors participating in QOF

Atrial fibrillation (AF)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Atrial Fibrillation and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-going management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF007(S)*. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.</td>
<td>9</td>
<td>40–70%</td>
</tr>
<tr>
<td>*NICE 2011 menu ID: NM45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF006(S)*. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc risk stratification scoring system in the preceding 15 months (excluding those whose previous CHA2DS2-VASc score was 2 or above).</td>
<td>8</td>
<td>50–90%</td>
</tr>
<tr>
<td>*NICE 2011 menu ID: NM46</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please note that these indicators have required to be re-numbered in order to avoid confusion with previous versions of the indicators and to ensure that the business rules accurately note the work done by practices*

Secondary prevention of coronary heart disease (CHD)

Coding
The practice records agreed diagnostic READ codes for patients diagnosed with Coronary Heart Disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD002(S). The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.</td>
<td>17</td>
<td>50–85%</td>
</tr>
<tr>
<td>CHD005(S). The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.</td>
<td>7</td>
<td>50–90%</td>
</tr>
<tr>
<td>CHD006(S). The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin. <em>NICE 2010 menu ID: NM07</em></td>
<td>10</td>
<td>45–80%</td>
</tr>
<tr>
<td>CHD007(S). The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>7</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**Heart failure (HF)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Heart Failure and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF002(S). The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by</td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>
specialist assessment between 3 months before and 12 months after entering on to the register.

### On-going management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF003(S). In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.</td>
<td>10</td>
<td>50–85%</td>
</tr>
<tr>
<td>HF004(S). In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.</td>
<td>9</td>
<td>50–75%</td>
</tr>
</tbody>
</table>

### Denominators

There are two denominators used for the HF indicators for the purposes of calculating APDF:

1. A denominator of all patients with HF is used to calculate APDF for HF002.
2. A denominator of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003(S) and HF004(S).

Denominator (1) is defined as all patients with HF. Denominator (2) is a sub-set of register one and is composed of patients with a diagnostic code for LVSD as well as for HF.

### Hypertension (HYP)

#### Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Hypertension and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP006(S). The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.</td>
<td>55</td>
<td>45–80%</td>
</tr>
</tbody>
</table>
Peripheral arterial disease (PAD)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Peripheral Arterial Disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAD002(S). The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less. NICE 2011 menu ID: NM34</td>
<td>2</td>
<td>40–90%</td>
</tr>
<tr>
<td>PAD004(S). The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken. NICE 2011 menu ID: NM33</td>
<td>2</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

Stroke and transient ischaemic attack (STIA)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Stroke or transient ischaemic attack and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA008(S). The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA.</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>
### Ongoing management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIA003(S). The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.</td>
<td>5</td>
<td>50–85%</td>
</tr>
<tr>
<td>STIA007(S). The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.</td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>STIA009(S). The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

### Diabetes mellitus (DM)

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Diabetes mellitus and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM002(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less. <em>NICE 2010 menu ID: NM01</em></td>
<td>8</td>
<td>45–71%</td>
</tr>
<tr>
<td>DM003(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less. <em>NICE 2010 menu ID: NM02</em></td>
<td>10</td>
<td>40–65%</td>
</tr>
<tr>
<td>DM006(S). The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).</td>
<td>3</td>
<td>50–90%</td>
</tr>
<tr>
<td>DM007(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months. <em>NICE 2010 menu ID: NM14</em></td>
<td>17</td>
<td>40–50%</td>
</tr>
</tbody>
</table>
DM008(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months. | 8 | 45–70% |

DM009(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months. | 10 | 50–90% |

DM012(S). The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.

NICE 2010 menu ID: NM13

DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.

ICE 2011 menu ID: NM27

DM018(S). The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March. | 3 | 50–90% |

### Asthma (AST)

#### Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Asthma and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before and any time after diagnosis.</td>
<td>15</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

| **Ongoing management** | | |
| AST003(S). The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of | 20 | 45–70% |
Scottish Quality and Outcomes Framework guidance for GMS contract 2015/16

asthma control using the 3 RCP questions.

*NICE 2011 menu ID: NM23*

<table>
<thead>
<tr>
<th></th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST004(S). The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.</td>
<td>6</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

**Chronic obstructive pulmonary disease (COPD)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with chronic obstructive pulmonary disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003(S). The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.</td>
<td>9</td>
<td>50–90%</td>
</tr>
<tr>
<td>COPD005(S). The percentage of patients with COPD and Medical Research Council dyspnoea grade≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months.</td>
<td>5</td>
<td>40-90%</td>
</tr>
<tr>
<td><em>NICE 2012 menu ID: NM63</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD007(S). The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>6</td>
<td>50-90%</td>
</tr>
</tbody>
</table>
Dementia (DEM)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Dementia and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td>DEM002(S). The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months.</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register.</td>
<td>6</td>
</tr>
</tbody>
</table>

Depression (DEP)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Depression and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial management</td>
<td>DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.</td>
<td>10</td>
</tr>
</tbody>
</table>

Denominators

There is no register indicator for the depression indicators. The denominator for the indicators in the depression area for the purpose of calculating the APDF is defined as all patients aged 18 or over, with a new diagnosis of depression in the preceding
1 April to 31 March, who have an unresolved record of depression in their patient record.

**Mental health (MH)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Schizophrenia, Bipolar Affective Disorder and other Psychoses and other patients on lithium therapy and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH002(S). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate.</td>
<td>6</td>
<td>40–90%</td>
</tr>
<tr>
<td>MH003(S). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months. <em>NICE 2010 menu ID: NM17</em></td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>MH004(S). The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months. <em>NICE 2010 menu ID: NM18</em></td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>MH005(S). The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months. <em>NICE 2011 menu ID: NM42</em></td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>MH006(S). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months. <em>NICE 2010 menu ID: NM16</em></td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>MH007(S). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months. <em>NICE 2010 menu ID: NM15</em></td>
<td>4</td>
<td>50–90%</td>
</tr>
</tbody>
</table>
The percentage of women aged 20 or over and who have not attained the age of 60 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.

NICE 2010 menu ID: NM20

MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.

NICE 2010 menu ID: NM21

MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.

NICE 2010 menu ID: NM22

### Denominators

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

### Remission from serious mental illness

Making an accurate diagnosis of remission can be challenging. In the absence of strong evidence of what constitutes ‘remission’ from serious mental illness, clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

- no record of antipsychotic medication;
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being ‘in remission’ they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002 to MH008(S).

The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as ‘in remission’ experience a relapse then this should be recorded as such in their patient record.

In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.
Where a patient has relapsed after being recorded as being in remission, their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

**Cancer (CAN)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Cancer, excluding non-melanotic skin cancers, on or after the 1st April 2003, and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis. <strong>NICE 2012 menu ID: NM62</strong></td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**Chronic kidney disease (CKD)**

**Coding**

The practice records agreed diagnostic READ codes for patients aged 18 and over diagnosed with Chronic Kidney Disease (US national Kidney Foundation: stage 3 to 5) and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD002(S). The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 15 months) is 140/85 mmHg or less.</td>
<td>11</td>
<td>45–70%</td>
</tr>
<tr>
<td>CKD003. The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB.</td>
<td>9</td>
<td>45–80%</td>
</tr>
<tr>
<td>CKD004(S). 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 preceding 15 months.</td>
<td>6</td>
<td>45–80%</td>
</tr>
</tbody>
</table>
Osteoporosis: secondary prevention of fragility fractures (OST)

Coding

The practice records agreed diagnostic READ codes for the following groups of patients and provides appropriate lifestyle advice at the time of diagnosis:

1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and

2. Aged 75 or over with a record of a fragility fracture and a diagnosis of osteoporosis on or after 1 April 2014.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent. <em>NICE 2011 menu ID: NM30</em></td>
<td>3</td>
<td>30–60%</td>
</tr>
<tr>
<td>OST005. The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent. <em>NICE 2011 menu ID: NM31</em></td>
<td>3</td>
<td>30–60%</td>
</tr>
</tbody>
</table>

**Denominators**

Although the coding for Osteoporosis OST002 and OST005 defines two separate denominators, the denominator for the purposes of calculating the APDF is defined as the sum of the number of patients in both denominators.

**Rheumatoid arthritis (RA)**

Coding

The practice records agreed diagnostic READ codes for patients aged 16 and over diagnosed with Rheumatoid Arthritis and provides appropriate lifestyle advice at the time of diagnosis.
### Ongoing management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA002(S). The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months. <em>NICE 2012 menu ID: NM58</em></td>
<td>5</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

### Palliative care (PC)

#### Coding

The practice records agreed diagnostic READ codes for patients of any age diagnosed as being in need of palliative care/support and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC002. The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

#### Denominator

There is no APDF calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a denominator during the financial year then they will be eligible for payment for PC002.

### Section 2.2: Public health (PH) domain

Section 2.2 applies to all GMS contractors participating in QOF.

### Cardiovascular disease – primary prevention (CVD-PP)
Scottish Quality and Outcomes Framework guidance for GMS contract 2015/16

### Ongoing management

| Thresholds |  
| --- | --- |
| **CVD-PP001(S)**. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS Board) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins.  
*NICE 2011 menu ID: NM26* | 10 | 40–90% |
| **CVD-PP002(S)**. The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet. | 5 | 40–75% |

### Disease register

The denominator for the purposes of calculating the APDF for the indicators in the CVD-PP area defined as follows: patients diagnosed with a first episode of hypertension on or after 1 April 2009, excluding patients with the following conditions:

- CHD or angina;
- stroke or TIA;
- peripheral vascular disease;
- familial hypercholesterolemia;
- diabetes;
- CKD (US National Kidney Foundation: Stage 3 to 5 CKD).

### Blood pressure (BP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
</table>
| **BP002(S)**. The percentage of patients aged 45 or over that have a record of blood pressure in the preceding 5 years.  
*NICE 2012 menu ID: NM61* | 15 | 40–80% |
Smoking (SMOK)

Coding

The practice records agreed diagnostic READ codes for the smoking status of patients aged 15 or over in the preceding 27 months and provides appropriate lifestyle advice at the time of recording.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK002(S). The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months. <em>NICE 2011 menu ID: NM38</em></td>
<td>25</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**Ongoing management**

SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

SMOK004(S). The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months. *NICE 2011 menu ID: NM40* | 12 | 40–90% |

SMOK005(S). The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months. *NICE 2011 menu ID: NM39* | 25 | 50–90% |

**Denominators for smoking**

The denominator for the purposes of calculating the APDF for SMOK002 and SMOK005(S) is defined as the sum of the number of patients on the denominators for each of the conditions listed in the indicators. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the denominator for SMOK002 and SMOK005(S).

There is no APDF calculation for, SMOK003 and SMOK004(S).

Smokers
For patients who smoke this recording should be made in the preceding 27 months for or in the preceding 15 months for SMOK002(S).

Non-smokers
It is recognised that life-long 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 in the preceding 27 months or in the preceding 15 months for SMOK002(S) until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked after their 25th birthday;
- never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patients inclusion on the SMOK002(S) denominator (e.g. one of the conditions listed on the SMOK002(S) denominator).

Ex-smokers
There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 27 months or in the preceding 15 months for SMOK002(S). Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

Cervical screening (CS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001(S). The contractor has a protocol that is in line with national guidance agreed with NHS Scotland for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates.</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>CS002(S). The percentage of women aged 20 or over and who have not attained the age of 60 whose notes record that a cervical screening test has been performed in the preceding 5 years.</td>
<td>11</td>
<td>45–80%</td>
</tr>
<tr>
<td>CS004. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
**Contraception (CON)**

**Coding**

The practice records agreed diagnostic READ codes for women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS, and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CON003(S). The percentage of women, aged 54 or under, prescribed emergency hormonal contraception one or more times in the preceding 15 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription.</td>
<td>3</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**Section 2.3. Quality and Safety (QS) domain**

Section 2.3 applies to all GMS contractors participating in QOF.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS001(S). The contractor identifies a liaison GP to link with the liaison member of staff within the local Health and Social Care Partnership</td>
<td>5</td>
</tr>
<tr>
<td>QS002(S). The practice will undertake a review of access (option A, B, or C – see guidance section), using the tool agreed between SG and SGPC and provide a practice action report of the findings to the NHS Board by 15th March 2016.</td>
<td>25</td>
</tr>
<tr>
<td>QS003(S). The practice participates in a process of continuous quality improvement by undertaking a review of a data set, agreed between SC and SGPC, provided by the NHS Board. The practice will provide an annual report, on a template agreed between the SG and SGPC by 15th March 2016, and participates in a 3 yearly peer review visit.</td>
<td>25</td>
</tr>
<tr>
<td>QS004(S). The contractor produces a list of 5 per cent of patients in the practice, as of 1st April 2015, who are predicted to be at significant risk of emergency admission or unscheduled care. This list can be produced using a risk profiling tool accessible to practices e.g. SPARRA, or where this is not available/required (by</td>
<td>5</td>
</tr>
</tbody>
</table>
local agreement), alternative arrangements can be agreed between the NHS Board and LMC.

QS005(S). The contractor identifies a minimum of 30 per cent (which can include continuing ACPs from the 2014-15 contract year) of those patients from the list produced in indicator QS004(S) who would most benefit from, and creates, an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient’s review should be determined in the light of their clinical and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.

QS006(S). The contractor holds at least 4 meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice’s patients.

QS007. The practice conducts two case note reviews, using a validated tool, to detect patient safety incidents, meets to discuss the results, and shares a reflective report on actions that arise from this with the NHS Board by 15th March 2016.

QS008. The practice conducts a safety climate survey with all staff, clinical and non-clinical, using a validated tool, meets to discuss the results, and shares a reflective report on actions that arise from this with the NHS Board by 15th March 2016.

Section 2.4: Medicines management (MM) domain

Section 2.4 applies to all GMS contractors participating in QOF

Medicines management (MM)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM001(S). The practice meets with the NHS Board prescribing adviser at least annually and agrees 3 actions related to prescribing.</td>
<td>4</td>
</tr>
<tr>
<td>MM002(S). The practice meets with the NHS Board prescribing adviser, has agreed 3 actions related to prescribing and subsequently provided evidence of change. The practice should undertake an audit of an area of prescribing</td>
<td>9</td>
</tr>
</tbody>
</table>
that is a clinical issue that has been agreed with the NHS Board prescribing adviser.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MM003(S). A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines. Standard 80 per cent.</td>
<td>10</td>
</tr>
</tbody>
</table>
Section 3: Clinical domain

Clinical domain introduction

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

- where the responsibility for on-going management rests principally with the general practitioner and the primary care team;

- 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;

- where the disease area is a priority.

Where evidence-based national guidance has not been included, this has usually been to limit the size and complexity of the framework, where this is the case links and/or references have been included.

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

Establishing and maintaining disease registers is good professional practice and ensures a defined population is identified for undertaking further evidence-based interventions. Disease registers also make it possible to call and recall patients effectively to provide systematic care and to undertake care audits and ensure that there is a basis for the calculation of achievement for any dependent indicators that remain within this disease area and that there is no apparent reduction in prevalence, which will continue to be reviewed on an annual basis and will be reflected in the final practice QOF payment.

For each indicator, detailed guidance supporting the indicator is provided under ‘rationale’ and where appropriate additional details around ‘reporting and verification’ requirements are also included.

The drugs which count towards achievement for the clinical and health improvement indicators are included in the Business Rules for the relevant year. The code clusters within the Business Rules are updated each April and October. For this reason, references to acceptable drugs are not included in the guidance. The Business Rules can be found on the National Services Scotland (NSS) Practitioner Services Division (PSD) website

‘xxx.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 an

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4 http://www.psd.scot.nhs.uk/professionals/medical/qof.html
electronic version of this guidance) is provided. When available, national guidelines have been used as the main evidence source, but individual papers are also quoted. In some areas, more extensive information is provided. The aim is to achieve a balance of providing helpful information without attempting to provide a textbook of medicine or replicating guidelines.

The indicators included in the QOF 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.

'xxx.2 Reporting and verification'

The SFE(Scotland) sets out the reporting requirements for contractors and the rules for the calculation of QOF payments. It states (see section 5.17 (c)-(e) of the directions):

(c) "contractors utilising computer systems approved by the NHS Board must make available to the NHS Board aggregated monthly returns relating to their achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;

(d) contractors not utilising computer systems approved by the NHS Board must make available to the NHS Board similar monthly returns, in such form as the Board reasonably requests (for example, the Board may reasonably request that contractors fill in manually a printout of the standard spread sheet in the form specified by the NHS Board); and

(e) all information supplied pursuant to or in accordance with this paragraph must be accurate."

The SFE 2015/16 (Scotland) states (section 6.3) that in order for a contractor claim payment for achievement “a contractor must make a return in respect of the information required of it by the Board in order for the Board to calculate its achievement payment”.

Data from GP clinical systems will be extracted automatically by a data extraction service and reported to NHS Boards. Contractors report achievement against indicators where automatic extraction is not available by self-declaration to NHS Boards.

The SFE 2015/16 (Scotland) states (paragraph 6.13(c): “The contractor must ensure that it is able to provide any information that the NHS Board may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to the Board on request. In verifying that an indicator has been achieved and information correctly recorded, the Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.”

Where 'reporting and verification' is included it provides additional information to support practices in meeting the criteria for the indicator. In some cases, examples of
information that the NHS Board may require contractors to provide for reporting and verification purposes are outlined.

The terms ‘notes’ and ‘patient record’ are used throughout this document to indicate either electronic or paper patient records.

## Atrial fibrillation (AF)

### Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Atrial Fibrillation and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF007(S)*. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy. <em>NICE 2011 menu ID: NM45</em></td>
<td>9</td>
<td>40–70%</td>
</tr>
<tr>
<td>AF006(S)*. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc risk stratification scoring system in the preceding 15 months (excluding those whose previous CHA2DS2-VASc score was 2 or above). <em>NICE 2011 menu ID: NM46</em></td>
<td>8</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

### AF – rationale for inclusion of indicator set

AF is common and significant cause or morbidity and mortality. The age-specific prevalence of AF is rising, presumably due to improved survival of patients with CHD (the commonest underlying cause of AF\(^5\)). One per cent of a typical practice population will be in AF; five per cent of patients aged 65 or over and nine per cent of patients aged 75 or over. AF is associated with a five-fold increase in risk of stroke\(^6\).


\(^{5}\) Psaty et al. Circulation 1997; 96: 2455-61
Coding and Lifestyle

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

The health of patients with Atrial Fibrillation can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


AF indicator 007(S) (NICE 2011 menu ID: NM45)

In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.

AF 007.1(S) Rationale

AF is the most common sustained cardiac arrhythmia and if left untreated is a significant risk factor for stroke and other morbidities.

NICE guideline CG180 was published in June 2014 (superseding NICE guideline CG36), building upon some of the guidance contained in SIGN 129, which supported Scottish QOF indicators AF005(S) and AF004 in 2014/15.

NICE Guideline CG180 states;

Stroke risk 1.4.1 Use the CHA2DS2-VASc stroke risk score to assess stroke risk in people with any of the following: symptomatic or asymptomatic paroxysmal,
persistent or permanent atrial fibrillation, atrial flutter, a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm. [new 2014]

Bleeding risk 1.4.2 Use the HAS-BLED score to assess the risk of bleeding in people who are starting or have started anticoagulation. Offer modification and monitoring of the following risk factors: uncontrolled hypertension, poor control of international normalised ratio (INR) (‘labile INRs’), concurrent medication, for example concomitant use of aspirin or a non steroidal anti inflammatory drug (NSAID), harmful alcohol consumption. [new 2014]

Antiplatelets 1.5.15 Do not offer aspirin monotherapy solely for stroke prevention to people with atrial fibrillation. [new 2014]

Interventions to prevent stroke 1.5.1 Do not offer stroke prevention therapy to people aged under 65 years with atrial fibrillation and no risk factors other than their sex (that is, very low risk of stroke equating to a CHA2DS2-VASc score of 0 for men or 1 for women). [new 2014]

Anticoagulation 1.5.2 Consider anticoagulation for men with a CHA2DS2-VASc score of 1. Take the bleeding risk into account. [new 2014]

1.5.3 Offer anticoagulation to people with a CHA2DS2-VASc score of 2 or above, taking bleeding risk into account. [new 2014]

1.5.4 Discuss the options for anticoagulation with the person and base the choice on their clinical features and preferences. [new 2014]

Anti-coagulation would not necessarily be indicated if the episode of AF was an isolated event that was not expected to re-occur (for example, one-off AF with a self-limiting cause).

This indicator uses the CHA2DS2-VASc risk stratification scoring system to inform treatment options. The use of a risk stratification scoring system is in line with European Society of Cardiology (ESC) guidance that states that ‘recommendations for therapy should be based on the presence (or absence) of risk factors for stroke and thromboembolism’.

AF 007.2(S) Reporting and verification
See indicator wording for requirement criteria.

AF indicator 006(S) (NICE 2011 menu ID: NM46)

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc risk stratification scoring system in the preceding 15 months (excluding those whose previous CHA2DS2-VASc score was 2 or above).

AF 006(S).1 Rationale
See AF 005.1
Where the CHA2DS2-VASc score is greater than 2 the patient is at high risk of having a future stroke and the patient should be offered treatment with anti-coagulation drug therapy.

**AF 006(S).2 Reporting and verification**
See indicator wording for requirement criteria.

## Secondary prevention of coronary heart disease (CHD)

### Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Coronary Heart Disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD002(S). The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.</td>
<td>17</td>
<td>50–85%</td>
</tr>
<tr>
<td>CHD005(S). The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.</td>
<td>7</td>
<td>50–90%</td>
</tr>
<tr>
<td>CHD006(S). The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin. ( NICE 2010 \text{ menu ID: NM07} )</td>
<td>10</td>
<td>45–80%</td>
</tr>
<tr>
<td>CHD007(S). The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>7</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

### CHD – rationale for inclusion of indicator set

CHD 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.
Coding should include all patients who have had coronary artery revascularisation procedures, such as coronary artery bypass grafting (CABG). Patients with Cardiac Syndrome X are not included on the CHD register.

Contactors should record those with a past history of myocardial infarction (MI) as well as those with a history of CHD.

**Coding and Lifestyle**

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

The health of patients with Coronary Heart Disease can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**CHD indicator 002(S)**

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

**CHD 002.1(S) Rationale**

This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of cardiovascular disease (CVD) through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.
The NICE clinical guideline on hypertension\textsuperscript{7} sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the hypertension indicator set. To summarise, patients with CHD and stage one hypertension are recommended drug therapy for hypertension.

The NICE clinical guideline on hypertension recommends a target blood pressure below 140/90 mmHg in patients aged 79 or under with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 or over, with treated hypertension. For the purpose of QOF, an audit standard of 150/90 mmHg has been adopted for this indicator.

A major overview of randomised trials showed that a reduction of 5–6 mmHg in blood pressure sustained over five years reduces coronary events by 20–25 per cent in patients with CHD\textsuperscript{8}.

**CHD 002.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**CHD indicator 005(S)**

The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.

**CHD 005.1(S) Rationale**
Both NICE\textsuperscript{9,10} and SIGN\textsuperscript{11,12} clinical guidelines recommend that aspirin (75 – 150 mg per day) is given routinely and continued for life in all patients with CHD unless there is a contraindication. Clopidogrel (75 mg/day) is an effective alternative in patients with contraindications to aspirin, or who are intolerant of aspirin.

**CHD 005.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**CHD indicator 006(S) (NICE 2010 menu ID: NM07)**

The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin.

**CHD 006.1(S) Rationale**

\textsuperscript{7}NICE clinical guideline CG127. Hypertension: clinical management of primary hypertension in adults 2011. \url{http://publications.nice.org.uk/hypertension-cg127}
\textsuperscript{8} Collins et al. Lancet 1990; 335: 827-38
\textsuperscript{9} NICE clinical guideline CG48. Secondary prevention in primary and secondary care for patients following MI 2007. \url{http://www.nice.org.uk/CG048}
\textsuperscript{10} NICE clinical guideline CG126. Management of stable angina 2011. \url{http://www.nice.org.uk/CG126}
\textsuperscript{11} SIGN clinical guideline 96. Management of stable angina 2007. Grade A recommendation. \url{www.sign.ac.uk/guidelines/fulltext/96/index.html}
\textsuperscript{12} SIGN clinical guideline 97. Risk estimation and the prevention of CVD 2007.Grade A recommendation. \url{www.sign.ac.uk/guidelines/fulltext/97/index.html}
There is evidence from meta-analyses and RCTs (level one evidence) for a range of relevant health outcomes, including mortality, to support all patients who have had an acute MI being offered treatment with a combination of the following drugs:

- an ACE-I OR ARB if ACE-I intolerant;
- dual antiplatelet therapy (aspirin, plus a second antiplatelet agent)\(^{13-14-15-16}\)
- a beta-blocker;
- statin;

There is also health economic evidence to suggest that these drug interventions are cost-effective. The evidence presented here is summarised from NICE clinical guideline CG48.

ACE-I
In the studies reviewed, short-term treatment with an ACE-I in unselected patients immediately after an MI was associated with a small reduction in mortality.

Long-term treatment with an ACE-I in patients with signs of heart failure (HF) and/or LVSD who have recently experienced an MI was associated with a substantial reduction in all-cause mortality, recurrent MI and re-admission for HF. Where patients are intolerant of an ACE-I (for example because of a cough or allergy) it is recommended that an ARB is substituted.

Aspirin and anti-platelet therapy
In the studies reviewed, treatment with aspirin after an MI reduced the risk of death and cardiovascular events. In a subgroup of patients with recent MI, aspirin and clopidogrel (an alternative anti-platelet therapy) have similar cardiovascular benefits.

Warfarin
Patients may be treated with anti-coagulants when they are intolerant of aspirin and an alternative anti-platelet therapy or for the management of co-morbid conditions such as AF and HF. Where a patient is treated with anti-coagulant therapy, anti-platelet therapy may not be clinically appropriate. For the purpose of this indicator, anti-coagulant therapy will be included in the ‘aspirin or an alternative anti-platelet therapy’ component of this indicator to cover this cohort of patients.

Beta-blocker
In the studies reviewed, in unselected patients after acute MI, long-term treatment with beta-blockers was associated with reduced mortality compared with placebo.

Statins


\(^{15}\)SIGN clinical guideline 96. Management of stable angina. 2007. Grade A recommendation. [www.sign.ac.uk/guidelines/fulltext/96/index.html](http://www.sign.ac.uk/guidelines/fulltext/96/index.html)

In a meta-analysis of primary and secondary prevention studies, treatment with a statin was associated with a reduction in all-cause mortality and cardiovascular mortality.

Further information:


**CHD 006.2(S) Reporting and verification**

This indicator requires a patient to be on four drugs, one from each of the following categories:

- an ACE-I OR an ARB if ACE intolerant; and
- either aspirin OR an alternative anti-platelet OR anti-coagulant therapy; and
- a beta-blocker; and
- a statin.

A patient will therefore be counted towards the target if they are:

a. receiving an ACE-I AND receiving either aspirin or an alternative anti-platelet or anti-coagulant therapy AND receiving a beta-blocker AND receiving a statin;

b. contraindicated for an ACE-I BUT receiving an ARB AND receiving either aspirin or an alternative anti-platelet or anti-coagulant therapy AND receiving a beta-blocker AND receiving a statin.

A patient will not be included in the denominator if they are:

a. exception reported using one of the nine QOF exception reporting criteria (unless they have a contraindication as per ‘b’ above but are receiving one of the alternative drugs);

b. receiving a drug from the last three groups but contraindicated for both an ACE-I and an ARB.

A patient will be included in the denominator and not in the numerator if they are:
a. not appropriately exception coded;
b. not receiving the medicines described above.

**CHD indicator 007(S)**

The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.

**CHD 007.1(S) Rationale**

This is a current recommendation from the Chief Medical Officer (CMO) and the Joint Committee on Vaccination and Immunisation (JCVI).

Further information


**CHD 007.2(S) Reporting and verification**

See indicator wording for requirement criteria.

**Heart failure (HF)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Heart Failure and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF002(S). The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 12 months after entering on to the register.</td>
<td>6</td>
<td>50–90%</td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF003(S). In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.</td>
<td>10</td>
<td>50–85%</td>
</tr>
<tr>
<td>HF004(S). In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction</td>
<td>9</td>
<td>50–75%</td>
</tr>
</tbody>
</table>
who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.

**HF – rationale for inclusion of indicator set**

HF 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 HF unless specified otherwise.

Two denominators are used for the purposes of calculating APDF for the HF indicators:

1) a denominator of patients with HF is used to calculate APDF for HF002
2) a denominator of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003(S) and HF004(S).

Denominator (1) is defined in Records. Denominator (2) is a sub-set of denominator (1) and is composed of patients with a diagnostic code for LVSD as well as HF.

**Coding and Lifestyle**

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

The health of patients with Heart Failure can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

**Further information**


[http://www.healthscotland.com/topics/health/alcohol/resources.aspx](http://www.healthscotland.com/topics/health/alcohol/resources.aspx)

SIGN clinical guideline 74. The management of harmful drinking and alcohol dependence in primary care 2008. 
http://www.sign.ac.uk/guidelines/fulltext/74/index.html

HF indicator 002

The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 12 months after entering on to the register.

HF002.1 Rationale

This indicator requires that all patients with suspected HF are investigated and this is expected to involve, as a minimum, further specialist investigation (such as echocardiography) and often specialist opinion. Serum natriuretic peptides can be used to determine whether patients with clinically suspected HF need a referral for echocardiography and their use is recommended as below. Specialists may include GPs identified by the NHS Board as having a special interest in HF. Many HF 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 NICE guidance recommends that patients with suspected HF receive both echocardiography and specialist assessment. The guidance also recommends that serum natriuretic peptides are measured in patients with suspected HF without previous MI. Patients with suspected HF who have had a previous MI or who have very high levels of serum natriuretic peptide are considered to require urgent referral due to their poor prognosis. The SIGN clinical guideline on the management of chronic HF recommends that echocardiography is performed in patients with suspected HF who have either a raised serum natriuretic peptide or abnormal electrocardiograph result to confirm the diagnosis and establish the underlying cause.

HF 002.2 Reporting and verification

See indicator wording for requirement criteria.

HF indicator 003(S)

In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.

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http://www.nice.org.uk/CG108/niceguidance/pdf/english

http://www.nice.org.uk/CG108/niceguidance/pdf/english


http://www.sign.ac.uk/guidelines/fulltext/95/index.html
**HF 003.1(S) Rationale**

There is strong clinical and cost-effectiveness evidence to support the use of ACE-I in all patients with HF with LVSD. ACE-I improve symptoms, reduce the hospitalisation rate and improve the survival rate. This is applicable in all age groups. ARBs are also effective in the treatment of patients with HF due to LVSD, but may only be used in patients intolerant of ACE-I.

It is possible to have a diagnosis of LVSD without HF, for example, asymptomatic people who might be identified coincidentally but who are at high risk of developing subsequent HF. In such cases, ACE-I’s delay the onset of symptomatic HF, reduce cardiovascular events and improve long-term survival. This indicator only applies to patients with HF and therefore excludes this other group of patients who are nevertheless to be considered for treatment with ACE-I.

NICE clinical guideline CG108 and SIGN clinical guideline 95 recommend that ACE-I is used as first-line therapy in all patients with HF due to LVSD and that ARBs are used only in patients who are intolerant of ACE-I.

**HF 003.2(S) Reporting and verification**

See indicator wording for requirement criteria.

**HF indicator 004(S)**

In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.

**HF 004.1(S) Rationale**

The evidence base for treating HF due to LVSD with beta blockers is at least as strong as the evidence base guiding the HF004(S) indicator on ACE-I (level 1a), with a 34 per cent reduction in major endpoints of beta-blockers on top of ACE-I compared to placebo and is a standard recommendation in all HF guidelines including NICE. The belief that beta-blockers are contraindicated in HF was disproved, at least for the licensed beta-blockers, in the late 1990’s and in some countries (especially in Scandinavia) beta-blockers have never been contraindicated in HF. Furthermore, there are no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised patients aged over 70 with significant benefits and no safety signal) and there are no contraindications for use in patients with COPD.

However, despite the evidence above, initiating beta-blockers in HF, or switching from one not licensed for HF, is more difficult because of the need to titrate from low doses and small increments over repeated visits. Patients also often suffer a

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22 CIBIS-II Investigators and Committees. Cardiac Insufficiency Bisoprolol Study II. Lancet 1999; 353:9-13
temporary deterioration in symptoms with beta-blocker initiation which needs monitoring.

The British National Formulary (BNF) states that “the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy”23.

NICE clinical guideline CG108 and SIGN clinical guideline 95 recommend that beta-blockers licensed for HF are used as first-line therapy in all patients with HF due to LVSD. CG108 recommends that beta-blockers are used in patients with defined co-morbidities such as older adults and those with peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

Contractors are advised that patients already prescribed an unlicensed beta-blocker prior to diagnosis of HF due to LVSD do not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded.

HF 004.2(S) Reporting and verification
See indicator wording for requirement criteria.

Patients already prescribed a beta-blocker unlicensed for heart failure will be excluded from this indicator.

**Hypertension (HYP)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Hypertension and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP006(S). The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.</td>
<td>55</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

23BNF. [http://bnf.org/bnf/bnf/current/119651.htm](http://bnf.org/bnf/bnf/current/119651.htm) (password protected site)
HYP – 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 care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and CHD in patients with treated 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 NICE clinical guideline on hypertension\(^{24}\) uses the following definitions:

**Stage 1 hypertension**
Clinic blood pressure is 140/90 mmHg or higher and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.

**Stage 2 hypertension**
Clinic blood pressure is 160/100 mmHg or higher and subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.

**Severe hypertension**
Clinic systolic blood pressure is 180 mmHg or higher or clinic diastolic blood pressure is 110 mmHg or higher.

Elevated blood pressure readings of greater than 140/90 mmHg on three separate occasions have generally been used to confirm sustained high blood pressure. However, the 2011 updated NICE clinical guideline on hypertension now recommends the use of ABPM to confirm the diagnosis of hypertension, particularly if a clinic blood pressure reading is 140/90 mmHg or higher.

The use of ABPM to confirm the diagnosis of hypertension is a change in practice and may take time to be integrated into routine clinical practice.

For patients aged 39 or under with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes, NICE recommend that practitioners consider seeking specialist evaluation of secondary causes of hypertension and a more detailed assessment of potential target organ damage. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these patients.

Further information
NICE public health guidance 25. Prevention of CVD 2011
**Coding and Lifestyle**

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

The health of patients with Hypertension can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

**Further information**


**HYP indicator 006(S)**

The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.

**HYP 006.1(S) Rationale**

This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension. Its intent is to promote the primary and secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

The NICE clinical guideline on hypertension recommends drug therapy in patients who are aged 79 or under with stage 1 hypertension who have one or more of the following:

1) target organ damage.

2) established CVD.
3) renal disease.
4) diabetes mellitus.
5) a 10-year CVD risk equivalent to 20 per cent or greater.

The NICE guideline recommends anti-hypertensive drug treatment for patients of any age with stage 2 hypertension. The guideline recommends that a referral for specialist evaluation of secondary causes of hypertension and a more detailed assessment of potential target organ damage is considered for patients aged 39 or under with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these patients.

The guideline also recommends that patients with hypertension have their care reviewed annually to monitor blood pressure, provide support and discuss lifestyle, symptoms and medication. However, the frequency of follow-up depends on factors such as the severity of hypertension, variability of blood pressure, complexity of the treatment regime, patient compliance and the need for non-pharmacological advice.

For QOF purposes it is assumed that repeat blood pressure measurements are undertaken every six months, with the audit standard at twelve months.

Further information

**HYP 006.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**Peripheral arterial disease (PAD)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Peripheral Arterial Disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAD002(S). The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less. <em>NICE 2011 menu ID: NM34</em></td>
<td>2</td>
<td>40–90%</td>
</tr>
</tbody>
</table>
PAD004(S). The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken.  
NICE 2011 menu ID: NM33 | 2 | 40–90%

### PAD – rationale for inclusion of indicator set

PAD is one of the three main categories of CVD and patients with PAD, including those who are asymptomatic, have an increased risk of mortality from CVD due to MI and stroke. The relative risks of all-cause mortality are two to three times that of age and sex matched to groups without PAD.

Treatment of PAD focuses on cardiovascular risk factor management. Smoking is a very important risk factor for PAD and management of PAD includes smoking cessation (see smoking indicator set). Other established risk factors are high blood pressure and diabetes. This would mean that patients with PAD and high blood pressure would also be included in the hypertension indicator set and patients with diabetes and PAD would also be included in the diabetes indicator set.

The intent of the PAD indicators is to improve the identification and management of PAD and ensure all patients, including those without established risk factors already covered in QOF, are managed for their cardiovascular risk.

Further information  
NICE clinical guideline CG147. Lower limb PAD 2012  
http://guidance.nice.org.uk/CG147/Guidance

Patients with PAD may have symptoms, but can also be asymptomatic. About 20 per cent of patients aged 60 or over have PAD, although only a quarter of these patients have symptoms. Symptoms become severe and progressive in approximately 20 per cent of patients with symptomatic PAD.

Reduced ankle brachial pressure index (ABPI) is an independent predictor of cardiac and cerebrovascular morbidity and mortality and may help to identify patients who would benefit from secondary prevention.

The SIGN clinical guideline on the diagnosis and management of PAD\(^2\) states that a resting ABPI of 0.9 or under has been shown in several clinical studies to be up to 95 per cent sensitive in detecting angiogram positive disease and around 99 per cent specific in identifying supposedly healthy subjects. The guideline also states that there is no strict definition of what constitutes a normal ABPI. In practice, an ABPI of below 0.9 is considered to be abnormal. The ABPI of patients with intermittent claudication typically lies between 0.5 and 0.9. Imaging may be appropriate to exclude PAD when there is a discrepancy between clinical presentation and ABPI.

\(^{2}\) SIGN clinical guideline 89. Diagnosis and management of PAD 2006.  
http://www.sign.ac.uk/guidelines/fulltext/89/index.html
Coding and Lifestyle

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

The health of patients with Peripheral Arterial Disease can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


PAD indicator 002 (NICE 2011 menu ID: NM34)

The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.

PAD 002.1 Rationale

Most cases of PAD are managed in primary care. The focus of treatment is on the cardiovascular complications of atherosclerosis (managing cardiovascular risk factors such as high blood pressure). Two small UK studies assessing clinical risk management based on the patient records of patients with PAD26,27 suggest that these patients have poor hypertension control, use low levels of statin and anti-platelet therapy and receive low levels of smoking cessation advice. This indicator addresses the issue of blood pressure control.

SIGN clinical guideline 89 recommends that hypertensive patients with PAD receive treatment to reduce their blood pressure. The guideline developers noted that treatment of PAD has often been considered difficult because of concerns that anti-hypertensive drugs, especially beta-blockers, may have adverse effects on PAD (for example, possible drug-induced peripheral vasoconstriction leading to further ischaemia in the leg). The developers did not find any strong evidence to suggest that beta-blockers should not be used in the presence of PAD, although no study was sufficiently large to demonstrate an absence of adverse effects with certainty.

Recommendation 2.6 in the guideline does not specify a target blood pressure in patients with PAD. However, the guideline developers considered that 140/90 mmHg is a desirable upper limit and that around one third to one half of patients with PAD would be considered hypertensive above this level.

The NICE clinical guideline on hypertension sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined within the rationale for the hypertension indicator set. All patients aged 79 or under with CVD and stage 1 hypertension (clinic blood pressure is 140/90 mmHg or higher and subsequent ABPM daytime average or HBPM average blood pressure is 135/85 or higher) are recommended drug therapy for hypertension.

The NICE guideline recommends a target clinic blood pressure below 140/90 mmHg in patients aged 79 or under with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 or over with treated hypertension.

For the purpose of QOF, a measurement of 150/90 mmHg has been adopted for this indicator.

Health economic modelling of PAD and the costs and consequences of treating high blood pressure over a patient's lifetime suggests that this treatment is a cost-effective use of NHS resources.

**PAD 002.2 Reporting and verification**
See indicator wording for requirement criteria.

**PAD indicator 004 (NICE 2011 menu ID: NM33)**

The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken.

**PAD004.1 Rationale**

Most cases of PAD are managed in primary care. The focus of management is on the secondary prevention of CVD. It is important to reduce the cardiovascular complications of atherosclerosis through appropriate cardiovascular risk factor management. Two small UK studies assessing clinical risk management based on the patient records of patients with PAD recommend that these patients have poor

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hypertension control, use low levels of statin and anti-platelet therapy, and receive low levels of smoking cessation advice. This indicator addresses the issue of prescribing anti-platelet therapy.

The SIGN clinical guideline on PAD\(^\text{31}\) states that anti-platelet therapy is recommended for patients with symptomatic PAD.

The Antithrombotic Trialists Collaboration (ATC) meta-analysis showed a 23 per cent reduction in serious vascular events in a subgroup of 9214 people with PAD who were treated with anti-platelet drugs\(^\text{32}\). Similar results were found in a second systematic review of the effects of anti-platelet therapy in patients with PAD\(^\text{33}\). When comparing the effects of different anti-platelet drugs, the ATC found no evidence of statistically significant differences between anti-platelets.

Further information:
NICE clinical guideline CG147. Lower limb PAD\(^\text{2012}\).
www.nice.org.uk/guidance/CG147

**PAD 004.2 Reporting and verification**
See indicator wording for requirement criteria.

Patients already prescribed an anti-coagulant will be excluded from the indicator.

**Stroke and Transient Ischaemic Attack (STIA)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Stroke or transient ischaemic attack and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA008(S). The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

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\(^{31}\) SIGN clinical guideline 89. Diagnosis and management of PAD 2006. www.sign.ac.uk/pdf/sign89.pdf


months before and 1 month after the date of the latest recorded stroke or the first TIA.

<table>
<thead>
<tr>
<th>Ongoing management</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>STIA003(S). The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.</td>
<td>5</td>
<td>50–85%</td>
</tr>
<tr>
<td>STIA007(S). The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.</td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>STIA009(S). The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**STIA – 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.

For patients diagnosed prior to 1 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 are not to be included in the retrospective coding. However, contractors may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.

It is up to the contractor to decide, on clinical grounds, when to diagnose a patient i.e. decide when a ‘dizzy spell’ becomes a TIA. Patient records coded with ‘Amaurosis fugax’, but without a code for TIA are excluded from the denominator.

**Coding and Lifestyle**

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

The health of patients with Stroke and transient ischaemic attack can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**STIA indicator 008(S)**

The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA.

**STIA 008.1(S) Rationale**

Specialist investigations are often only accessible by a referral to secondary care services, therefore this indicator reflects referral activity rather than confirmation by specific scanning investigations.

The National Audit Office (NAO) report \(^{34}\) highlights that UK national guidelines recommend that all patients with suspected TIA are assessed and investigated within seven days, but notes that only a third of patients 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.

Contractors are advised 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 patients. It is recommended that a new TIA in someone who has had previous TIAs is treated as an urgent case.

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

**STIA 008.2(S) Reporting and verification**

See indicator wording for requirement criteria.

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STIA indicator 003(S)

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

STIA 003.1(S) Rationale

This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

In one major overview, a long-term difference of 5-6 mmHg in usual diastolic blood pressure (DBP) is associated with approximately 30–40 per cent less stroke over five years\(^{35}\). The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in patients with prior stroke or TIA\(^{36}\).

The NICE clinical guideline on hypertension\(^{37}\) sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the rationale for the hypertension indicator set. To summarise, all patients aged 79 or under with CVD and stage one hypertension (clinic blood pressure is 140/90 mmHg or higher and subsequent ABPM daytime average of HBPM average blood pressure is 135/85 mmHg or higher) are recommended drug therapy for hypertension.

The SIGN clinical guideline on the management of patients with stroke or TIA\(^{38}\) recommends that patients who have had a stroke or TIA and have hypertension is treated to less than 140/85 mmHg.

The NICE clinical guideline on hypertension recommends a target clinic blood pressure below 140/90 mmHg in patients aged 79 or under with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 or over, with treated hypertension.

For the purpose of QOF, an audit standard of 150/90 mmHg has been adopted.

Further information

STIA 003.2(S) Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 007(S)

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\(^{35}\) Collins et al. Lancet 1990; 335:827-38
\(^{36}\) PROGRESS collaborative group, Lancet 2001: 358: 1033-41
The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.

**STIA 007.1(S) Rationale**
Long-term anti-platelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. It is advised that anti-platelet therapy is prescribed for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

The BNF\(^{39}\) makes the following recommendations:

"Following a TIA, long-term treatment with modified-release dipyridamole 200 mg twice daily in combination with aspirin 75 mg once daily is recommended. If patients are intolerant of aspirin, or it is contra-indicated, then modified-release dipyridamole alone is recommended. If patients are intolerant of dipyridamole, or it is contraindicated, then aspirin alone is recommended. Patients who are intolerant of both aspirin and dipyridamole should receive clopidogrel alone [unlicensed use].

Following an ischaemic stroke (not associated with AF – see below), long-term treatment with clopidogrel 75 mg once daily is recommended. If clopidogrel is contraindicated or not tolerated, patients should receive modified-release dipyridamole 200 mg twice daily in combination with aspirin 75 mg once daily. If both aspirin and clopidogrel are contraindicated or not tolerated, then modified-release dipyridamole alone is recommended. If both dipyridamole and clopidogrel are contraindicated or not tolerated, than aspirin alone is recommended."

It is advised that patients with stroke associated with AF are reviewed for long-term treatment with warfarin or an alternative anti-coagulant (see the AF disease area indicator set).

Further information

**STIA 007.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**STIA indicator 009(S)**

The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.

**STIA 009.1(S) Rationale**
While there have been no RCTs looking at the impact of flu vaccination specifically in patients with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke\(^{40}\).

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\(^{39}\) BNF 62. [http://bnf.org/bnf/index.htm](http://bnf.org/bnf/index.htm)

\(^{40}\) Lavallee et al. Stroke 2002; 33: 513-518; Nichol et al. NEJM 2003; 1322-32
This is a current recommendation from the CMO and the JCVI.

Further information

**STIA 009.2(S) Reporting and verification**
See indicator wording for requirement criteria.

### Diabetes mellitus (DM)

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Diabetes mellitus and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| DM002(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.  
*NICE 2010 menu ID: NM01* | 8 | 45–71% |
| DM003(S). The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less.  
*NICE 2010 menu ID: NM02* | 10 | 40–65% |
| DM006(S). The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs). | 3 | 50–90% |
| DM007(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.  
*NICE 2010 menu ID: NM14* | 17 | 40–50% |
| DM008(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months. | 8 | 45–70% |
| DM009(S). The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months. | 10 | 50–90% |
DM012(S). The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.

*NICE 2010 menu ID: NM13*

<table>
<thead>
<tr>
<th>DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICE 2011 menu ID: NM27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DM018(S). The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

**DM – rationale for inclusion of indicator set**

Diabetes mellitus (DM) 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 GP 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 NICE and SIGN.

The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework (NSF) for Diabetes website also includes details of the evidence behind a range of recommendations.

NICE has also published guidance on a number of aspects of diabetic control.

**Further information**


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

A greater understanding and knowledge of the complexities of diabetes has led to increasing difficulty in accurately diagnosing or classifying the type of diabetes. In March 2011, a report by the Royal College of General Practitioners (RCGP) and NHS Diabetes was published which examined the issue of coding, classification and diagnosis of diabetes in primary care in England [42]. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes [43]. In line with this report, diabetes diagnosis should include all types of diabetes within the proposed algorithm. Gestational diabetes should continue to be excluded from this denominator.

If it is too early in the clinical course to diagnose the specific type of diabetes, or if the specific diagnosis is uncertain, contractors are asked to use the parent term ‘diabetes mellitus’. Contractors are expected to update these patients’ records when their specific type of diabetes is confirmed. This is advised to be within six to 12 months of the initial diagnosis of diabetes mellitus.

This denominator does not specify how the diagnosis is made and a record of the diagnosis will, for the purposes of the QOF, be regarded as sufficient evidence of diabetes. However, there are a substantial number of patients with diabetes who remain undiagnosed and also a number of patients receiving treatment with an incorrect diagnosis of diabetes. Contractors are therefore encouraged to adopt a systematic approach to the diagnosis of diabetes.

The World Health Organisation (WHO) 2006 [44] states that fasting plasma glucose ≥7.0 mmol/l (126 mg/dl) or 2-h plasma glucose ≥11.1 mmol/l (200 mg/dl) is used as criteria for diagnosing diabetes.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM [45]. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values, and there are no conditions present that preclude its accurate measurement.

measurement. An HbA1c of 48 mmol/mol (6.5 per cent)\textsuperscript{46} is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/mol (6.5 per cent).

The use of HbA1c for diagnosing diabetes can avoid the problem of day-to-day variability of glucose values and importantly it avoids the need for the patient to make preceding dietary preparations (such as fasting or consuming a glucose drink).

The WHO also recommends that the diagnosis of diabetes in an asymptomatic patient is not made on the basis of a single abnormal plasma glucose or HbA1c value. At least one additional HbA1c or plasma glucose test result with a value in the diabetic range is required, either fasting, from a random (casual) sample, or from an oral glucose tolerance test (OGTT).

From April 2014 the business rules for this indicator were updated to include a new READ code for “diabetes in remission”. Successful management of diabetes with lifestyle, medication, pancreatic or islet cell transplant and/or bariatric surgery may result in glucose levels falling below those diagnostic of diabetes. However these people may still experience the macrovascular and microvascular complications of diabetes and therefore need continued monitoring. Experts from the diabetes classification working group have endorsed the use of this code for people where treatment has normalised hyperglycaemia but still require continued monitoring.

Practices may wish to review their patient records and re-code patients previously coded as “diabetes resolved” as “diabetes in remission” if they still require monitoring for the reasons outlined above. The use of “diabetes resolved” continues to be appropriate for example in cases of misdiagnosis.

**Coding and Lifestyle**

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

The health of patients with Diabetes Mellitus can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


\textsuperscript{46} HbA1c should now be reported to the International Federation of Clinical Chemistry (IFCC) units of mmol/mol rather than the Diabetes Control and Complications Trial (DCCT) percentage.


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


DM indicator 002(S) (NICE 2010 menu ID: NM01)

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.

**DM 002.1(S) Rationale**

Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

DM003(S) sets a target of 140/80 mmHg as per the target recommended by NICE47 while the target of 150/90 mmHg has been set for those patients who cannot manage this, such as those with retinopathy, micro-albuminuria or cerebrovascular disease.

Setting a blood pressure target at a higher level, but expecting most patients to have blood pressure below this, is intended to encourage practitioners to address the needs of the minority of patients whose blood pressure is hard to control and will avoid the possibility of perverse incentives to focus efforts away from those at highest absolute risk.

**DM 002.2(S) Reporting and verification**

See indicator wording for requirement criteria.

DM indicator 003(S) (NICE 2010 menu ID: NM02)

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less.

**DM 003.1(S) Rationale**

Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

The target of 140/80 mmHg has been set as per the target recommended by NICE.

**DM 003.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**DM indicator 006(S)**
The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).

**DM 006.1(S) Rationale**
The progression of renal disease in patients with diabetes is slowed by treatment with ACE-I and trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. Although trial evidence is based largely on ACE-I, it is believed that similar benefits occur from treatment with ARBs in patients who are intolerant of ACE-I.

It is recommended that patients with a diagnosis of micro-albuminuria or proteinuria are commenced on an ACE-I or considered for treatment with ARBs.

Further information
http://www.sign.ac.uk/guidelines/fulltext/116/index.html

**DM 006.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**DM indicator 007(S) (NICE 2010 menu ID: NM14)**
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.

**DM 007.1(S) Rationale**
The three target levels for HbA1c (59, 64 and 75 mmol/mol) in QOF are designed to provide an incentive to improve glycaemic control across the distribution of HbA1c values. The lower level may not be achievable or appropriate for all patients. The 2009 NICE clinical guideline on the management of type 2 diabetes advises against pursuing highly intensive management to levels below 48 mmol/mol in certain patient sub-groups.

There is a near linear relationship between glycaemic control and death rate in patients with type 2 diabetes. In the EPIC Norfolk population cohort, a one per cent higher HbA1c was independently associated with 28 per cent higher risk of death, an association that extended below the diagnostic cut off for diabetes. These results

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suggest that, as with blood pressure and cholesterol, over the longer term at least, the lower the HbA1c the better\textsuperscript{50}. However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial highlighted the risks of adopting an aggressive treatment strategy for patients at risk of CVD. In the trial’s intervention group, HbA1c fell from 8.1 per cent to 6.4 per cent, but this was associated with increased mortality\textsuperscript{51}. However, a recent meta-analysis did not confirm such an increase in risk\textsuperscript{52} and reassuringly, the ADVANCE study\textsuperscript{53} and the Veteran Affairs Diabetes Trial\textsuperscript{54} found no increase in all-cause mortality in their intensive treatment groups. Also, long-term follow up of the UK Prospective Diabetes Study demonstrated a ‘legacy effect’ with fewer deaths after ten years in those initially managed intensively\textsuperscript{55}.

A retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim\textsuperscript{56}. The study found that, among people whose treatment had been intensified by the addition of insulin or a sulphonylurea, there was no benefit in reducing HbA1c below 59 mmol/mol, although these differences were not statistically significant. The mortality rate was higher among those with the tightest control (this lowest decile of cohort had HbA1c below 6.7 per cent; median = 6.4 per cent). The reasons for these findings are unclear, but they raise further questions about the possibility of some groups of patients for whom a tight glycaemic target is inappropriate.

The NICE clinical guideline on type 2 diabetes identifies the following key priorities for implementation to help people with type 2 diabetes achieve better glycaemic control:

- Offer structured education to every patient and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform patients 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 HbA1c:

  1) involve the patient in decisions about their individual HbA1c target level, which may be above that of 48mmol/mol set for people with type 2 diabetes in general.

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\textsuperscript{51} ACCORD Study Group. Effects of intensive glucose lowering in type 2 diabetes 2008. NEJM; 358: 2545-59


\textsuperscript{53} ADVANCE collaborative group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. NEJM 2008; 358: 2560-72


\textsuperscript{55} Holman RR, Paul SK, Bethel MA et al. 10-year follow-up of intensive glucose control in type 2 diabetes 2008. NEJM; 359: 1577-89

2) encourage the patient to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life.

3) offer therapy (lifestyle and medication) to help achieve and maintain the HbA1c target level.

4) inform a patient with higher HbA1c that reduction in HbA1c towards the agreed target is advantageous to future health.

5) avoid pursuing highly intensive management to levels of less than 48 mmol/mol.

The NICE and SIGN clinical guidelines are consistent\textsuperscript{57}.

Given that there is strong evidence to support tight glycaemic control in type 1 diabetes, which is reflected in current NICE and SIGN guidelines, this indicator aims to balance risks and benefits for patients with type 2 diabetes. Younger patients with little co-morbidity are more likely to reap the benefits of tighter control, whereas less stringent goals may be more appropriate for patients with established CVD, those with a history of hypoglycaemia, or those requiring multiple medications or insulin to achieve a NICE suggested target HbA1c of 48 mmol/mol.

From June 2009 the way in which HbA1c results are reported in the UK changed. A standard specific for HbA1c was prepared by the IFCC so that HbA1c reported by laboratories is traceable to the IFCC reference method and global comparison of HbA1c results is possible. From 1 June 2011, results were reported only as IFCC-HbA1c mmol/mol (see table one below).

Table 1. IFCC values expressed as mmol/mol

<table>
<thead>
<tr>
<th>DCCT values for HbA1c (%)</th>
<th>IFCC values for HbA1c (mmol/mol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>20</td>
</tr>
<tr>
<td>5.0</td>
<td>31</td>
</tr>
<tr>
<td>6.0</td>
<td>42</td>
</tr>
<tr>
<td>6.5</td>
<td>48</td>
</tr>
<tr>
<td>7.0</td>
<td>53</td>
</tr>
<tr>
<td>7.5</td>
<td>59</td>
</tr>
<tr>
<td>8.0</td>
<td>64</td>
</tr>
<tr>
<td>9.0</td>
<td>75</td>
</tr>
<tr>
<td>10.0</td>
<td>86</td>
</tr>
<tr>
<td>11.0</td>
<td>97</td>
</tr>
<tr>
<td>12.0</td>
<td>108</td>
</tr>
</tbody>
</table>

DM 007.2(S) Reporting and verification
See indicator wording for requirement criteria.

**DM indicator 008(S)**

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months.

**DM 008.1(S) Rationale**
See DM 007.1(S)

Auditing the proportion of patients with an HbA1c below 64 mmol/mol is designed to provide an incentive to improve glycaemic control across the range of HbA1c values.

**DM 008.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**DM indicator 009(S)**

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.

**DM 009.1(S) Rationale**
See DM 007.1(S)

Auditing the proportion of patients with an HbA1c below 75 mmol/mol is designed to provide an incentive to improve glycaemic control amongst those with high levels of HbA1c who are at particular risk.

**DM 009.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**DM indicator 012(S) (NICE 2010 menu ID: NM13)**

The percentage of patients with diabetes, on the register, with a record of foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.

**DM 012.1(S) Rationale**
Patients with diabetes are at high risk of foot complications. Evaluation of skin, soft tissue, musculoskeletal, vascular and neurological condition on an annual basis is important for the detection of feet at raised risk of ulceration.

The foot inspection and assessment includes:

- identifying the presence of sensory neuropathy (loss of ability to feel a monofilament, vibration or sharp touch) and/or the abnormal build-up of callus;
- identifying when the arterial supply to the foot is reduced (absent foot pulses, signs of tissue ischaemia or symptoms of intermittent claudication);
• identifying deformities or problems of the foot (including bony deformities, dry skin or fungal infection), which may put it at risk;

• identifying other factors that may put the foot at risk (which may include reduced capacity for self-care, impaired renal function, poor glycaemic control, cardiovascular and cerebrovascular disease, or previous amputation).

The NICE clinical guideline on type 2 diabetes advises that foot risk is classified as:

• at low current risk: normal sensation, palpable pulses;

• at increased risk: neuropathy or absent pulses or other risk factor;

• at high risk: neuropathy or absent pulses plus deformity or skin changes or previous ulcer;

• ulcerated foot.

The practitioner carrying out the inspection and assessment is advised to:

• discuss with the patient their individual level of risk and agree plans for future surveillance;

• initiate appropriate referrals for expert review of those with increased risk;

• give advice on action to be taken in the event of a new ulcer/lesion arising;

• give advice on the use of footwear which will reduce the risk of a new ulcer/lesion;

• give advice on other aspects of foot care which will reduce the risk of a new ulcer/lesion.

For the purposes of QOF the Read codes for ‘moderate risk’ are used to record the concept of ‘increased risk’.

**DM 012.2(S) Reporting and verification**

See indicator wording for requirement criteria.

**DM indicator 014 (NICE 2011 menu ID: NM27)**

The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.

**DM 014.1 Rationale**

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Diabetes is a progressive long-term medical condition that is predominantly managed by the person with the diabetes and/or their carer as part of their daily life. Accordingly, understanding of diabetes, informed choice of management options and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. These needs are not always fulfilled by conventional clinical consultations. Structured educational (SE) programmes have been designed not only to improve people’s knowledge and skills, but also to help motivate and sustain people with both type 1 and type 2 diabetes in taking control of their condition and in delivering effective self-management. The indicator requires that SE is offered (preferably through a group education programme) to every person with diabetes and/or their carer from the time of diagnosis, with annual reinforcement and review. An alternative education programme of equal standard maybe offered to people unable or unwilling to participate in group education sessions.

The NICE technology appraisal on patient education models\textsuperscript{59} and the NICE clinical guideline on type 2 diabetes\textsuperscript{60} considered SE models for diabetes to be both clinically and cost-effective. There are a number of SE programmes available for diabetes. Some programmes will be more suitable for type 1 diabetes and others for type 2 diabetes.

The NICE quality standard for diabetes in adults\textsuperscript{61} is based on NICE clinical guidelines for diabetes\textsuperscript{62}. The NICE quality statement on SE states that ‘People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education’. The NICE quality standard states that a patient educational programme meets five key criteria laid down by the DH and the Diabetes UK Patient Education Working Group\textsuperscript{63}:

\begin{itemize}
  \item Any programme should be evidence-based and suit the needs of the individual. The programme should have specific aims and learning objectives. It should support the learner plus his or her family and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes’
  \item The programme should have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials and is written down;
  \item The programme should be delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the
\end{itemize}

\textsuperscript{59} NICE technology appraisal TA60. Guidance on the use of patient education models for diabetes 2003. \texttt{www.nice.org.uk/guidance/TA60}
\textsuperscript{60} NICE clinical guideline CG87. Type 2 Diabetes: the management of type 2 diabetes 2010. \texttt{www.nice.org.uk/guidance/CG87}
\textsuperscript{61} NICE quality standard. Diabetes in adults 2010. \texttt{www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp}
\textsuperscript{62} NICE clinical guideline CG15. Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults 2004. \texttt{www.nice.org.uk/guidance.CG15}
learners and who are trained and competent to deliver the principles and content of the programme;

- The programme should be quality assured and be reviewed by trained, competent, independent assessors who measure it against criteria that ensure consistency;
- The outcomes from the programme should be regularly audited.

This indicator suggests referral to a programme within nine months of entry onto the diabetes register to be appropriate for people with type 1 or type 2 diabetes. A timeframe of nine months for this indicator has been set to take into account the differing expectations for referral into SE programmes from diagnosis for people with type 1 and type 2 diabetes.

Some practices may be able to deliver SE programmes in-house. These programmes would need to meet the requirements outlined above. A NICE commissioning guide on patient education programmes for people with type 2 diabetes\(^{64}\) gives further information on providing services.

If there is no one in the practice competent to provide a structured education programme the contractor should refer the patients to a local dietetic service for that service. If that local service does not exist then the practice can exception report the patients.

**DM 014.2 Reporting and verification**
See indicator wording for requirement criteria.

**DM indicator 018(S)**

The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.

**DM 018.1(S) Rationale**
This is a current recommendation from the CMO and the JCVI.

Further information

**DM 018.2(S) Reporting and verification**
See indicator wording for requirement criteria.

Asthma (AST)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Asthma and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before and any time after diagnosis.</td>
<td>15</td>
<td>45–80%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST003(S). The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions. NICE 2011 menu ID: NM23</td>
<td>20</td>
<td>45–70%</td>
</tr>
<tr>
<td>AST004(S). The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.</td>
<td>6</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

AST – 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.

Proactive structured review as opposed to opportunistic or unscheduled review is associated with reduced exacerbation rates and days lost from normal activity. The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most patients, 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 is in doubt.

A proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400 mls or more on FEV<sub>1</sub> – but do not return to over 80 per cent predicted and have a significant smoking history. These patients should be coded as having both asthma and COPD.

**Children**

A definitive diagnosis of asthma can be difficult to obtain in young children. Asthma is to 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.

Focus the initial assessment in children suspected of having asthma on:

- presence of key features in the history and examination;
- careful consideration of alternative diagnoses.

Further information

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 the 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.

It is for this reason that asthma coding is reviewed annually by searching for patients with a history of asthma, excluding those who have had no prescription for asthma-related drugs in the preceding 12 months.

**Coding and Lifestyle**

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

The health of patients with Asthma can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.
Further information


AST indicator 002

The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis.

AST 002.1 Rationale

There is no single infallible test to confirm a diagnosis of asthma. On the basis of the clinical history and examination it will be possible to decide if the probability of asthma is high, intermediate or low and the aim of investigations is to demonstrate objectively the presence of variability in order to support or reject the diagnosis. There are Read codes for ‘suspected asthma’ and ‘suspected respiratory condition’ which may be used whilst investigations are undertaken and the diagnosis confirmed.

Further information about the diagnosis of asthma is provided in the BTS-SIGN asthma guideline. It is crucial that diagnostic spirometry is performed to published quality standards.

Asthma history

The diagnosis of asthma is suspected when a patient presents a history of variable wheeze, chest tightness, shortness of breath or cough, commonly triggered by viral

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infections and/or allergy and/or exercise. A personal or family history of atopy (including positive skin prick testing) increases the probability of asthma.

**If asthma is probable**

In symptomatic patients airway obstruction may be demonstrated by spirometry (FEV₁/FVC ratio <0.7) and (if available) nitric oxide can be used to measure airway inflammation.

Variability of symptoms and/or lung function may be demonstrated in a reversibility test or may occur spontaneously over time in response to triggers or to treatment; demonstration of variability supports the diagnosis of asthma and may be conveniently achieved in primary care in a number of ways:

- **Spirometry** may be used to demonstrate reversibility in symptomatic patients with demonstrated airflow obstruction. A bronchodilator reversibility test can be performed with inhaled or nebulised short acting beta agonist and if the obstruction reverses then asthma is confirmed. Significant reversibility is a change in FEV₁ >12 per cent and 200 ml (the absolute change is scaled down according to predicted FEV₁ in children). Increases of >400 mls are strongly suggestive of asthma. Lower levels of bronchodilator reversibility may be demonstrated in some patients with COPD. Normal spirometry, however, does not exclude asthma; indeed the variable nature of asthma means that many of the milder patients seen in primary care will be asymptomatic at the time of the lung function test and will have completely normal lung function with no reversibility at the time of testing;

- **Variability of PEF.** This may be demonstrated by monitoring diurnal, or day to day variation (recorded twice a day for two weeks using the same peak flow meter) and/or demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks of inhaled steroids, or up to two weeks after oral steroid treatment) and/or after exposure to triggers (such as exercise, laughter, or allergens). Significant variability is a change of 20 per cent and >60 l/min (the absolute change is scaled down in children to 20 per cent of predicted PEF). PEF are effort dependent and patients need to be taught the correct technique;

- **Variability in objective measures of asthma symptom scores** (e.g. RCP questions, ACQ, ACT questionnaire, or GINA Control Tool). Symptom scores may be particularly useful in patients unable to undertake accurate serial measures of lung function and to aid clinical interpretation of lung function (e.g. normal lung function in a symptomatic patient might suggest an alternative cause for the symptoms).

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69 Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. Euro Respiratory Journal 1999;14:902-7
A trial of treatment, with repeated lung function measurements and/or symptoms scores over time will demonstrate objective improvement of symptoms and lung function in people with asthma, thereby confirming the diagnosis. In children it is particularly important to reduce and stop treatment to exclude spontaneous improvement\(^{72}\).

**If the probability of asthma is intermediate**

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations\(^{73}\). More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

**If another diagnosis is more likely**

If an alternative diagnosis is suspected, investigation and management are to follow guidelines for that condition.

**Co-morbidity: asthma and COPD**

A proportion of patients with asthma will have both asthma and COPD i.e. they have airway obstruction that does not reverse to normal but also have substantial reversibility\(^{74}\).

**AST 002.2 reporting and verification**

See indicator wording for requirement criteria.

**AST indicator 003(S) (NICE 2011 menu ID: NM23)**

The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions.

**AST 003.1(S) Rationale**

Structured care has been shown to produce benefits for patients with asthma. The reckoning of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. The BTS/SIGN clinical guideline\(^{75}\) proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

The clinical guideline recommends the use of standard questions for the monitoring of asthma. Proactive structured review, rather than opportunistic or unscheduled

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\(^{72}\) Brand P. New guidelines on recurrent wheeze in preschool children: implications for primary care. PCRJ 2008; 17:243-245


review, is associated with reduced exacerbation rate and fewer days lost from normal activity.

The QOF now explicitly requires that the following RCP questions\(^{76}\) are used 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 (for example, housework, work/school, etc.)?

The questions are to be asked at the same time and as part of the review. A response of ‘No’ to all questions is consistent with well-controlled asthma\(^{77}\).

If the asthma appears to be uncontrolled, the following are to be managed appropriately before increasing asthma therapy:

- smoking behaviour (because smoking interferes with asthma control);
- poor inhaler technique;
- inadequate adherence to regular preventative asthma therapy;
- rhinitis.

There is increasing evidence to support personalised asthma action plans in adults with persistent asthma. Contractors 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 their best peak flow (that is, peak flow when they are well). Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients aged 19 or over no particular time limit is needed for measuring best peak flow. However in view of the reduction in peak flow with age, it is recommended that the measurement be updated every few years. For patients aged 18 or under the peak flow will be changing; therefore it is recommended that the best peak flow be re-assessed annually. Inhaler technique is to be reviewed regularly. The BTS/SIGN clinical guideline emphasises the importance of assessing ability to use inhalers before prescribing and regularly reviewing technique, especially if control is inadequate.

\(^{76}\)RCP. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: patient focused approach.

Inhalers are to be prescribed only after patients have received training in the use of the device and have demonstrated satisfactory technique. Reassess inhaler technique as part of their structured asthma review.

During an asthma review the following takes place:

- assess symptoms (using the three RCP questions);
- measure peak flow;
- assess inhaler technique;
- consider a personalised asthma plan.

If the asthma appears to be uncontrolled, follow the additional steps outlined above.

**AST 003.2(S) Reporting and verification**
See indicator wording for requirement criteria.

The Business Rules require that contractors code the review and the responses to the three RCP questions separately and on the same day in order to meet the requirements of this indicator.

**AST indicator 004(S)**

The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.

**AST 004.1(S) 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.

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 the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control.

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

**AST 004.2(S) Reporting and verification**
See indicator wording for requirement criteria.

A number of ‘smoking habit’ codes have been removed from the relevant code clusters from April 2014 as they cannot be used to identify if the patient is a current

smoker, an ex-smoker or has never smoked. Accepted codes are available in the associated Business Rules80.

Chronic obstructive pulmonary disease (COPD)

Coding

The practice records agreed diagnostic READ codes for patients diagnosed with Chronic obstructive pulmonary disease and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003(S). The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.</td>
<td>9</td>
<td>50–90%</td>
</tr>
<tr>
<td>COPD005(S). The percentage of patients with COPD and Medical Research Council dyspnoea grade≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months.</td>
<td>5</td>
<td>40–90%</td>
</tr>
<tr>
<td>NICE 2012 menu ID: NM63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD007(S). The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.</td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

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 GPs and members of the primary care team with onward referral to secondary care when required. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

A diagnosis of COPD is considered in any patient who has symptoms of a 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 COPD002.1

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 contractors may wish to carry out post bronchodilator spirometry for confirmation.

NICE clinical guideline CG101 recommended a change to the diagnostic threshold for COPD in 2010.

Table 2. Gradation of severity of airflow obstruction

<table>
<thead>
<tr>
<th>Post bronchodilator FEV1/FVC</th>
<th>FEV1 % predicted</th>
<th>Severity of airflow obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Post bronchodilator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post bronchodilator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post bronchodilator</td>
</tr>
<tr>
<td>&lt; 0.7</td>
<td>≥ 80%</td>
<td>Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage 1 – Mild</td>
</tr>
<tr>
<td>&lt; 0.7</td>
<td>50-79%</td>
<td>Mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage 2 – Moderate</td>
</tr>
<tr>
<td>&lt; 0.7</td>
<td>30-49%</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage 3 – Severe</td>
</tr>
<tr>
<td>&lt; 0.7</td>
<td>&lt; 30%</td>
<td>Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage 4 – Very severe**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage 4 – Very severe**</td>
</tr>
</tbody>
</table>

* Symptoms present to diagnose COPD in patients with mild airflow obstruction (see recommendation 1.1.1.1).
** Or FEV1 (forced expiratory volume in one second) < 50 per cent with respiratory failure.

Where patients have co-existing COPD and asthma they should be coded for both diseases. Approximately 15 per cent of patients with COPD will also have asthma.
Coding and Lifestyle

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

The health of patients with Chronic obstructive pulmonary disease can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


COPD indicator 002

The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register.

COPD 002.1 Rationale

A diagnosis of COPD relies on clinical judgement based on a combination of history, physical examination and confirmation of the presence of airflow obstruction using spirometry.

The NICE clinical guideline on COPD83 provides the following definition of COPD:

airflow obstruction is defined as a reduced FEV\textsubscript{1}/FVC ratio (where FEV\textsubscript{1} is forced expired volume in one second and FVC is forced vital capacity), such that FEV\textsubscript{1}/FVC is $< 0.7$;

- if FEV\textsubscript{1} is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

The NICE clinical guideline requires post bronchodilator spirometry for diagnosis and gradation of severity of airways obstruction. Failure to use post bronchodilator readings has been shown to overestimate the prevalence of COPD by 25 per cent\textsuperscript{84}. Spirometry is to be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400 mcg salbutamol).

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

Routine reversibility testing is not recommended. However, where doubt exists 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. Where asthma is present, these patients would 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 FEV\textsubscript{1} of less than 80 per cent of predicted normal as well as an appropriate medical history.

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

The guideline on COPD recommends that all health professionals involved in the care of patients with COPD have access to spirometry and be competent in the interpretation of the results. Quality statement 1 (diagnosis) in the NICE quality standard for COPD in adults\textsuperscript{85}, states that patients with COPD have the diagnosis confirmed by post bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.

From April 2011 the diagnostic codes for this indicator were updated to include new codes for post bronchodilator spirometry. The previous codes for reversibility testing will not be acceptable for QOF purposes.

**COPD 002.2 Reporting and verification**
See indicator wording for requirement criteria.

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\textsuperscript{84} Johannessen et al. Thorax 2005; 60(10): 842-847
\textsuperscript{85} NICE quality standard on COPD 2011.
[http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp](http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp)
COPD indicator 003(S)

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

COPD 003.1(S) 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 is based on NICE clinical guideline CG101 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:

1. current lung function.
2. exacerbation history.
3. degree of breathlessness (Medical Research Council (MRC) dyspnoea scale).

A tool such as the Clinical COPD Questionnaire\textsuperscript{86} 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 is to 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 in the NICE clinical guideline on COPD, section 1.1, diagnosing COPD table one.

COPD 003.2(S) Reporting and verification

See indicator wording for requirement criteria.

COPD indicator 005(S) (NICE 2012 menu ID: NM63)

The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months.

COPD 005.1(S) Rationale

As COPD progresses, patients often become hypoxaemic. Many patients tolerate mild hypoxaemia well, but once the resting partial pressure of oxygen in arterial blood (PaO2) falls below 8 KPa patients begin to develop signs of right-sided HF (cor

\textsuperscript{86} Clinical COPD Questionnaire. \url{http://www.ccq.nl/}
pulmonale), principally peripheral oedema. The prognosis is poor and if untreated the five year survival is less than 50 per cent.

In stable COPD, patients use oxygen therapy for long periods during the day and night. Long-term oxygen therapy can improve survival in patients with COPD who have severe hypoxaemia, where PaO2 is less than 8 KPa. It can also reduce the incidence of polycythaemia (that is, raised red cell count), reducing the progression of pulmonary hypertension and improving psychological wellbeing.

NICE clinical guideline CG101 recommends that patients with oxygen saturations of 92 per cent or lower when breathing air, be considered for oxygen therapy. Pulse oximetry (SpO2) provides an estimate of arterial oxygen saturation (SaO2) and is non-invasive.

Pulse oximetry allows practitioners to assess patients' level of oxygen saturation to determine if whether referral for clinical assessment and long-term oxygen therapy is appropriate. Pulse oximetry is a valuable screening tool for identifying patients who are appropriate for referral for long-term oxygen therapy. A normal pulse oximetry reading (SpO2 greater than 92 per cent) can reliably identify patients who do not need referral. However, pulse oximetry cannot predict which patients with an abnormal reading (SpO2 of 92 per cent or lower) have sufficiently severe hypoxaemia to require long-term oxygen therapy, therefore these patients require further assessment.

**COPD 005.2(S) Reporting and verification**

See indicator wording for requirement criteria.

The Business Rules require that a record that pulse oximetry has been performed AND the resulting oxygen saturation value are recorded to meet the requirements for this indicator.

**COPD indicator 007(S)**

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

**COPD 007.1(S) Rationale**

This is a current recommendation from the CMO and the JCVI.

Further information

**COPD 007.2(S) Reporting and verification**

See indicator wording for requirement criteria.

**Dementia (DEM)**

Coding
The practice records agreed diagnostic READ codes for patients diagnosed with Dementia and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM002(S). The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months.</td>
<td>15</td>
<td>35–70%</td>
</tr>
<tr>
<td>DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register.</td>
<td>6</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

**DEM – 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 the age of 80. The annual incidence of vascular dementia is 1.2/100 overall person years at risk and is the same in all age groups. Alzheimers disease accounts for 50–75 per cent of cases of dementia.

The annual incidence of dementia of the Alzheimers 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 where there is altered functioning in terms of activities of daily living.

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 code 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.
Coding and Lifestyle

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

The health of patients with Dementia can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


DEM indicator 002(S)

The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months.

DEM 002.1(S) Rationale

The face-to-face review focuses on support needs of the patient and their carer. In particular the review addresses four key issues:

1. an appropriate physical and mental health review for the patient.

2. if applicable, the carer’s needs for information commensurate with the stage of the illness and his or her and the patient’s health and social care needs.

3. if applicable, the impact of caring on the care-giver.

4. communication and co-ordination arrangements with secondary care (if applicable).
A series of well-designed cohort and case control studies have demonstrated that patients with Alzheimer-type dementia do not complain of common physical symptoms, but experience them to the same degree as the general population. Patient assessments therefore include the assessment of any behavioural changes caused by:

- concurrent physical conditions (e.g. joint pain or inter-current 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 could also be considered as it is more common in patients with dementia than those without.\(^{87}\)

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia.\(^{88}\) 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 can contact the carer’s own GP for further support and treatment.

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

Further information

NICE clinical guideline CG42. Dementia. Supporting people with dementia and their carers in health and social care


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\(^{87}\) Burt et al. Psychol Bull 1995; 117: 285-305

\(^{88}\) Eccles et al. BMJ 1998; 317: 802-808


SIGN clinical guideline 86. Managing patients with dementia 2006. [http://www.sign.ac.uk/pdf/sign86.pdf](http://www.sign.ac.uk/pdf/sign86.pdf)


DEM 002.2(S) Reporting and verification
See indicator wording for requirement criteria.
Verification—the NHS Board may require randomly selecting a number of patient 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.

**DEM indicator 003 (NICE 2010 menu ID: NM09)**

The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register.

**DEM 003.1 Rationale**

There is no universal consensus on the appropriate diagnostic tests to be undertaken in those with suspected dementia. However, a review of 14 guidelines and consensus statements found considerable similarity in recommendations\(^89\). The main reason for undertaking investigations in a patient with suspected dementia is to exclude a potentially reversible or modifying cause for the dementia and to help exclude other diagnoses (e.g. delirium). Reversible or modifying causes include metabolic and endocrine abnormalities (e.g. vitamin B12 and folate deficiency, hypothyroidism, diabetes and disorders of calcium metabolism).

The NICE clinical guideline on dementia\(^90\) states that a basic dementia screen is performed at the time of presentation, usually within primary care. It includes:

- routine haematology;
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function);
- thyroid function tests;


\(^{90}\) NICE clinical guideline CG42. Dementia. Supporting people with dementia and their carers in health and social care 2006. [www.nice.org.uk/GC42](http://www.nice.org.uk/GC42)
• serum vitamin B12 and folate levels.

**DEM 003.2 Reporting and verification**
See indicator wording for requirement criteria.

For the purpose of this indicator, if a test for HbA1c has been carried out within the timeframe permitted by this indicator, then a test for glucose would not be required. All tests are required to be carried out (with the exception of glucose in the above scenario) to meet the requirements of this indicator. Where the test is declined by the patient, then the patient may be exception reported.

This indicator only applies to patients with a new diagnosis of dementia in the QOF year. However the workload has the potential to span more than one QOF year. Therefore the associated Business Rules cover 18 months to capture patients whose care could span more than one QOF year i.e. between six months before and 6 months after a new diagnosis is recorded.

### Depression (DEP)

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Depression and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.</td>
<td>10</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

**DEP – rationale for inclusion of the indicator set**

Depression is common and disabling.

In 2000, the estimated point prevalence for a depressive episode among people aged 16 or over and under the age of 74 in the UK was 2.6 per cent (males 2.3 per cent, females 2.8 per cent). If the broader and less specific category of 'mixed depression and anxiety' is included, these figures increase dramatically to 11.4 per cent (males 9.1 per cent, females 13.6 per cent91). It contributes 12 per cent of the

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total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world's disabling diseases\textsuperscript{92}. 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.

The NICE clinical guideline for depression in adults\textsuperscript{93} states that patients with suspected depression have a comprehensive assessment which includes severity of symptoms, degree of functional impairment and/or disability associated with the possible depression and duration of the episode.

Consideration may also be given to factors which may have affected the development, course and severity of this episode such as past history of depression, previous treatments and access to personal and social support. The guideline also recommends that people with depression are asked directly about suicidal ideation and intent.

There is no register indicator for the depression indicators. The denominator for the indicators in the depression area for the purpose of calculating the APDF is defined as all patients aged 18 or over, with a new diagnosis of depression in the preceding 1 April to 31 March, who have an unresolved record of depression in their patient record.

It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should try to find out the diagnosis date in order to record this and invite the patient for a review within the timeframe for DEP002. If the date of diagnosis is unknown or the letter arrives too late then the contractor records the date of diagnosis as the date the letter arrives and invites the patient for review within the timeframe for DEP002 from that date.

Suspected depression seen in secondary care may not always be referred to specialist mental health services for further assessment and management. It may be in the form of a discharge letter from an acute medical or surgical ward, A&E or from an outpatient appointment. It may be reasonable in these circumstances for a contractor to contact the patient to ask them to attend for an assessment to assess if they have a clinical diagnosis of depression. In such cases, the coding can be carried out at that time.

**Coding and Lifestyle**

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


\textsuperscript{93} NICE clinical guideline CG90. Depression in adults 2009. \url{http://publications.nice.org.uk/depression-in-adults-cg90}
The health of patients with Depression can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**DEP indicator 003 (NICE 2012 menu ID: NM50)**

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier that 10 days after and not later than 56 days after the date of diagnosis.

**DEP 003.1 Rationale**

The NICE clinical guideline on depression in adults states that patients with mild depression or sub-threshold symptoms be reviewed and re-assessed after initial presentation, normally within two weeks.

CG90 recommends that patients with mild or moderate depression who start antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide.

This indicator promotes a single depression review between 10 days and 56 days after the date of diagnosis. For some patients this may not be their first review as they will have been reviewed initially within a week of the diagnosis. Unless a patient’s symptoms have resolved, further reviews may be required. Practitioners are reminded of the importance of regular follow-up in this group of patients to monitor
response to treatment, identify any adherence issues and provide on-going support. This review could address the following:

- a review of depressive symptoms;
- a review of social support;
- a review of alternative treatment options where indicated;
- follow-up on progress of external referrals;
- an enquiry about suicidal ideation;
- highlighting the importance of continuing with medication to reduce the risk of relapse;
- the side-effects and efficacy of medication. In the USA, 40 per cent of patients prescribed an antidepressant will discontinue its use within one month. Analysis of the GPRD94 from 1993 to 2005 found that more than half of patients treated with antidepressants had only received prescriptions for one or two months of treatment and that this pattern had not changed over the 13-year period.

Additionally, clinicians may wish to use formal assessment questionnaires such as PHQ9, HADS and BDI-II to monitor response to treatment.

In most clinical circumstances, the review would be performed during a face-to-face consultation so that body language and non-verbal cues may be observed. However, there is some evidence that telephone review may be appropriate for patients starting antidepressants\(^\text{95,96}\) or for patients with mild depression who are not considered at increased risk of suicide and:

- the patient is well known to the GP who is conducting the telephone consultation;
- the GP feels confident in their ability to perform a telephone consultation in this context;
- the patient has failed to attend a face-to-face review and is proactively contacted on the telephone by a GP;
- the patient has expressed a preference for telephone follow-up.

Only face-to-face or telephone contact with a GP or nurse practitioner is acceptable to meet the requirements for this indicator.

**DEP 003.2 Reporting and verification**

See indicator wording for requirement criteria.

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Those patients whose on-going case is being provided by specialist mental health services should be exception reported.

It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should try to find out the diagnosis date in order to record this and invite the patient for a review within the timeframe for DEP003. If the date of diagnosis is unknown or the letter arrives too late then the contractor records the date of diagnosis as the date the letter arrives and invites the patient for review within the timeframe for DEP003 from that date.

Suspected depression seen in secondary care may not always be referred to specialist mental health services for further assessment and management. It may be in the form of a discharge letter from an acute medical or surgical ward, A&E or from an outpatient appointment. It may be reasonable in these circumstances for a contractor to contact the patient to ask them to attend for an assessment to assess if they have a clinical diagnosis of depression. In such cases, the coding can be carried out at that time.

There is no register indicator for the depression indicators. The denominator for the indicators in the depression area for the purpose of calculating the APDF is defined as all patients aged 18 or over, with a new diagnosis of depression in the preceding 1 April to 31 March, who have an unresolved record of depression in their patient record.

Verification - the NHS Board may wish to ask contractors about the percentage of telephone reviews conducted and who they were delivered by.

**Mental health (MH)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Schizophrenia, Bipolar Affective Disorder and other Psychoses and other patients on lithium therapy and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH002(S). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate.</td>
<td>6</td>
<td>40–90%</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>NICE 2010 menu ID</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>MH003(S)</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.</td>
<td>NM17</td>
</tr>
<tr>
<td>MH004(S)</td>
<td>The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdL ratio in the preceding 15 months.</td>
<td>NM18</td>
</tr>
<tr>
<td>MH005(S)</td>
<td>The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months.</td>
<td>NM42</td>
</tr>
<tr>
<td>MH006(S)</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months.</td>
<td>NM16</td>
</tr>
<tr>
<td>MH007(S)</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.</td>
<td>NM15</td>
</tr>
<tr>
<td>MH008(S)</td>
<td>The percentage of women aged 20 or over and who have not attained the age of 60 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.</td>
<td>NM20</td>
</tr>
<tr>
<td>MH009</td>
<td>The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.</td>
<td>NM21</td>
</tr>
<tr>
<td>MH010</td>
<td>The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.</td>
<td>NM22</td>
</tr>
</tbody>
</table>

**MH – rationale for inclusion of indicator set**

This indicator set reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs.
Indicators MH002(S) – MH008(S) relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders. Indicators MH009 and MH010 relate to the care of patients who are currently prescribed lithium. In order to create a denominator for other indicators contractors need to record an appropriate READ code for individuals with a diagnosis of serious mental illness i.e. schizophrenia, bipolar or other affective disorders and other patients on lithium therapy.

For many patients with mental health problems, the most important indicators relate to the interpersonal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options.

This indicator set focuses on patients with serious mental illness. There are separate indicator sets that focus on patients with depression and dementia.

**Mental health indicators MH003(S) – MH008(S)**

It is recommended that patients receive an annual health promotion and prevention review and advice appropriate to their age, gender and health status.

The components of an annual review have been separated out to create a series of indicators. The annual timeframe for these indicators is in line with the NICE clinical guideline on schizophrenia.\(^{97}\)

The NICE clinical guideline on bipolar disorder\(^ {98}\) recommends that patients with bipolar affective disorder 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 aged 40 or over even if there is no other indication of risk;
- plasma glucose level;
- weight;
- smoking status and alcohol use;
- blood pressure.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD.\(^ {99}\)

**Remission from serious mental illness**


Historically, patients have been added to the mental health disease register for schizophrenia, bipolar affective disorder and other psychoses, but over time it has become apparent that it would be appropriate to exclude some of them from the associated indicators because their illness is in remission.

Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the ‘remission code’ is largely based on clinical judgement. A longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery is used.

In the absence of strong evidence of what constitutes ‘remission’ from serious mental illness, it is advised that clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

- no record of antipsychotic medication;
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being ‘in remission’ they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002 to MH008(S).

The accuracy of this diagnosis and the coding should be reviewed on an annual basis by a GP. If a patient who has been coded as ‘in remission’ experience a relapse then this should be recorded as such in their patient record.

In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.

The denominator includes patients with a current condition and also those recorded as being in remission, however patients recorded as 'in remission' will be excluded from mental health indicators MH002(S) to MH008(S).

**Coding and Lifestyle**

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

The health of patients with Schizophrenia, Bipolar Affective Disorder and other Psychoses and other patients on lithium therapy can be improved by the provision of appropriate lifestyle advice.
It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**MH indicator 002(S)**

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

**MH 002.1(S) Rationale**

This indicator reflects good professional practice and is supported by NICE clinical guidelines\(^\text{101}\).

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

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

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

2. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement. People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with on-going mental health problems had no social contacts outside mental health services.\(^\text{102}\)

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

4. Occupational status. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (office of national statistics (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 among users of mental health services with up to 90 per cent wishing to go into or back to work.\(^\text{103}\)

5. "Early warning signs" from the patient's perspective that may indicate a possible relapse.\(^\text{104}\) 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 patient thinks may have acted as triggers.

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

It is recommended that a care plan is accurate, easily understood, reviewed annually and discussed with the patient, their family and/or carers. If a patient is treated under the care programme approach (CPA), then they have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of QOF.

Where a patient has relapsed after being recorded as being in remission their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

**MH 002.2(S) Reporting and verification**

See indicator wording for requirement criteria.


\(^{103}\) See Grove and Drurie. Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK, 1999.

Verification - the NHS Board may require contractors to randomly select a number of care plans to ensure that they are being maintained annually.

**MH indicator 003(S) (NICE 2010 menu ID: NM17)**

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.

**MH 003.1(S) Rationale**

Patients with schizophrenia have mortality between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. A recent prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population. The NICE clinical guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population. A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans’ administration facilities found a prevalence of hypertension of 35 per cent.

There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of patients with asthma, patients with schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups.

Recording (and treating) cardiovascular risk factors are therefore very important for patients with a serious mental illness.

**MH 003.2(S) Reporting and verification**

See indicator wording for requirement criteria.

**MH indicator 004(S) (NICE 2010 menu ID: NM18)**

The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months.

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MH 004.1(S) Rationale
A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hyperlipidaemia of 23 per cent\(^\text{109}\). Patients with schizophrenia also have a much higher risk of raised total cholesterol:hdrl ratio than the general population\(^\text{110}\).

MH 004.2(S) Reporting and verification
See indicator wording for requirement criteria.

From April 2012, patients with established CVD are excluded from this indicator because the intention of the indicator is to help manage CVD risk in patients with a serious mental illness without established CVD. If a patient already has CVD, then the cholesterol:hdrl ratio test is not required.

MH indicator 005(S) (NICE 2011 menu ID: NM42)

The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months.

MH 005.1(S) Rationale
This indicator supports annual case finding for diabetes through the use of random or fasting blood glucose or HbA1c measurement.

Studies have suggested that people with mental health disorders have a higher prevalence of chronic diseases, including diabetes, compared with the general population. For example, a US cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of diabetes of 17 per cent. The relative risk of developing DM is reported to be two to three times higher in people with schizophrenia than in the general population.

There is insufficient evidence to support the use of blood glucose testing in patients of all ages with schizophrenia, bipolar affective disorder or other psychoses and therefore an age limit of 40 or over has been adopted for this indicator.

The WHO diagnostic criteria\(^\text{111}\) states that fasting plasma glucose ≥7.0 mmol/l (126 mg/dl) or 2–h plasma glucose ≥11.1 mmol/l (200 mg/dl) should be used as criteria for diagnosing diabetes.

In January 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of HbA1c for diagnosing DM\(^\text{112}\). The WHO recommend that HbA1c can

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be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values, and there are no conditions present that preclude its accurate measurement. A HbA1c of 48 mmol/l\(^{113}\) is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/l does not exclude diabetes diagnosed using glucose tests. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/l.

This is an important change in practice. The inclusion of HbA1c as well as plasma glucose to incentivise case finding for diabetes in patients with serious mental illness has the potential to simplify and improve access to diabetes case finding and improve adherence to the indicator. The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and avoids the need for the patient to make preceding dietary preparations (such as fasting or consuming a glucose drink).

**MH 005.2(S) Reporting and verification**
See indicator wording for requirement criteria.

Patients in whom diabetes has already been diagnosed are excluded from the denominator for this indicator as these patients are managed according to the diabetes indicator set.

**MH indicator 006(S) (NICE 2010 menu ID: NM16)**

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months.

**MH 006.1(S) Rationale**

The general population in developed countries is experiencing an escalation in cardiovascular risk factors, such as obesity and lack of exercise and increased rates of type 2 diabetes. Superimposed on this are lifestyle issues (not all actively chosen) for people with psychosis, generating an escalation of cardiovascular risks\(^{114}\).

In particular, patients with psychosis may lead more sedentary lives, eat less fruit and vegetables, be much more likely to be obese, are two to three times more likely to smoke cigarettes and five times more likely to smoke heavily\(^{115}\). In addition to lifestyle factors, anti-psychotic drugs vary in their liability for metabolic side-effects, such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance and dyslipidaemia), which is a predictor of type 2 diabetes and CHD\(^{116}\).

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Approximately 40 per cent of patients with schizophrenia are obese\textsuperscript{117} and obesity is also common in people with bipolar disorders\textsuperscript{118}.

Further information

NICE clinical guideline CG43. Obesity. The prevention, identification, assessment and management of overweight and obesity in adults and children 2006.\url{http://www.nice.org.uk/CG043}

SIGN clinical guideline 115. Management of obesity 2010.\url{http://guidance.nice.org.uk.CG115}

\textbf{MH 006.2(S) Reporting and verification}

See indicator wording for requirement criteria.

\textbf{MH indicator 007(S) (NICE 2010 menu ID: NM15)}

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.

\textbf{MH 007.1(S) Rationale}

Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects\textsuperscript{119}. The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol for men and 14 units of alcohol for women a week\textsuperscript{120, 121}. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse\textsuperscript{122}.

\textbf{MH 007.2(S) Reporting and verification}

See indicator wording for requirement criteria.

\textbf{MH indicator 008(S) (NICE 2010 menu ID: NM20)}

The percentage of women aged 20 or over and under the age of 60 with schizophrenia, bipolar affective disorder and other psychoses whose records note that a cervical screening test has been performed in the preceding 5 years.

\textbf{MH 008.1(S) Rationale}

\textsuperscript{117}Hennekens C, Hennekens A, Hollar D. Schizophrenia and increased risks of CVD. Am Heart Journal 150: 1115-21 2005.
A report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less likely to have had a cervical sample taken in the preceding five years (63 per cent) compared with the general population (73 per cent). This did not apply to patients with bipolar affective disorder. This finding may reflect an underlying attitude that such screening is less appropriate for women with schizophrenia. This indicator therefore encourages contractors to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to national guidelines.

**MH 008.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**MH indicator 009 (NICE 2010 menu ID: NM21)**

The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.

**MH 009.1 Rationale**
It is important to check thyroid and renal function regularly in patients taking lithium, as there is a much higher than normal incidence of hypothyroidism and hypercalcaemia and of abnormal renal function tests. Overt hypothyroidism has been found in between eight per cent and 15 per cent of patients on lithium.

NICE clinical guideline CG38 recommends that practitioners check thyroid function every six months together with levels of thyroid antibodies if clinically indicated (for example, by the thyroid function tests). It also recommends that renal function tests are carried out every six months and more often if there is evidence of impaired renal function.

**MH 009.2 Reporting and verification**
See indicator wording for requirement criteria.

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

**MH indicator 010 (NICE 2010 menu ID: NM22)**

The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.

**MH 010.1 Rationale**
Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from inter-current illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDs) which may reduce lithium excretion.

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The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium for bipolar disorder, which demonstrated that wrong or unclear dose or strength and monitoring were key issues for lithium therapy. A search of all medication incidents related to the use of lithium reported to the National Reporting and Learning System between November 2003 and December 2008 identified a total of 567 incidents. Two of these resulted in 'severe' harm to the patient, although the majority were reported as 'no harm' events.

NICE clinical guideline CG38 states that for patients with bipolar disorder on lithium treatment, prescribers:

- monitor serum levels normally every three months;
- monitor older adults carefully for symptoms of lithium toxicity, because they may develop high serum levels of lithium at doses in the normal range and lithium toxicity is possible at moderate serum levels.

The aim is to maintain serum lithium levels between 0.6 and 0.8 mmol/l in patients who are prescribed lithium for the first time. For patients who have relapsed previously while taking lithium or who still have sub-threshold symptoms with functional impairment while receiving lithium, a trial of at least six months with serum lithium levels between 0.8 and 1.0 mmol/l should be considered. If the range differs locally, the NHS Board will be required to allow for this.

Where a contractor is prescribing lithium, they are responsible for checking that routine blood tests have been done (not necessarily by the practice) and for following up patients who default.

**MH 010.2 Reporting and verification**
See indicator wording for requirement criteria.

Due to the way repeat prescribing works in general practice, patient on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

**Cancer (CAN)**

**Coding**

The practice records agreed diagnostic READ codes for patients diagnosed with Cancer, excluding non-melanotic skin cancers, on or after the 1st April 2003, and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
</table>

124 NPSA alert 0921. Safer lithium therapy 2009: [www.nrls.npsa.uk/alerts](http://www.nrls.npsa.uk/alerts)

Ongoing management

| CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis. NICE 2012 menu ID: NM62 | 6 | 50–90% |

**CAN – rationale for inclusion of indicator set**

It is recognised that the principal active management of cancers occurs in the secondary care setting. However, general practice often has a key role in the referral and subsequent support of these patients and in ensuring that care is appropriately co-ordinated. This indicator set is not evidence-based but does represent good professional practice.

Cancer coding should be done when the diagnosis is confirmed, as the intention is to ensure appropriate care and follow-up for patients with a diagnosis of cancer. For the purposes of the denominator all cancers are included except non-melanomatous skin lesions.

**Coding and Lifestyle**

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

The health of patients with Cancer can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


[http://www.healthscotland.com/topics/health/alcohol/resources.aspx](http://www.healthscotland.com/topics/health/alcohol/resources.aspx)

SIGN clinical guideline 74. The management of harmful drinking and alcohol dependence in primary care 2008. 
http://www.sign.ac.uk/guidelines/fulltext/74/index.html

CAN indicator 003 (NICE 2012 menu ID: NM62)

The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis.

CAN 003.1 Rationale
A GP will have an average of eight or nine new cancer diagnoses per year and will be looking after 20 to 30 patients with cancer. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management. Given the importance of primary care practitioners making early contact with patients who have been diagnosed with cancer, the timeframe for this indicator has been set at 6 months.

Most practices will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. These patients quickly resume consultations in general practice at an increased rate to pre-diagnosis and treatment, therefore primary care has an important role in managing survivorship. This review represents an initial opportunity to address patients’ needs for individual assessment, care planning and on-going support and information requirements.

A cancer review in primary care includes:

- The patient’s individual health and support needs, which will vary with, for example, the diagnosis, staging, age and pre-morbid health of the patient and their social support networks. In collaboration with the National Cancer Survivorship Initiative (NCSI)\(^{126}\), Macmillan primary care community has produced a template\(^{127}\) which recommends that this could cover a discussion of the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer’s details;

- The coordination of care between sectors.

Further information on survivorship and the potential role for primary care can be found on the NCSI website\(^{128}\).

It is preferable that a review should be face-to-face in most cases, making contact with a patient over the telephone will meet the requirements for this indicator. Where contact is made over the phone, an offer of a subsequent face-to-face review is advised.


\(^{128}\)NCSI website. http://www.ncsi.org.uk/
CAN 003.2 Reporting and verification
See indicator wording for requirement criteria.

Verification – the NHS Board may wish to review records where a review is claimed to confirm that both elements have been completed.

Chronic kidney disease (CKD)
Coding

The practice records agreed diagnostic READ codes for patients aged 18 and over diagnosed with Chronic Kidney Disease (US national Kidney Foundation: stage 3 to 5) and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD002(S). The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 15 months) is 140/85 mmHg or less.</td>
<td>11</td>
<td>45–70%</td>
</tr>
<tr>
<td>CKD003. The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB.</td>
<td>9</td>
<td>45–80%</td>
</tr>
<tr>
<td>CKD004(S). 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 preceding 15 months.</td>
<td>6</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

CKD – rationale for inclusion of indicator set

The international classification developed by the US National Kidney Foundation describes five stages of CKD using an estimated glomerular filtration rate (eGFR) to measure kidney function (see table three). Patients with CKD stages 3 to stage 5 have, by definition, less than 60 per cent of their kidney function. Stage three is a moderate decrease in glomerular filtration rate (GFR) with or without other evidence of kidney damage. Several groups (NICE, SIGN, UK Consensus) have recommended splitting stage three into 3A and 3B (table three). Stage 4 is a severe decrease in GFR with or without other evidence of kidney damage and stage 5 is established renal failure. This indicator set refers to patients with stage 3 to stage 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 six per cent. The prevalence in females was

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129 Coresh et al JAMA. 2007; 298(17): 2038-2047
higher than in males (6.9 per cent verses 4.9 per cent). In the fully adjusted model, the prevalence of low GFR was strongly associated with diagnosed diabetes (OR, 1.54; 95 per cent CI, 1.28-1.80) and hypertension (OR, 1.98; 95 per cent CI, 1.73-2.67) as well as higher BMI (OR, 1.08; 95 per cent CI, 1.02-1.15 per 5-unit increment of BMI).

In the UK the prevalence of CKD stage 3 to 5 was 8.5 per cent and was higher in females, 10.6 per cent in females versus 5.8 per cent in males. The Association of Public Health Observatories (APHO) has modelled the prevalence of CKD for England and Wales based on the results of the study by Stevens et al and report a population prevalence of 8.9 per cent.

**Table 3. eGFR to measure kidney function**

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

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

Further information

This indicator set applies to patients with stage 3, 4 and 5 CKD (eGFR <60 mL/min/1.73 m² 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.

Only a minority of patients with stage 1 or 2 CKD go on to develop more advanced disease and symptoms do not usually appear until stage 4. Where eGFR has persistently been recorded below 60 the CKD (stage 3) label continues to apply, even if future management may lead to an improvement in eGFR.

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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 CVD. The presence of proteinuria is a key risk multiplier at all stages of CKD and CKD is an independent risk factor for CVD and a multiplier of other risk factors.\textsuperscript{132}

Further information

NICE clinical guideline CG73. Early identification and management of CKD in adults in primary and secondary care 2008.\url{http://www.nice.org.uk/C73}

SIGN clinical guideline 103. Diagnosis and management of CKD in adults 2008.\url{http://www.sign.ac.uk/guidelines/fulltext/103/index.html}

These indicators reflect both of the guidance documents.

1. ACR is the preferred measure of proteinuria.

2. NICE suggests blood pressure is 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 blood pressure audit standard of 145/85 mmHg in this guidance for 40 to 70 per cent of the CKD population.

3. NICE recommends that the use of ACE-I when there is hypertension and an ACR of \(\geq 30\) mg/mmol. However, when ACR \(\geq 70\)mg/mmol NICE recommends ACE-I even in the absence of hypertension. As with BP there are stricter standards in diabetes.

4. NICE divides stage 3 into stage 3a and 3b. NICE recommend testing for bone disease and anaemia in stage 3b (eGFR 30 to 44), as well as stages 4 and 5.

5. NICE also recommends addition of the suffix (p) to denote significant proteinuria, defined as an ACR \(\geq 30\)mg/mmol (PCR \(\geq 50\) mg/mmol).

Patients aged 18 or over with a persistent eGFR or GFR of \(<60\) ml/min/1.73 m\(^2\) should be coded for CKD. From 2006, eGFR has been reported automatically when serum creatinine concentration is measured. Studies of general practice computerised patient records show that it is feasible to identify patients with CKD\textsuperscript{133} and that computer records are a valid source of data\textsuperscript{134}.

The coding of patients with CKD will enable appropriate advice, treatment and support for the patient to preserve kidney function and to reduce the risk of CVD.

Eating a meal containing protein 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.

\textsuperscript{132} Wali and Henrich. Cardiol Clin 2005; 23(3): 343-62
\textsuperscript{133} de Lusignan et al. Fam Pract 2005; 22(3): 234-41
\textsuperscript{134} Anandarajah et al. Nephrology Dial Transplant 2005; 20(10): 2089-96
Coding and Lifestyle

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

The health of patients with Chronic kidney disease can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


CKD indicator 002(S)

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

CKD 002.1(S) Rationale

Studies have shown that in patients aged 65 or over and in patients with diabetes, normal blood pressure is hard to achieve but is important\textsuperscript{135}.

The NICE clinical guideline on CKD\textsuperscript{136} recommends that in patients with CKD the clinician aims to keep the systolic blood pressure below 140 mmHg (target range 120-139 mmHg) and the DBP below 90 mmHg. In patients with CKD and diabetes and also in people with an ACR 70 mg/mmol or more (approximately equivalent to PCR 100 mg/mmol or more, or urinary protein excretion 1g/24hr or more) the


clinician aims to keep the systolic blood pressure below 130 mmHg (target range 120-129 mmHg) and the DBP below 80 mmHg.

The SIGN clinical guideline on CKD\textsuperscript{137} recommends that blood pressure be controlled to slow the deterioration of the glomerular filtration rate and reduce proteinuria. Patients with >1 g/day of proteinuria (approximately equivalent to a PCR of 100 mg/mmol) have a target maximum systolic blood pressure of 130 mmHg.

The lower the blood pressure achieved the better for patient care therefore an audit standard of 140/85 mmHg has been adopted for this indicator.

**CKD 002.2(S) Reporting and verification**
See indicator wording for requirement criteria.

**CKD indicator 003**

The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB.

**CKD 003.1 Rationale**

ACE-I 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\textsuperscript{138}.

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 ACR or PCR in the urine or to use a stick test.

The SIGN clinical guideline on CKD\textsuperscript{139} 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 the NICE clinical guideline on CKD\textsuperscript{140} suggests that the ACR be used in all patients.

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

A systematic review has shown that investigation for infection of asymptomatic patients with one "+" or more is not indicated\textsuperscript{141}. It is advised that practitioners only send a midstream urine sample or perform another test to look for infection if there are symptoms.

\textsuperscript{139}SIGN clinical guideline 103. Diagnosis and management of CKD in adults 2008
\textsuperscript{140}NICE clinical guideline CG73. CKD in adults in primary and secondary care 2008
\textsuperscript{141}Carter JL et al Nephrology Dial Transplant. 2006 Nov; 21 (11):3031-7
It is not possible to derive a simple correct 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 (see table four).

**Table 4. Approximate equivalent ACR, PCR and 24-hour urinary protein excretion**

<table>
<thead>
<tr>
<th>ACR (mg/mmol)</th>
<th>PCR (mg/mmol)</th>
<th>24-hour urinary protein excretion (g/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>50</td>
<td>0.5</td>
</tr>
<tr>
<td>70</td>
<td>100</td>
<td>1</td>
</tr>
</tbody>
</table>

**CKD 003.2 Reporting and verification**
See indicator wording for requirement criteria.

**CKD indicator 004(S)**

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 preceding 15 months.

**CKD 004.1(S) Rationale**
Quantitative measurement of proteinuria will enable appropriate management of patients with CKD. There is good observational evidence linking proteinuria to adverse outcomes.142

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

SIGN recommends the use of ACE-I 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 blood pressure 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.

**CKD 004.2(S) Reporting and verification**
See indicator wording for requirement criteria.

---

Osteoporosis: secondary prevention of fragility fractures (OST)

Coding

The practice records agreed diagnostic READ codes for the following groups of patients and provides appropriate lifestyle advice at the time of diagnosis;

1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and

2. Aged 75 or over with a record of a fragility fracture and a diagnosis of osteoporosis on or after 1 April 2014.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.</td>
<td>3</td>
<td>30–60%</td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST005. The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent.</td>
<td>3</td>
<td>30–60%</td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OST – rationale for inclusion of indicator set

Osteoporotic fragility fractures can cause substantial pain and severe disability and are associated with decreased life expectancy. Osteoporotic fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They also occur in the arm (humerus), pelvis, ribs and other bones. Fractures of the hands and feet (for example metacarpal and metatarsal fractures) are not generally regarded as osteoporotic fragility fractures.

Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

In order to create a denominator enabling achievement of OST002 and OST005, the contractor will need to code those patients in the practice who are:
1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; and

2. Aged 75 or over with a record of a fragility fracture and a diagnosis of osteoporosis on or after 1 April 2014.

Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has described this as a force equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fractures\textsuperscript{143}.

Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue. The WHO defines osteoporosis as a bone mineral density of 2.5 or more standard deviations below that of a normal young adult (T-score of -2.5 or less) measured by a central dual-energy X-ray absorptiometry (DXA) scan. Bone mineral density is the major criterion used to diagnose and monitor osteoporosis.

The NICE clinical guideline on osteoporosis fragility fractures\textsuperscript{144} recommends that a diagnosis of osteoporosis may be assumed in women and men aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible\textsuperscript{145}. The SIGN clinical guideline on the management of osteoporosis\textsuperscript{146} recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish that bone mass density (BMD) is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

In April 2014 the denominator for people aged 75 or over was amended to require that practices record a diagnosis of osteoporosis in addition to a fragility fracture.

A code for osteoporosis may be applied without a DXA scan in women and men aged 75 or over with a fragility fracture unless the responsible clinician considers a DXA scan to be clinically appropriate and feasible. In those circumstances, it would be good practice to record that the clinician has decided against doing a DXA scan.

Osteoporotic fragility fractures can cause substantial pain and severe disability, and are associated with decreased life expectancy. Osteoporotic fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They also occur in the arm (humerus), pelvis, ribs and other bones. Fractures of the hands and feet (for example, metacarpal and metatarsal fractures) are not generally regarded as osteoporotic fragility fractures.

In women, the prevalence of osteoporosis increases markedly with age after menopause, from approximately two per cent at 50 years, rising to more than 25 per

\textsuperscript{143}WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.
\textsuperscript{144}NICE clinical guideline CG146. Osteoporosis fragility fracture 2012. http://www.nice.org.uk/CG146
cent at 80 years. The NICE cost impact report for technology appraisal TA161 uses a prevalence of 11 per cent of post-menopausal women aged 50 or over with osteoporosis and a clinically apparent osteoporotic fragility fracture, rising to 19 per cent for ages 65 or over. There are an estimated 180,000 new fragility fractures in postmenopausal women in the UK each year; three quarters in women aged 65 or over.

Postmenopausal women with an initial fracture are at substantially greater risk of subsequent fractures. Half of patients with a hip fracture have previously had a fragility fracture of another bone.

Hip fractures are associated with increased mortality; estimates of the relative mortality risk vary from two to greater than ten in the 12 months following hip fracture. However, it is unclear to what extent this can be attributed to fracture alone, as opposed to pre-existing co-morbidity\textsuperscript{147}.

The SIGN clinical guideline recommends that patients who have suffered one or more fragility fractures are priority targets for investigation and treatment of osteoporosis.

This indicator promotes structured case finding for osteoporosis in patients who have had a fragility fracture. Its aim is to promote the secondary prevention of fragility fracture in patients with osteoporosis.

The Business Rules for this disease area will look for the following criteria:

In patients aged 50 or over and who have not attained the age of 75:

- the earliest DXA scan with a positive result of osteoporosis;
- the earliest diagnosis of osteoporosis;
- a fragility fracture at any point on or after the implementation date (1 April 2012).

In patients aged 75 or over:

- a fragility fracture at any point on or after the implementation date (1 April 2014).

Patients with fragility fractures sustained in the last three months of the year will be excepted from this indicator. These patients will be included if the clinician decides that DXA scanning is inappropriate or unfeasible. Although this indicator defines two separate registers, the disease register for the purposes of calculating the APDF is defined as the sum of the number of patients on both registers.

**Coding and Lifestyle**

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

\textsuperscript{147} WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.
The health of patients with Osteoporosis can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**OST indicator 002 (NICE 2011 menu ID: NM30)**

The percentage of patients aged 50 or over and who have not attained the age of 75 with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent

**OST 002.1 Rationale**

The management of osteoporosis includes lifestyle advice, such as advice on adequate nutrition, regular weight-bearing exercise, stopping smoking and avoiding alcohol, to reduce the risks of osteoporosis. Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

The SIGN clinical guideline on the management of osteoporosis addresses the pharmacological management in three groups of postmenopausal women: postmenopausal women with multiple vertebral fractures (DXA scan not essential but other destructive diseases are excluded); postmenopausal women with osteoporosis determined by DXA scan and a history of at least one vertebral fracture; and postmenopausal women with osteoporosis determined by DXA scan with or without a previous non-vertebral fracture.

For all these groups bone-sparing agents are indicated to reduce subsequent fracture risk. NICE technology appraisal TA161 states that the bone-sparing agent alendronate is recommended as a treatment option for the secondary prevention of osteoporotic fragility fractures in postmenopausal women who are confirmed to have osteoporosis. When the decision has been made to initiate treatment with alendronate, it is recommended that the preparation prescribed is chosen on the basis of the lowest acquisition cost available. The bone-sparing agents risedronate and etidronate are recommended as alternative treatment options for secondary prevention of osteoporotic fragility fractures in postmenopausal women:

- who are unable to comply with the special instructions for the administration of alendronate, or have a contraindication to or are intolerant of alendronate and

- who also have a combination of T-score, age and number of independent clinical risk factors for fracture as indicated in the following table.

Table 5. T-scores (SD) at (or below) which risedronate or etidronate is recommended when alendronate cannot be taken

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>-3.0</td>
<td>-3.0</td>
<td>-2.5</td>
</tr>
<tr>
<td>55-59</td>
<td>-3.0</td>
<td>-3.0</td>
<td>-2.5</td>
</tr>
<tr>
<td>60-64</td>
<td>-3.0</td>
<td>-3.0</td>
<td>-2.5</td>
</tr>
<tr>
<td>65-69</td>
<td>-3.0</td>
<td>-2.5</td>
<td>-2.5</td>
</tr>
<tr>
<td>70 or over</td>
<td>-2.5</td>
<td>-2.5</td>
<td>-2.5</td>
</tr>
</tbody>
</table>

*Independent clinical risk factors for fractures are parental history of hip fracture, alcohol intake of four or more units per day, and rheumatoid arthritis.

**Treatment with risedronate or etidronate is not recommended.

In deciding between risedronate and etidronate, clinicians and patients need to balance the overall proven effectiveness profile of the drugs against their tolerability and adverse effects in individual patients.

The SIGN clinical guideline makes recommendations on men with a diagnosis of osteoporosis determined by DXA scan. It states that to reduce fracture risks at all sites, men with low BMD and/or a history of one or more vertebral fractures or one non-vertebral osteoporotic fractures are treated with oral alendronate.

It is recommended that calcium and vitamin D supplementation are used in combination with bone-sparing agents. The guideline also recommends that patients who have had a fragility fracture who require treatment with a bone-sparing agent also receive appropriate calcium and/or vitamin D supplementation.

**OST 002.2 Reporting and verification**

See indicator wording for requirement criteria.

**OST indicator 005 (NICE 2011 menu ID: NM31)**

The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent.
OST 005.1 Rationale
See OST 002.1.

NICE and SIGN recommend bone-sparing agents for the secondary prevention of osteoporotic fragility fractures in people confirmed to have osteoporosis. In April 2014 this indicator was amended so only people with a record of a diagnosis of osteoporosis in addition to a record of a fragility fracture are included in the denominator. This indicator does not require that a diagnosis of osteoporosis is confirmed by DXA scan in patients aged 75 or over with a fragility fracture but it is recommended clinical practice that this group are considered for a DXA scan. NICE recommends that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible. SIGN recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish BMD is sufficiently low before starting treatment with bone-sparing agents (biophosphonates), unless the patient has suffered multiple vertebral fractures.

OST 005.2 Reporting and verification
See indicator wording for requirement criteria.

Rheumatoid arthritis (RA)

Coding

The practice records agreed diagnostic READ codes for patients aged 16 and over diagnosed with Rheumatoid Arthritis and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA002(S). The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months. NICE 2012 menu ID: NM58</td>
<td>5</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

RA – rationale for inclusion of indicator set

Rheumatoid arthritis (RA) is a chronic, disabling auto-immune disease characterised by inflammation in the peripheral joints, which causes swelling, stiffness, pain and progressive joint destruction. For a small proportion of people with RA, inflammatory disease outside the joints (for example, eye and lung disease, vasculitis) can pose a significant problem. RA affects around one per cent of the population; of these people, approximately 15 per cent have severe RA.

\[^{149}\text{NICE technology appraisal TA161.}\]
Although the confirmation of diagnosis and initiation of treatment may take place in secondary care, primary care has an important role to play in the management of RA. This may include checking cardiovascular risk and blood pressure, checking the person's risk for osteoporosis and assessing for signs of low mood or depression. An annual face-to-face review in primary care is an opportunity to assess the effect of the disease upon the person’s life, for example side effects to medication and whether they would benefit from any referrals to the multi-disciplinary team.

The RA denominator should include patients aged 16 or over with established and recent-onset disease and in whom there is a definite diagnosis of RA, irrespective of evidence of positive serology and current disease activity status.

When creating the denominator from historical diagnoses, the diagnosis may have been made by either a GP or a specialist. In future, it is anticipated that new diagnoses will be made by a specialist.

The denominator is restricted to patients aged 16 or over, to conform to international standards for differentiating RA from juvenile idiopathic arthritis.

The denominator also includes patients with inactive RA. There are three potential groups of patients whose disease may be referred to as inactive:

- patients who are being treated and whose disease is in remission;
- patients who are not receiving treatment for RA but have evidence of past disease, for example, joint deformities. This type of RA is sometimes known as ‘burnt out’ RA. These patients are on the register as they remain at risk of the systemic effects of RA;
- patients who are not receiving treatment for RA who have no evidence of past disease but there is doubt about their diagnosis. The contractor may wish to request erythrocyte sedimentation rate (ESR) or plasma viscosity, C-reactive protein (CRP), rheumatoid factor and hand X-ray to determine the accuracy of the diagnosis. Inaccurate diagnoses can be removed from the patient’s patient record which would also remove them from the register.

Recognition of synovitis in primary care and prompt referral for specialist advice is key to the early identification and treatment of RA. Synovitis is inflammation of the membrane that lines the inside of synovial joints (most of the joints in the body). Symptoms of inflammation include pain, swelling, heat and loss of function of an affected joint.

Identifying recent-onset RA can be challenging in primary care because of the variety of ways in which synovitis can present itself and the small number of patients who have RA compared with the number of patients with musculoskeletal symptoms. The NICE clinical guideline on RA\textsuperscript{150} recommends that patients with persistent synovitis are referred for specialist opinion. Urgent referral is needed when any of the following are present:

\textsuperscript{150} NICE clinical guideline CG79. RA 2009. \url{http://publications.nice.org.uk/rheumatoid-arthritis-cg79}
• the small joints of the hands or feet are affected;
• more than one joint is affected;
• there has been a delay of three months or longer between the onset of symptoms and seeking medical advice.

Early identification of recent-onset RA is important because long-term outcomes are improved if disease modifying anti-rheumatic drugs (DMARDs) treatment is started within three months of the onset of symptoms.

**Coding and Lifestyle**

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

The health of patients with Rheumatoid arthritis can be improved by the provision of appropriate lifestyle advice.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


[http://www.healthscotland.com/topics/health/alcohol/resources.aspx](http://www.healthscotland.com/topics/health/alcohol/resources.aspx)


**RA indicator 002(S) (NICE 2012 menu ID: NM58)**

The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months.

**RA 002.1(S) Rationale**
RA is a chronic disease with a variable course over a long period of time. Therefore, there is a need for regular monitoring to determine disease status, assess severity, efficacy and toxicity of drug therapy and identify co-morbidities or complications.

Patients with satisfactorily controlled established disease require review appointments for on-going drug monitoring, additional visits for disease flares and rapid access to specialist care. RA and its treatment can also have a negative effect upon a patient's quality of life. It is recommended that contractors review the following aspects of care with a patient:

- disease activity and damage, which may include requesting C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) or plasma viscosity test;
- a discussion of DMARDS, if relevant;
- the need for referral for surgery;
- the effect the disease is having on their life, for example employment or education;
- the need to organise appropriate cross-referral within the multi-disciplinary team.

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease upon the patient's life and whether they would benefit from any referrals to the multi-disciplinary team.

If a face to face review has been held in a specialist setting and the contractor is satisfied that all of the relevant areas been covered, and the results recorded in the patient's practice record then there is no need to re-do this review in the practice.

**RA002.2(S) Reporting and verification**

See indicator wording for requirement criteria.

Verification - the NHS Board may wish to review patient records to ensure that all essential elements of the review have been performed.

### Palliative care (PC)

**Coding**

The practice records agreed diagnostic READ codes for patients of any age diagnosed as being in need of palliative care/support and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC002. The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
patients on the palliative care register are discussed.

PC – 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\textsuperscript{151} was published in July 2008. It builds on work such as the NHS cancer plan 2000, NICE guidance 2004 and NHS EOLC programme 2005.

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

- since the introduction of this indicator set over 99 per cent of practices now using a palliative care register;
- 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 NAO e.g. unnecessary hospital admissions during the last months of life.

The National EoLC Strategy suggests that all contractors adopt a systematic approach to EoLC 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 per cent 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 the GSF\textsuperscript{152} to primary care and its associated audit tool, the ADA, are associated with a considerable degree of research and evaluation. The GSF provides ideas and tools that help contractors to focus on implementing high quality patient-centred care.

About one per cent of the population in the UK die each year (over half a million), with 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

\textsuperscript{152}\textsuperscript{GSF. http://www.goldstandardsframework.org.uk/}
of patients have a sudden death. It may therefore be possible to predict the majority of deaths, however, this is difficult and errors occur 30 per cent of the time. Two thirds of errors are based on over optimism and one third on 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. This 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\(^{153}\).

A patient is included in the denominator 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 '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 one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of the GSF website).

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 denominator applies to all patients fulfilling the criteria regardless of age or diagnosis.

The creation of a denominator will not in itself improve care but it enables the wider practice team to provide more appropriate and patient focussed care.

**Coding and Lifestyle**

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

The health of patients in need of palliative care/support can be improved by the provision of appropriate lifestyle advice.

\(^{153}\) NAO EoLc Report. '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 quarter of these had been in hospital for over a month'. November 2008.
It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


http://www.healthscotland.com/topics/health/alcohol/resources.aspx


**PC indicator 002**

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

**PC002.1 Rationale**

The aims of multidisciplinary case review meetings are to:

- ensure all aspects of the patients care have been considered and documented in the patients records;
- 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 staff directly employed by the contractor find use of a checklist during the meeting helpful, as it helps to ensure all aspects of care are covered e.g. supportive care register (SCR) templates SCR1 and SCR2 the assessment tools on the GSF website.

**PC 002.2 Reporting and verification**
See indicator wording for requirement criteria.

Verification - the NHS Board may request that the contractor provides evidence that the meetings took place which could be in the form of minutes of the meetings. Contractors may also be required to provide written evidence describing the system for initiating and recording meetings.
Section 4: Public health domain

Public health domain introduction

The public health (PH) domain has been introduced to QOF from April 2014 to reflect the part of QOF to be dedicated to evidence-based PH and primary prevention indicators.

The clinical and health improvement indicators within this domain follow the layout of the clinical domain indicators, referring to sections on the indicator rationale and reporting and verification.

The additional services indicators, within this domain either:

1. follow the format of the four areas below along with information to support the indicator:
   - contractor guidance
   - reporting and verification

2. follow the format of the clinical domain indicators.

Further detail on the above two formats is included in the ‘format’ section below.

Format

For each of the indicators (X.X) using the first format above, there are four descriptions unless it is reported electronically.

X.1 Rationale
This section contains a range of information, dependent on the indicator, including:

- justification for the indicator
- a more detailed description of the indicator
- references which contractors may find useful.

X.2 Reporting and verification
This section outlines the evidence which NHS Boards may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested. In some instances no evidence will be required but may be requested by NHS Boards at any time.
Cardiovascular disease – primary prevention (CVD-PP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD-PP001(S). In those patients with a new</td>
<td>10</td>
<td>40–90%</td>
</tr>
<tr>
<td>diagnosis of hypertension aged 30 or over and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>who have not attained the age of 75, recorded</td>
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<tr>
<td>between the preceding 1 April to 31 March</td>
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<td></td>
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<tr>
<td>(excluding those with pre-existing CHD,</td>
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<tr>
<td>diabetes, stroke and/or TIA), who have a</td>
<td></td>
<td></td>
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<tr>
<td>recorded CVD risk assessment score (using an</td>
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<tr>
<td>assessment tool agreed with the NHS CB) of ≥20%</td>
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<td></td>
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<tr>
<td>in the preceding 15 months: the percentage</td>
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<td></td>
</tr>
<tr>
<td>who are currently treated with statins.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM26</td>
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<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD-PP002(S). The percentage of patients</td>
<td>5</td>
<td>40–75%</td>
</tr>
<tr>
<td>diagnosed with hypertension (diagnosed on or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>after 1 April 2009) who are given lifestyle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>advice in the preceding 15 months for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>increasing physical activity, smoking</td>
<td></td>
<td></td>
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<tr>
<td>cessation, safe alcohol consumption and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>healthy diet.</td>
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</tr>
</tbody>
</table>

CVD-PP – rationale for inclusion of indicator set

Cardiovascular disease (CVD) is the most common cause of death in the UK and importantly for patients, the major cause of premature death (before the age of 65). Moreover, of greater significance for the NHS, CVD is not the commonest cause of disability (through stroke and HF 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 works and evidence-based interventions can dramatically reduce risk. This was evidenced in North Karelia when CVD mortality was reduced by 50 per cent through rigid implementation of public health and individual patient interventions. 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, where 68 per cent of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in patients without recognised CHD compared to 32 per cent in CHD patients.
CVD-PP indicator 001(S) (NICE menu 2011: NM26)

In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins.

CVD-PP 001.1(S) Rationale
For primary prevention of CVD, people at risk need to be identified before CVD has become established. To assess risk in those likely to be at high-risk (for example, people with hypertension) a validated assessment tool is needed that evaluates a range of modifiable and non-modifiable risk factors.

The NICE clinical guideline on lipid modification recommends statin therapy for the primary prevention of CVD for adults who have an estimated 20 per cent or greater 10-year risk of developing CVD.

A number of risk assessment tools can be used to estimate cardiovascular risk for this QOF indicator. These include:

- ASSIGN
- Framingham;
- Joint British Society 2 (JBS2);
- QRISK.

The four assessment tools listed above allow a structured risk assessment to be undertaken. However, each has a different age threshold; so to include the use of all three tools, the age range for this indicator has been set at aged 30 or over and under the age of 75. Contractors will be expected to use one of the four tools to assess their patients. If the tool normally available on the contractor’s clinical system is not age appropriate, one of the other tools maybe used.

Framingham and JBS2 are based on the American Framingham equations. These equations are of limited use in the UK because they were developed in a historic US population. The equations overestimate risk by up to 50 per cent in most contemporary northern European populations, particularly for people living in more affluent areas and underestimate risk in higher risk populations, such as people who are the most socially deprived. Framingham makes no allowance for a family history of premature CHD and does not take account of ethnicity, but does have a full data set.

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The newer risk score QRISK has the advantage of including other variables, such as measures of social deprivation, ethnicity and family history. QRISK uses data from UK general practice databases.

ASSIGN
ASSIGN is a cardiovascular risk score developed in Dundee University, Scotland in 2006. ASSIGN includes social deprivation for the first time, and family history of cardiovascular disease with the classic risk factors. It identifies people free of cardiovascular disease most likely to develop it over ten years. ‘High risk’ (score 20 or more) implies risk-lowering medication and/or other medical help. ASSIGN is the cardiovascular risk score chosen for use by SIGN (Scottish Intercollegiate Guidelines Network) and Scottish Government Health Directorates and is therefore the recommended CVD risk assessment tool in Scotland. ASSIGN was updated in 2013 and the latest version should be used.

Framingham and JBS2
The variables needed to estimate risk using the Framingham tool are age, sex, systolic blood pressure (mean of two previous systolic readings), total cholesterol, high density lipoprotein cholesterol, smoking status and presence of left ventricular hypertrophy. JBS2 uses the Framingham variables with the exception of the presence of left ventricular hypertrophy.

Framingham is an assessment of actual, not estimated, risk. The values used should have been recorded no longer than six months before the date of the risk assessment and before any treatment for hypertension. Framingham is not suitable for patients with pre-existing CVD (CHD, angina, stroke, TIA or PAD), diabetes, CKD (if the patient has an eGFR below 60) or familial hypercholesterolemia, or in patients already taking lipid-lowering medication before a new diagnosis of hypertension.

The Framingham risk score may be used in patients aged 35 or over and under the age of 75. JBS2 may be used in people aged 40 or over.

QRISK
The QRISK CVD risk calculator was developed by doctors and academics working in the NHS and is based on routinely collected data from GPs across the country. The current version of QRISK is QRISK2. QRISK2 uses the following variables to calculate CVD risk: self-assigned ethnicity, age, sex, smoking status, systolic blood pressure, total cholesterol, HDL cholesterol, BMI, family history of CHD in a first degree relative younger than 60, Townsend deprivation score, treated hypertension, type 2 diabetes, renal disease, AF and RA.

QRISK2 may be used in patients aged 30 or over and under the age of 85.

Clinical effectiveness of primary prevention
For people without clinical evidence of CVD, statin therapy is associated with a reduction of fatal and nonfatal MI and the composite outcome CHD death or nonfatal

158 QRISK. www.qrisk.org
MI, fatal and nonfatal stroke and revascularisation. In trials predominantly comprising primary prevention but including a minority of people with established CVD, meta-analysis found that statin therapy was associated with a reduction in the risk of all-cause mortality, fatal and nonfatal MI and the composite outcomes of CHD death, nonfatal MI, fatal or nonfatal stroke and coronary revascularisation. For primary prevention lower intensity statins are safe and cost-effective. It is recommended that treatment for the primary prevention of CVD in patients with hypertension be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

The NICE clinical guideline on lipid modification makes recommendations on how a 10-year CVD risk score of 20 per cent or greater should be managed. It also makes recommendations on communication between practitioners and patients about CVD risk assessment and treatment. These include the following.

- Setting aside adequate time during the consultation to provide information on risk assessment and to allow any questions to be answered;
- Documenting the discussion relating to the consultation on risk assessment and the patient’s decision;
- Offering information about the person’s absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. This information:
  1. presents individualised risk and benefit scenarios.
  2. presents the absolute risk of events numerically.
  3. uses appropriate diagrams and text.

See www.npci.org.uk for more information about explaining risk.

The guideline also recommends that if the patient's CVD risk is considered to be at a level that merits intervention but they decline the offer of treatment, they are advised that their CVD risk should be considered again in the future. The guideline also notes that CVD risk may be underestimated in people who are already taking anti-hypertensive or lipid modification therapy, or who have recently stopped smoking. It recommends that clinical judgement be used in such cases to decide on further treatment of risk factors in people who are below the 20 per cent CVD risk threshold.

For patients with hypertension, the guideline recommends that before they are offered lipid modification therapy for primary prevention, all other modifiable CVD risk factors are considered and their management optimised if possible. Baseline blood tests and clinical assessment are to be performed and co-morbidities and secondary causes of dyslipidaemia treated. Assessment includes:

- smoking status;
- alcohol consumption;
- BMI or other measures of obesity (see the NICE clinical guideline on Obesity\textsuperscript{159});
- fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available);
- fasting blood glucose;
- renal function;
- liver function (transaminases);
- TSH if dyslipidaemia is present.

The NICE guideline on lipid modification also recommends that the decision whether to initiate statin therapy is made after an informed discussion between the responsible clinician and the person about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy. The guideline also states that a target for total or LDL cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD and that once a person has been started on a statin for primary prevention, repeat lipid measurement is unnecessary. It is recommended that clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.

CVD-PP 001.2(S) Reporting and verification
See indicator wording for requirement criteria.

Patients with the following conditions are excluded from this indicator:
- CHD or angina;
- stroke or TIA;
- peripheral vascular disease;
- familial hypercholesterolemia;
- diabetes;
- CKD with an eGFR below 30.

Verification - the NHS Board may request that the contractor randomly selects a number of case records of patients recorded as having had a risk assessment, 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. The NHS Board may also require contractors to demonstrate that age-appropriate risk assessment tools have been used.

\textsuperscript{159} NICE clinical guideline CG43. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children 2006. www.nice.org.uk/guidance/CG43
CVD-PP indicator 002(S)

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

CVD-PP 002.1(S) Rationale

There is considerable evidence to support the positive impact of 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 also by reducing lifestyle risks.

It is recommended that contractors refer to recognised guidance on advising patients on lifestyle risk.

Further information


CVD-PP 002.2(S) Reporting and verification

See indicator wording for requirement criteria.

Verification – the NHS Board may request that the contractor randomly selects a number of patient 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.

Blood pressure (BP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
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BP indicator 001(S) (NICE 2012 menu ID: NM61)

The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years.

**BP 001.1(S) Rationale**

This indicator replaces two 2012/13 indicators from the organisational domain on the measurement of blood pressure (Records 11 and 17). The previous two indicators have been merged to reflect changes in the construction of the indicator. The merged indicator is measured as a fractional indicator in common with other clinical and PH indicators. This change allows for the measurement of continuous quality improvement.

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. Guideline recommendations for the diagnosis and treatment of hypertension are to be followed by practitioners when deciding on whether to treat raised blood pressure.

The age limit of aged 45 or over has been chosen as the vast majority of patients develop hypertension after this age. It is also to align the indicator more closely with the vascular checks programme and the cost-effectiveness modelling undertaken to support that programme. The age range 45 or over, coupled with a five year reference period, is designed to ensure that a blood pressure measurement takes place by the time someone reaches the age of 45.

It is anticipated that contractors will opportunistically check blood pressures in all adult patients.

**BP 001.2(S) Reporting and verification**

See indicator wording for requirement criteria.

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**Smoking (SMOK)**

**Coding**

The practice records agreed diagnostic READ codes for the smoking status of patients aged 15 or over in the preceding 27 months and provides appropriate lifestyle advice at the time of recording.

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SMOK002(S). The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months.

**Thresholds**

<table>
<thead>
<tr>
<th>Thresholds</th>
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<tbody>
<tr>
<td>25</td>
</tr>
<tr>
<td>50–90%</td>
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**NICE 2011 menu ID:** NM38

### Ongoing management

SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

<table>
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<th>Thresholds</th>
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<td>2</td>
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</table>

SMOK004(S). The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months.

**Thresholds**

<table>
<thead>
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<th>Thresholds</th>
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<tbody>
<tr>
<td>12</td>
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<tr>
<td>40–90%</td>
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</table>

**NICE 2011 menu ID:** NM40

SMOK005(S). The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months.

**Thresholds**

<table>
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<tr>
<th>Thresholds</th>
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<tbody>
<tr>
<td>25</td>
</tr>
<tr>
<td>50–90%</td>
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</table>

**NICE 2011 menu ID:** NM39

### Requirements for recording smoking status

**Smokers**

For patients who smoke this recording should be made in the preceding 27 months or in the preceding 15 months for SMOK002.

**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 in the preceding 27 months or in the preceding 15 months for SMOK002 until the end of the financial year in which the patient reached the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach the age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoke after their 25th birthday;
- never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patients inclusion on the
SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

Ex-smokers

There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 27 months or in the preceding 15 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

There is evidence that when doctors and other healthcare professionals advise patients to stop smoking, this is effective. This indicator examine whether smoking status is recorded in the patient record.

The denominator for SMOK004(S) requires that current smokers are recorded as such in the preceding 27 months and non-smokers are recorded as such in the preceding 27 months up to and including 25 years of age. Patients aged 25 or over who have never smoked need a latest smoking status of 'never smoked' which has been recorded after the patient's 25th birthday. Patients aged 25 or under need a latest smoking status of 'never smoked' which has been recorded in the preceding 27 months to be classed as 'never smoked'.

There are two ways in which patients can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 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 contractors may choose to record ex-smoking status on an annual basis for three consecutive QOF years (1 April to 31 March). Thereafter, smoking status may only need to be recorded if there is a change.

For the purposes of QOF users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.

There is no APDF calculation for SMOK003 or SMOK004.

**SMOK indicator 002(S) (NICE 2011 menu ID: NM38)**

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

**SMOK002.1(S) Rationale**

**CHD**

Smoking is known to be associated with an increased risk of CHD.


**PAD**

PAD is associated with older age and with smoking. Cigarette smoking is a very important contributor to PAD and as such the management of PAD includes smoking cessation.

**Stroke or TIA**

There are few RCTs 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 be advocated.


**Hypertension**

There is no strong direct link between smoking and blood pressure. However, there is overwhelming evidence of the relationship between smoking and cardiovascular and pulmonary diseases. The NICE clinical guideline on hypertension recommends that patients who smoke are offered advice and help to stop smoking.

**Diabetes**

The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.

**COPD**

Smoking cessation is the single most effective and cost-effective intervention to reduce the risk of developing COPD and stop its progression.


**Asthma**

There are a surprisingly small number of studies on smoking related 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. Smoking reduces the benefits of inhaled steroids and  

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this adds further justification for recording this outcome\textsuperscript{162}. There is also epidemiological evidence that smoking is associated with poor asthma control\textsuperscript{163}.

**CKD**
There is good evidence from observational studies that patients with CKD are at increased cardiovascular risk and hence the rationale for including CKD here.

**Schizophrenia, bipolar affective disorder or other psychoses**
Patients with a serious mental illness are far more likely to smoke than the general population (61 per cent of patients with schizophrenia and 46 per cent of patients with bipolar disorder smoke compared to 33 per cent of the general population). Premature death and smoking related diseases, such as respiratory disorders and heart disease, are however, more common among patients with serious mental illness who smoke than in the general population of smokers\textsuperscript{164}.

**Non-smokers**
It is recognised that life-long 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 in the preceding 24 months for SMOK001 or in the preceding 12 months for SMOK002(S) until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked after their 25th birthday;
- never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patients inclusion on the SMOK002(S) register (e.g. one of the conditions listed on the SMOK002(S) register).

**Ex-smokers**
There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 27 months or in the preceding 15 months for SMOK002(S). Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.
For the purposes of QOF users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.

**SMOK 002.2(S) Reporting and verification**
See indicator wording for requirement criteria.

\textsuperscript{162} Tomlinson JE, McMahon AD, Chaudhuri R et al. Efficacy of low and high dose inhaled corticosteroids in smokers versus non-smokers with mild asthma. Thorax 2005; 60:282-7


\textsuperscript{164} McDonald C. Cigarette smoking in patients with schizophrenia. BJP 2000; 176: 596-7
For patients who smoke this recording is to be made in the preceding 15 months. Ex-smokers are to be recorded as described above. Those who have never smoked are to be recorded as such in the preceding 15 months up to and including the age of 25.

The disease register for the purposes of calculating APDF for SMOK002 and SMOK005(S) is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities i.e. diabetes and CHD are only counted once.

**SMOK indicator 003**

The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

**SMOK 003.1 Rationale**

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 to 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 contractor and implemented. The provision of dedicated smoking cessation services remains the responsibility of the NHS Board.

**SMOK 003.2 Reporting and verification**

See indicator wording for requirement criteria.

Verification - the NHS Board may choose to review prescribing data and may also examine the literature available for patients who wish to quit smoking. Signs of implementation may be evident in the contractor's prescribing data or in the patient leaflets that are used by the contractor.

There is no APDF calculation for SMOK003.

**SMOK indicator 004(S) (NICE 2011 menu ID: NM40)**

The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months

**SMOK 004.1(S) Rationale**

Smoking remains the main cause of preventable morbidity and premature death, leading to an estimated annual average of 86,500 deaths between 1998 and 2002 in
England\textsuperscript{165}. It is the primary reason for the gap in healthy life expectancy between the rich and the poor\textsuperscript{166}.

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, CHD and other circulatory diseases, stomach and duodenal ulcers, ED and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis (US DH and Human Services 2004).

Women who smoke during pregnancy have a substantially higher risk of spontaneous abortion (miscarriage) than those who do no smoke. Smoking can also cause complications in pregnancy and labour, including ectopic pregnancy, bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes\textsuperscript{167}.

Around 43 per cent of patients who smoke try to quit each year, often several times a year. Many of these attempts fail because they are made without treatment and the aim of this domain is to increase the proportion of quit attempts that succeed by providing best available support and treatment. The one year continuous abstinence rate in untreated smokers who try to quit without help is about three per cent\textsuperscript{168}. There is evidence that when doctors and other health professionals advise on smoking cessation and particularly when they offer support and treatment, that people are more likely to quit.

Around four per cent of patients who quit without using either pharmacotherapy or behavioural support will remain abstinent at 12 months. With pharmacotherapy and brief supervision from a GP or other clinician, this would be about eight per cent. If a patient takes up the offer of referral to an NHS Stop Smoking Service or a specially trained member of staff directly employed by the contractor, such as a practice nurse, providing regular weekly support, the one year continuous abstinence rate doubles to about 15 per cent.

See SMOK005.1(S) for guidance on 'support and treatment' and smoking cessation.

**SMOK 004.2(S) Reporting and verification**
See indicator wording for requirement criteria.

There is no APDF calculation for SMOK004.

**SMOK indicator 005(S) (NICE 2011 menu ID: NM39)**

The percentage of patients with any of any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as

current smokers who have a record of an offer of support and treatment within the preceding 15 months.

**SMOK 005.1(S) Rationale**

This indicator relates to patients who are on the disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma and mental health who are recorded as current smokers.

In 2009, 21 per cent of the adult population of Great Britain were cigarette smokers. The overall prevalence of smoking has been at this level since 2007\(^{169}\). At any one time, about 12 per cent of smokers intend to stop smoking in the last month\(^{170}\). Around 43 per cent of the population of England have tried to stop in the past year, but only two to three per cent of the population succeed in stopping\(^{171}\).

There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone.

For example, a Cochrane review that included 132 trials of nicotine replacement therapy (NRT), with over 40,000 people in the main analysis, found evidence that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70 per cent\(^{172}\).

NHS Stop Smoking Services, combine psychological support and medication. Results for April 2008 to March 2009 showed that 671,259 people who had contact with the service had set a quit date. Four weeks later, 337,054 people had successfully quit (based on self-report) representing half of those who set a quit date\(^{173}\).

'An offer of support and treatment' therefore means offering a referral or self-referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy (but only if the offer of pharmacotherapy at this point fits with local Board policy). Where such support is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

The NICE public health guidance on smoking cessation\(^{174}\) states that healthcare professionals who advise on, or prescribe, NRT, varenicline or bupropion:


\(^{172}\) Stead LF, Perera R, Bullen C etc al. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews. 2008. John Wiley and Sons, Ltd no.1


\(^{174}\) NICE public health guidance 10. Smoking cessation services. [http://www.nice.org.uk/guidance/PH10](http://www.nice.org.uk/guidance/PH10)
1. offer NRT, varenicline or bupropion, as appropriate, to patients who are planning to stop smoking.

2. offer advice, encouragement and support, including referral to the NHS Stop Smoking Service, to help patients in their attempt to quit.

3. when deciding which therapies to use and in which order, discuss the options with the client and take into account:
   - whether a first offer of referral to the NHS Stop Smoking Service has been made;
   - contraindications and the potential for adverse effects;
   - the client’s personal preferences;
   - the availability of appropriate counselling or support;
   - the likelihood that the client will follow the course of treatment;
   - their previous experience of smoking cessation aids.

The guidance also states that managers and providers of NHS Stop Smoking Services:

1. offer behavioural counselling, group therapy, pharmacotherapy, or a combination of treatments that have been proven to be effective.

2. ensure clients receive behavioural support from a person who has had training and supervision that complies with the ‘Standard for training in smoking cessation treatments’175 or its updates.

3. provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups.

4. provides services in the language chosen by clients, wherever possible.

For further information see NICE public health guidance 1 and 10176 and the Primary Care Respiratory Society UK statement on managing smoking cessation in primary care177.

SMOK 005.2(S) Reporting and verification
See indicator wording for requirement criteria.

The disease register for the purposes of calculating APDF for SMOK002 and SMOK005(S) is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities i.e. diabetes and CHD are only counted once.
Public health domain – additional services

For contractors providing additional services the following indicators apply.

Please note exception reporting does not apply to those additional services indicators that do not have achievement thresholds.

Cervical screening (CS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001(S). The contractor has a protocol that is in line with national guidance agreed with NHS Scotland for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates.</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>CS002(S). The percentage of women aged 20 or over and who have not attained the age of 60 whose notes record that a cervical screening test has been performed in the preceding 5 years.</td>
<td>11</td>
<td>45–80%</td>
</tr>
<tr>
<td>CS004. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years.</td>
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</table>

CS indicator 001(S)

The contractor has a protocol that is in line with national guidance agreed with the NHS Board for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates.

CS 001.1(S) Rationale

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 outside the practice and is recommended to be in line with national guidance.

See guidance on exception reporting in section CS 002.1(S) contractor guidance.

The contractor’s protocol could be in the form of a written policy covering the issues outlined in the indicator wording.
CS 001.2(S) Reporting and verification
See indicator wording for requirement criteria.

The relevant practice staff are to be aware of the policy and the NHS Board may require that the contractor can demonstrate how the systems operate.

CS indicator 002(S)

The percentage of women aged 20 or over and who have not attained the age of 60 whose notes record that a cervical screening test has been performed in the preceding 5 years.

CS 002.1(S) Rationale
This indicator is designed to encourage and incentivise contractors to continue to achieve high levels of uptake in cervical screening.

The contractor may be required to provide evidence of the number of eligible women, aged 20 or over and under the age of 60, who have had a cervical screening test performed in the last 5 years/60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 45 and 80 per cent, in a similar way to the clinical indicators.

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

(In Scotland the central screening programme will call eligible women at least 3 times - 4 when it is for follow up)

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman
to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

Scotland. NHS Cancer Screening Programme.  
http://www.nsd.scot.nhs.uk/services/screening/cervicalscreening/index.html

**CS 002.2(S) Reporting and verification**  
See indicator wording for requirement criteria.

The NHS Board may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number exception reported and the number who have had a cervical screening test performed in the preceding five years. Contractors can exception report patients in the same way as the clinical indicators and the NHS Board may enquire how patients who are exception reported are identified and recorded.

**CS indicator 004**

The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years.

**CS 004.1 Contractor guidance**  
In this audit the criteria, the 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 sample-takers who are obvious outliners in relation to the reading laboratory's average for inadequate samples.

**CS 004.2 Written evidence**  
See indicator wording for requirement criteria.

The NHS Board may require that an audit of inadequate samples is recorded.

The NHS Board may also request a discussion takes place with sample-takers covering the audit and any educational needs which arose and how these were met.
Contraception (CON)

Coding

The practice records agreed diagnostic READ codes for women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS, and provides appropriate lifestyle advice at the time of diagnosis.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CON003(S). The percentage of women, aged 54 or under, prescribed emergency hormonal contraception one or more times in the preceding 15 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription.</td>
<td>3</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

CON – rationale for inclusion of indicator set

The vast majority of contractors are providing the additional service for contraception and many are also providing enhanced services including long acting reversible contraception (LARC) methods. All contractors providing any level of contraception need to be able to advise women about all methods to ensure they can make an informed choice. It is advised that clinical staff in practices are aware of local services and local referral pathways.

This indicator set seeks to increase the awareness of women seeking Emergency Contraception in general practices of LARC methods and thus to increase the percentage of women using these methods\textsuperscript{178}.

CON003 requires the contractor to READ code women aged 54 or under who have been prescribed emergency contraception at least once in the last fifteen months

General practice provides 80 per cent of prescribed contraception in the UK. This denominator is applicable to all methods of emergency contraception that have been prescribed by the contractor.

- Emergency hormonal contraception (EHC);
- Intrauterine device (IUD);
- Intrauterine system (IUS);

\textsuperscript{178} See also J Fam Plann Reprod Health Care; 34(4): 000-000 “Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods. 2008. Anna Glasier, Jane Scorer, Alison Bigrigg.
Coding is prospective from 1 April 2009.

**CON indicator 003(S)**

The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 15 months by the contractor, who have received information from the contractor about LARC at the time of or within 1 month of the prescription.

**CON 003.1(S) Rationale**

Women requiring EHC are 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 on-going method of contraception at the same time as EHC is given.

Some women seeking EHC 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 on-going contraception if required.

Information from the contractor in written and verbal form. 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, indicated LARC and non-LARC methods clearly through the use of shading.

**CON 003.2(S) Reporting and verification**

See indicator wording for requirement criteria.
Section 5: Quality and Safety (QS) domain

Section 2.3 applies to all GMS contractors participating in QOF.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS001(S). The contractor identifies a liaison GP to link with the liaison member of staff within the local Health and Social Care Partnership</td>
<td>5</td>
</tr>
<tr>
<td>QS002(S). The practice will undertake a review of access (option A, B, or C – see guidance section), using the tool agreed between SG and SGPC and provide a practice action report of the findings to the NHS Board by 15th March 2016</td>
<td>25</td>
</tr>
<tr>
<td>QS003(S). The practice participates in a process of continuous quality improvement by undertaking a review of a data set, agreed between SC and SGPC, provided by the NHS Board. The practice will provide an annual report, on a template agreed between the SG and SGPC by 15th March 2016, and participates in a 3 yearly peer review visit.</td>
<td>25</td>
</tr>
<tr>
<td>QS004(S). The contractor produces a list of 5 per cent of patients in the practice, as of 1st April 2015, who are predicted to be at significant risk of emergency admission or unscheduled care. This list can be produced using a risk profiling tool accessible to practices e.g. SPARRA, or where this is not available/ required (by local agreement), alternative arrangements can be agreed between the NHS Board and LMC.</td>
<td>5</td>
</tr>
<tr>
<td>QS005(S). The contractor identifies a minimum of 30 per cent (which can include continuing ACPs from the 2014-15 contract year) of those patients from the list produced in indicator QS004(S) who would most benefit from, and creates, an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient’s review should be determined in the light of their clinical and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.</td>
<td>30</td>
</tr>
<tr>
<td>QS006(S). The contractor holds at least 4 meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice’s patients.</td>
<td>10</td>
</tr>
<tr>
<td>QS007. The practice conducts two case note reviews, using a validated tool, to detect patient safety incidents, meets to discuss</td>
<td>6</td>
</tr>
</tbody>
</table>
the results, and shares a reflective report on actions that arise from this with the NHS Board by 15th March 2016.

<table>
<thead>
<tr>
<th>QS008. The practice conducts a safety climate survey with all staff, clinical and non-clinical, using a validated tool, meets to discuss the results, and shares a reflective report on actions that arise from this with the NHS Board by 15th March 2016.</th>
</tr>
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<tr>
<td>5</td>
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</tbody>
</table>

**QS indicator 001(S)**

The contractor identifies a liaison GP from within the GP Practice to link with the liaison member of staff within the local Health and Social Care Partnership

**QS001.1(S) Rationale**

The development of health and social care integration is a key priority for the Scottish Government’s 2020 Vision, and GP leadership and engagement is also of importance to the success of the new Health and Social Care Partnerships, and in particular the planning for services in locality groups.

As a first step in achieving this outcome the practices will identify a named GP in every GP practice in Scotland to link with the liaison member of staff within the local Health and Social Care Partnership.

The inclusion of this indicator is to acknowledge and support the key part that general practitioners and their staff can play in the development of local health and social care systems.

It is intended that the identified GP will liaise with the evolving Health and Social Care Partnerships, and thereby become integral to the development and leadership of this work from 2014/15 onward e.g. Locality Planning.

The intention of this indicator is not to resource general practitioner involvement in the development of local health and social care systems, as that will be resourced by local partnerships, but rather to ensure that at least one GP in each practice is identified as the liaison link between the practice and the local partnership i.e. he/she will be expected to be able to input to local developments/decision-making.

**QS001.2(S) Reporting and verification**

The practice will be expected to identify a nominated GP when requested by the local NHS Board/health and social care partnership

**QS indicator 002(S)**

The contractor undertakes a review of access in the GP Practice, using a tool and template agreed between SGPC and SG, and submits to the Board by 15th March 2016, an annual reflective Practice Access Action Report (PAAR) (Options A and B), or implement two PDSA cycles, complete and share an Access story board and attend a regional meeting/complete the actions outlined in the flow chart below (Option C)..
QS 002.1(S) Rationale

The Scottish Government (SG) and Scottish General Practitioners Committee (SGPC) have agreed that Access is an important issue for patients in Scotland and have therefore agreed to review patient access to GPs as part of the GP contract.

In order to achieve that outcome Practices are required to undertake an assessment of access (option A, B, or C – see guidance section) and to submit a report to the Board by 15th March 2016, on a template agreed between the SG and SGPC.

The review of access will be in two parts;

- An assessment of demand/patient flow using recognised tools/methodologies
- Practices will be encouraged to involve patients in this process and share the contents of these reports in a way which is appropriate and reasonable for GP practices and understandable by patients.

Executive Summary; The three steps to review access and prioritise improvements (full supporting documentation to be found in Appendix A)

Practices are guided to adopt three principles and a three step process to undertake the review and prepare their PAAR. This involves systematically using practical, tried and tested tools to; increase their knowledge of their patients and services; to know how well they are doing; thereby identifying any desired improvements to make.

Please note

The updated flow chart below incorporates the three QS002(S) options available to practices this year but it is entirely up to practices which option they chose to undertake in 2015-16 i.e. they can chose to do Option A (same as QS002(S) in 20014-15), or Option B, or Option C. The flow chart below makes clear what needs to be done for each option.
The Three Steps Access Tool

General Medical Service Contract 2015/16: Undertaking the review of access and preparing the Practice Access Action Report (PAAR)

Three steps to review access and prioritise improvements in patient flow
1. Know your patients and practice

- Review patient flow diagram to identify new constraints/bottlenecks. (Option A and B)
- Record queries coming into the practice. (Option A and B)
- Use the data collection form provided to record whether or not people have been seen at the right time, by the right person (Option A and B)
- Use the data collection forms provided to record appointments (Option A and B)

2. Know how well you are doing

- Use the Queries Tool to analyse queries (Option A and B)
- Use the Capacity Tool to analyse resources available for clinical assessment and care (Option A and B)
- Analyse appointment demand, activity and capacity using the Planning and Scheduling tool (Option B)
- Analyse the right time, right person data using the Right Time/Right Person tool (Option B)

3. Know what improvements to prioritise

- Agree priorities, key actions and timelines (Options A, B C)
- Prepare, use and share Practice Access Action Report (Options A and B)
- Implement two PDSA access cycles of change between May 15 and Jan 16 (Option C)
- Complete Access Story Board and share with virtual access network (Option C)
- Attend regional face-to-face network session (Option C)
Background

This indicator requires GP practices to undertake a review of access and to produce a Practice Access Action Report (PAAR). The principle aim of this indicator is that, wherever possible, every person receives the right assessment and care, at the right time, in the right place, from the right person, thereby maximising capacity and efficiency and helping practices to better cope with their patients’ needs.

The requirement for the patient access indicator is as follows;

The contractor undertakes a review of access in the GP Practice, using a tool and template agreed between SGPC and SG, and submits to the Board by 15th March 2016, a Practice Access Action Report (PAAR) (Options A and B), or implement two PDSA cycles, complete and share an Access story board and attend a regional meeting/complete the actions outlined in the flow chart below (Option C). This indicator can be broken down into three components as follows:

1. Practices undertake an annual assessment of current demand; assessing both met and unmet need, utilising an agreed template.

2. Practices are encouraged to involve patients in their proposals for developing access in the practice in an appropriate and meaningful way for GP practices; this could include choosing from a range of options, from sharing proposals with patients for comment, though to full patient focus/participation group discussion. Practices should indicate within the body of the report whether they involved patients and if so how this was accomplished.

3. Practices then submit a Practice Access Action Report (PAAR), of the findings to the NHS Board (Options A and B), or implement two PDSA cycles, complete and share an Access story board and attend a regional meeting/complete the actions outlined in the flow chart below (Option C).

Benefits to practices and patients

The assessment will support practices to build on previous efforts and initiatives to quantify and, if possible, better meet patient need; directly from patients’ needs and indirectly from information obtained from the practice and other parts of the system. This activity should aid understanding of the points in the patient journey where quality and safety can become compromised. The collection and analysis of the information obtained may also help practices to accurately quantify, and potentially maximise, the capacity that they have available to meet and manage the needs of their patients.

The preparation of the ‘Patient Access Action Report’ (Options A and B) and activity in Option C will assist practices to identify where to focus their valuable clinical resources and energies. It may also afford the opportunity for dialogue and sharing of knowledge and risk with both their patients and the wider health and social care system.

The principles
1. **Know your patients and service**

This means collecting data to help examine the flow of patients into and through the practice; frequency of attendance; nature, pattern and variability of requests; nature, pattern and variability of appointments offered; capacity of staff and rooms; profile of the work e.g. planned/unplanned/seasonal.

2. **Know how well you are doing**

This is about working out your capacity and demand; how slots are used; what the patient experience is; where and how long the waits or delays are; where constraints might exist e.g. prescriptions, bloods, holiday effects and chronic disease clinics. It involves organising and analysing the data and presenting information clearly in a way that aids priority setting for improvement.

3. **Know what improvements to prioritise**

This will form the basis of the Patient Access Action Report. Reviewing the information that has been collected with practice partners, staff and patients will help identify good practice, show what is causing the greatest challenges to patients and staff, where practice and patient time could be better utilised.

**This year for the review of access there are three different options to choose from, all have the same number of QOF points attached:**

**Consistent with the stability agreement practices can continue with the same process as last year (Option A). However, practices can choose to undertake a different process should they so wish (Options B or C). All three options require different activity but have the same number of QOF points attached.**

**Option A**

<table>
<thead>
<tr>
<th>1. Plan the work, communicate with the team and set date to start. (Select a typical week(s))</th>
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</thead>
<tbody>
<tr>
<td>2. Review high level patient flow map.</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>3. Record incoming queries from all routes</td>
<td>Appendix 2</td>
</tr>
<tr>
<td>4. Collect available appointments</td>
<td>Appendix 3</td>
</tr>
<tr>
<td>5. Record appointment requests from all routes and lost and extra appointments</td>
<td>Appendix 4 and 5</td>
</tr>
<tr>
<td>6. Record appropriateness of consultations</td>
<td>Appendix 6</td>
</tr>
<tr>
<td>7. Review/analyse the data</td>
<td>Appendix 7 and 8</td>
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</table>

(Choose **Option B** to use the
### Scottish Quality and Outcomes Framework guidance for GMS contract 2015/16

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| **8. Discuss the analyses and any additional information such as annual access survey and patient and carer views** | • Queries Tool Appendix 7  
• Capacity Tool Appendix 8  
• Right Time/ Right Person Tool Appendix 9  
• Planning and Scheduling Tool Appendix 10 | These tools aid comparison of your demand, capacity and activity. |
| **9. Complete Practice Action Report Form** | Appendix 11 |
### Option B

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<tbody>
<tr>
<td>1.</td>
<td>Plan the work, communicate with the team and set date to start. (Select a typical week(s))</td>
<td>Appendix 1</td>
</tr>
<tr>
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</tr>
<tr>
<td>5.</td>
<td>Record appointment requests from all routes and lost and extra appointments</td>
<td>Appendix 4 and 5</td>
</tr>
<tr>
<td>6.</td>
<td>Record appropriateness of consultations using the Right Time/Right Person Form.</td>
<td>Appendix 6</td>
</tr>
<tr>
<td>7.</td>
<td>Analyse the queries data</td>
<td>Appendix 7</td>
</tr>
<tr>
<td>8.</td>
<td>Record and analyse staff and partner time available using Capacity Tool provided</td>
<td>Appendix 8</td>
</tr>
<tr>
<td>9.</td>
<td>Analyse the consultations data using the Right Time/Right Person Tool.</td>
<td>Appendix 9</td>
</tr>
<tr>
<td>10.</td>
<td>Analyse appointment data using the Planning and Scheduling tool. (Demand, capacity and activity.)</td>
<td>Appendix 10</td>
</tr>
<tr>
<td>11.</td>
<td>Discuss the analyses and any additional information such as annual access survey and patient and carer views</td>
<td>Appendix 11</td>
</tr>
<tr>
<td>12.</td>
<td>Complete Practice Action Report Form</td>
<td>Appendix 11</td>
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</table>

Dates of supporting webexes to guide and facilitate the use of tools will be posted on the PSD GMS Contract site [http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html](http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html)
Option C

1. Plan two access cycles of change between May 2015 and January 2016, communicate with the team and set date to start.

   Links to useful tools and methods will be posted on the PSD GMS Contract site http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html

2. Use access and improvement tools and measurement for improvement to prove that change has been successful

   Links to useful tools and methods will be posted on the PSD GMS Contract site http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html

3. Complete the Story Board templates provided

   Appendix 12

4. Share Story Boards including measurements with peers via Practice Access Network

   A web site link will be posted on the PSD GMS Contract site http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html

5. Attend one regional event to share learning

   Details will be posted on the PSD GMS Contract site http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html

The accompanying practical quality improvement resources

1. Provide practices with a tried and tested flow map, data collection forms, data entry and analysis tools and a Practice Access Action Report template.
2. Build on and extend practice beyond previous initiatives, guidance and materials.
3. Support the development of a sustainable systematic approach across Scotland to reviewing access, improving patient flow and planning how to best use the resources available in order to meet patient needs.

QS 002.2(S) Reporting and verification

The practice will submit a Practice Access Action Report (PAAR) to the NHS Board, using the agreed template, by 15th March 2016(Options A and B), or implement two PDSA cycles, complete and share an Access story board and attend a regional meeting/complete the actions outlined in the flow chart above (Option C).
QS Indicator 003(S)

The practice participates in a process of continuous quality improvement by undertaking a review of a data set, agreed between SGPC and SG, provided by the NHS Board. The practice provides an annual report, on a template agreed between the SG and SGPC, and participates in a 3 yearly peer review visit.

**QS 003.1(S) Rationale**

Across the healthcare system, there is increasing use of data and improvement tools to analyse, reflect upon, and improve the quality of care that is provided to patients. These approaches are broad in method, and involve familiar tools to general practice such as audit and significant event analysis, alongside newer techniques such as the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles.

Examples of these resources and tools can be found at the NHS Scotland Quality Hub web site:


or at the NHS Education for Scotland website:


This commitment to improving the Quality of care is an intrinsic component of professionalism and a core requirement of appraisal and revalidation. The provision of useful and relevant data that enables and supports this activity will allow general practice to demonstrate continuous improvement in key areas of healthcare and should be underpinned by the following principles:

- Achieves consistent high quality, safe, effective and person centred care across the country;
- Facilitates the continuous improvement of healthcare;
- Reduces bureaucracy;
- Does not result in disadvantaged groups of patients or drive inappropriate care;
- Stabilises funding into general practice;
- Maximises the opportunity for appropriate clinical input from the whole system;
- Is flexible to local health priority and need;
- Provides sufficient assurance around clinical governance and contract delivery.

**Data review – general**
Practices will be provided with data for key and relevant domains of their care and activity. This data will, where possible, be benchmarked against peers and will allow reflection and analysis of their achievement when compared to an appropriate reference group. The presentation of data should be as straightforward as possible. The level of detail provided to practices is important and should be in an easy to understand format; too much data is as harmful as too little.

The activity relating to this indicator should not be used for performance management purposes.

All work associated with this indicator would be eligible for inclusion in the process of appraisal and revalidation.

Data review - national datasets and designated datasets

The Scottish Government and Scottish General Practitioners Committee will agree at least six national datasets. Two of the national datasets will be “designated datasets” (agreed between SG and SGPC) for discussion in all practices across Scotland.

Data review - local datasets

NHS boards and Local Medical Committees will agree between 2 and 4 datasets (both the number of datasets and the content to be agreed).

Annual quality report

Practices will be provided with the national and local data sets. Practices will discuss the 2 national designated datasets and one local dataset the NHS board will designate as being considered likely to be the most useful to have in the discussion with that practice. The practice will then choose:

- 1 additional national dataset
- 1 additional local datasets

Practices will be provided with a template (agreed between SG and SGPC) that will be used to structure practice analysis and report. Reports will be returned to the NHS board by 15 March 2016.

Quality Improvement Visit (once every three years)

The purpose of these visits will be to assist practices by sharing learning and approaches to continuous quality improvement to improve care. A facilitative Quality Improvement Visit to each practice, performed by peers, on a three year cycle, will accompany the annual report. The peer group will include a practising GP and a practice manager (practice will have the right to one change of visitor). By agreement between the practice and the board there may be other members in the visiting team (e.g. a local clinical director, health board manager, retired GP or
practice nurse) in supporting roles. All visitors will have had training or relevant experience and Boards and LMCs will review and agree the pool of visitors.

The Quality Improvement visit will discuss:

- 5 quality datasets agreed between the board and practice (from the practice annual quality report(s) if available otherwise the practice current quality datasets, as specified above)
- The practice access report(s) if available

The visit will last a maximum of three hours it will involve one GP, normally a practice manager, and other practice staff as deemed appropriate by the practice. The practice will be given at least 6 weeks’ notice of the visit.

SG and SGPC will agree a reporting template for the visit. The reporting template for the visit will include a section for feedback from practices on the experience and it is intended that Board level aggregate outputs from the meetings will be made available to SG and SGPC, in order to inform future Quality Report and visit cycles/iterations.

It is anticipated that in areas where this type of visit is not yet established, the programme of visits will not have started until after 1 April 2015.

**QS 003.2(S) Reporting and verification**

The practice will share the Practice Continuous Quality Improvement report (PCQIR) on issues and themes that arise from this with the NHS Board before 15 March 2016 and participate in a 3 yearly Practice Continuous Quality Improvement Visit.
3 Steps to developing a Practice Annual Continuous Quality Improvement Report; (Individual practices involved in Step 3 only)

**Step 1**

**NATIONAL**; agreed by the Scottish Government and BMA (SGPC)

4 - 6 national dataset items will be agreed, and up to 2 of them will be designated*  
*Designated; all practices will include – see Step 3 below

**Step 2**

**LOCAL**; agreed by the local NHS Board and LMC

2 - 4 local dataset items will be agreed

**Step 3**

**PRACTICE**

From the 6 – 10 national and local data set items developed above, practices will include discussion on the following in their annual continuous quality Improvement report and tri-annual visit (using the provided template)

1. The 2 nationally designated dataset items

2. 1 additional national (non-designated) dataset item; chosen by the practice from the national list provided in Step 1 above

3. 1 additional local dataset item; chosen by the practice from the local list produced above in Step 2 above

4. 1 additional local dataset item; chosen by the Board from the local list produced in Step 2 above

The practice will therefore cover 5 areas in the annual quality report, and 6 at their tri-annual visit (5 areas being the dataset areas covered in their annual report for that year and the 6th area being the practice review of Access reports completed since the last tri-annual quality visit, or any done prior to the first quality visit)
QS indicators 004(S)/005(S)

QS004(S). The contractor produces a list of 5 per cent of patients in the practice, as of 1st April 2015, who are predicted to be at significant risk of emergency admission or unscheduled care. This list can be produced using a risk profiling tool accessible to practices e.g. SPARRA, or where this is not available/ required (by local agreement), alternative arrangements can be agreed between the NHS Board and LMC.

QS005(S). The contractor identifies a minimum of 30 per (which can include continuing ACPs from the 2014-15 contract year) of those patients from the list produced in indicator QS004(S) who would most benefit from, and creates, an Anticipatory Care Plan (the ACP must include a poly-pharmacy review), be shared with the local out of hours service and has an appropriate review date. The frequency of each patient’s review should be determined in the light of their clinical and care needs. The contractor will be responsible for ensuring that an appropriate system is in place for monitoring and reviewing the patients identified in this cohort.

QS 004/5.1(S) Rationale

It is generally acknowledged that appropriate Anticipatory Care Planning (ACP) for the cohort of patients in a practice identified as being at high risk of emergency hospital admission can improve the quality of care, reduce the risk of medication harm as well as the number of emergency admissions, and lengths of stay, for those patients.

Effective stratification of the population by their level of risk, using a validated risk assessment tool e.g. SPARRA, is required in order to best identify those patients at the highest risk of admission. Risk profiling followed by the targeted development and sharing of Anticipatory Care Plans can achieve the above aims and at the same time encourage better communication between professionals, patients and their family/carers.

As poly-pharmacy can significantly increase both the risk of harm from medicines and the risk of emergency admissions, and as a significant proportion of the patients identified at high risk of emergency by SPARRA or alternative risk profiling tools will often be on multiple medications, a poly-pharmacy review has been included in the anticipatory care planning process.

Where risk profiling tools have been procured by the NHS Board, these can be used to determine the 5 per cent. If the risk profiling process moves away from an external tool such as SPARRA, to any other method (see below), then that alternative method should be agreed between Boards and practices. It is expected that most of the ACP patients would be identified from the SPARRA list, or alternative tool but it is recognised that an increasing proportion will not and will instead be chosen at the discretion of the clinical team. In all cases it would be expected that the decision to choose these patients for an ACP could be clinically justified.
Where risk profiling tools are not available, or thought to be clinically helpful, practices will be required to determine the required 5 per cent by alternative means e.g. by examining their patient records, holding discussions with other members of the multi-disciplinary team, or through the use of QOF register information to identify patients with co-morbidities or other complex needs, in order to identify those patients most likely to be at significant risk of unscheduled admission or unscheduled/unplanned care.

The practice will be required to identify a minimum of 30 per cent of those patients from the list produced in QS004(S) who would most benefit from review and active intervention to reduce their need for unscheduled care. For each of these patients, the practice will develop and agree with the patient an ACP which should be shared with the patient, with where possible a copy kept at the patient’s place of residence. Where a patient has an ACP that was created before 31 March 2015, this will require to be maintained and updated after 1st April if it is to count towards the 30% total for 2015-16. If an identified patient dies during the period before 15 March 2016, after an ACP has been developed and agreed, then this care plan will be appropriate for inclusion as part of this indicator.

An ACP should, as a minimum, include the following information:

- patient name, date of birth, sex and contact details;
- name and contact details of patient's carer/responsible adult (if applicable);
- lead professional for the individual patient - often called key worker;
- date of assessment and suitable review date(s);
- relevant patient medical conditions;
- medication and poly-pharmacy review;
- allergies (if applicable);
- emergency plans (if appropriate);
- information on other health care professional involved in the patients care e.g. psychiatric nurse (if applicable);
- key messages e.g. patient specific goals (e.g. rescue medication), incapacity information, action to be taken in the event of deterioration, entry access code to patient's home, information on key holder for patient's home, patient's first language etc.;
- patient consent, if given, that this information can be shared with other healthcare professional involved in the patients care (i.e. OOH, community staff etc.) and/or discussed with the multi-disciplinary team.

In addition to the above, the following information should also be included in the active management plan if appropriate:

- Cardiopulmonary resuscitation - yes/no - indication as to whether or not this has been discussed and if so, giving any details;
- Patient’s preferred place of death e.g. home/hospital.
Contractors are required to use the eKIS as the summary of the Anticipatory Care Plan and should consider leaving a hard copy in the patient’s home, if that is judged to be clinically appropriate.

The practice will be responsible for ensuring that an appropriate system is in place for monitoring and review of the patients identified. The frequency of review should be determined in light of the patient’s clinical and care needs.

Appropriate READ codes should be used to denote patients on the list for QS004(S) and to record when patients have had an ACP created under QS005(S). The completion of the poly-pharmacy review should be recorded in the patient medical record via the use of an appropriate READ code and medication can be updated as appropriate e.g. after any medication changes following hospital discharge.

With the necessary consent the practice should ensure that the record is uploaded such that the NHS Board can make it accessible to the other health professionals that might need to be involved in that patient’s care e.g. out of hours and secondary care services (use of eKIS will ensure that this happens automatically).

**QS 004.2(S) Reporting and verification**

The contractor produces a list of 5 per cent of patients in the practice, who are predicted to be at significant risk of emergency admission or unscheduled care. The practice will need to make the list available, if requested, by the NHS Board.

**QSP 005.2(S) Reporting and verification**

The practice provides an active management plan (ACP) for the 30% of patients identified from the list of patients in QS004. Each plan should be agreed with the patient, and where appropriate, carers. The practice will need to make available examples of plans developed, including the poly-pharmacy review, if requested by the NHS Board.

**QS indicator 006(S)**

The contractor holds at least 4 meetings during the year to review the needs of the relevant patients in the practice ACP cohort, to agree any required changes in the patient management and to share learning/ identify learning needs. These meetings should be open to multi-disciplinary professionals who support the practice’s patients.

**QS 006.1(S) Rationale**

In order to remain fit for purpose ACPs may require updating and, on occasion, discussion at a multidisciplinary (MDT) meeting. Not all patients will require regular discussion at the MDT meeting and many will have their ACP updated in between regular meetings.
However, regular (4 times a year) MDT meetings will allow all members of the MDT to review ACPs for relevant patients in the ACP cohort, as identified by the practice, or any member of the team; the decision about which patients are relevant for discussion will be made by the members of the MDT.

During these meetings, the group should discuss the active management plans to identify any learning needs and related changes in patient management to help improve patient care so as to reduce unscheduled admissions or unscheduled care.

The multi-disciplinary professionals who are invited to these meetings should be those who support the practice's patients being discussed at the meeting. It may include, but is not limited to, the following professionals:

- community nursing staff;
- adult social care representatives;
- allied health professionals;
- palliative care team;
- community mental health professionals;
- pharmacists.

**QS 006.2(S) Reporting and verification**

The contractor will be required to submit an anonymised summary of the MDT meetings, in a format agreed between the SG and SGPC, to the NHS Board before 15 March 2016. The summary noting the discussions that have taken place at the meeting, any learning points or changes in patient management identified and what action has been taken to address them.

**QS indicator 007(S)**

The Practice conducts two case note reviews, using a validated tool, to detect patient safety incidents, meets to discuss the results, and shares a reflective report on actions and themes that arise from this with the NHS Board.

**QS007.1(S) Rationale**

To identify and reduce patient safety incidents within practices a trigger tool is a simple checklist for a number of selected clinical “triggers”. A reviewer looks for these triggers when screening medical records for patients who may have been unintentionally harmed. The use of rapid structured case note review using a trigger tool in high risk patient groups can identify patient safety incidents and near misses which practice teams can learn from and so reduce the risk of future patients from being harmed.
Using the NES Primary Care Trigger Tool each practice will complete a structured case note review twice during 2015/16, at least 3 months apart. This review should be conducted on 25 patients in total drawn from the following risk groups:

- Patients on DMARD therapy;
- Patients with diagnosis of LVSD;
- Patients on Warfarin therapy;
- Patients with a higher SPARRA score e.g. over 40 years;
- Recent admissions with COPD;
- Care home residents;
- Patients on chronic district nursing caseload;
- Patients aged 75 years on 6 or more medications.

When conducting the case note review, if five patient safety incidents have been detected before all 25 records have been reviewed, then it is not necessary to review the remaining records. The suggested maximum number of records to review is 25, even if five patient safety incidents have not been detected.

The usual number of months for the review period is three; reviewers may choose a longer period if they wish. To allow relevant correspondence to return from other health care colleagues, it is suggested that at least one month gap is used between date of review and specified review period.

The rationale for choosing a specific sub-population of patient records to review is that it increases the likelihood of detecting patient safety incidents. There is no single “correct” group to choose.

Explanation of Triggers

- Three or more consultations in 7 days refers to the frequency of contact between a patient and her/his practice. Consultations may be face to face, home visits or by telephone and may take place with any member of the practice team;
- New High priority read code refers to any computer code added during the period of review considered to be a “priority”. For example, in VISION software it would include any “new problem” or a “priority 1” code;
- New Allergy read code added refers to any allergy coded during the period of review;
- Repeat medication item discontinued refers to any prescribed item discontinued during the period of review;
- Out of Hours/ A+E attendance refers to any out of hours or A+E attendance by a patient during the period of review. Each attendance should be indicated by a tick in the boxes next to the trigger. Where patients are transferred directly from out of hours to A+E only one tick should be made as the journey relates to a single episode of health care;
- Hospital Admission refers to any unplanned or planned admission. For at least 24 hours during the period of review. The admission correspondence and the period
just before and after the admission should be screened for the presence of potential patient safety incidents;

- Hb <10 refers to a haemoglobin of <10 g/dl recorded during the period of review. It is a prompt to consider the possibility of a patient safety incident and general care of a patient and does not signify by itself error or harm;
- eGFR reduction of 5 or more, prompts the reviewer to screen the record for the presence of an eGFR measure recorded during the review period. In practice it may be necessary to compare this to a previous measure recorded prior to the review period to determine whether there was a reduction or otherwise. If a reduction is indicated, screen the record for additional information to determine if a patient safety incident has occurred;
- There is no correct number of triggers. The nature and type of pre-defined triggers are determined by the reviewer. Additional triggers may be added for the purpose of the review. For example, if the reviewer decides to review a sample of patients prescribed warfarin then she/he may specify a further trigger e.g. “INR >5 or INR<1.8”.

The practice will meet to reflect on the findings of the case note reviews and identify any actions to be taken to reduce the likelihood of patient safety incidents recurring.

**QS007.2 (S) Reporting and Verification**

Each practice will produce a summary report on the themes and the actions that arise from these discussions on an agreed template for each round of review and return this to the NHS Board no later than 15 March 2016.

**Review Findings**

- Describe each detected patient safety incident in sufficient detail so that others can understand exactly “what happened” and “why it happened” if this is immediately apparent;
- Recording the gender and age of the patient concerned is helpful, but patient identifiers such as name and CHI numbers should not be included;
- Subjectively “priority score” each patient safety incident by combining the severity and preventability scores. This is intended to help prioritise the order in which patient safety incidents are considered for action;
- During record reviews, “action” is often taken, e.g. amending, adding or removing prescribed items; adding or amending clinical codes; recording entries or arranging for recommendations from other health care settings to be implemented; arranging further investigations, appointments or referring for further treatment. Please briefly document these types of actions in the box provided;
- A list of possible further actions is outlined. Please tick one box each time you plan to take that specific action e.g. if you plan to conduct significant event analysis for two patient safety incidents, tick two boxes next to this option.

**Learning Needs**
• Provide a reflective report in this section about any other action the practice intend to take, including any learning needs/and or actions the practice intends to take after the meeting.

**QS indicator 008(S)**

The practice conducts a safety climate survey with all staff, clinical and non-clinical, using a validated tool, meets to discuss the results, and shares a reflective report on actions that arise from this with the NHS Board.

**QS008.1(S) Rationale**

To develop practice teams safety culture by using a validated safety climate survey in conjunction with reflective practice.

A positive safety culture is essential to delivering safe, high quality care in any environment. It is recognised that systems and organisational issues are major contributors to harm in primary care and that harm is more likely to occur when there is sub-optimal teamwork and communication and a lack of focus on quality or safety. Health care teams with a positive safety culture are more likely to learn openly and effectively from error and harm.

Measurement and reporting of safety climate survey should be performed using a validated tool such as GP-Safequest. This is a 30 item questionnaire is specifically designed to be used by all members of primary care teams in the UK.

All GPs and practice employed staff (clinical and non-clinical) will undertake the safety climate survey. Following the survey all staff should be made aware of the reported results and the practice should meet to discuss and identify any areas for improvement and actions to be taken over the next 12 months. Practices may choose to assess progress by repeating this process on a 12 monthly cycle.

• The practice manager or nominated person may access the webpage: [www.healthcareimprovementscotland.org/safetyclimate.aspx](http://www.healthcareimprovementscotland.org/safetyclimate.aspx) and selects login;
• If this is the first time that your practice has completed the survey you will be invited to register. Otherwise, this “login” details from a previous survey should be used. The username is the national practice code. There is a “forgotten password” function if required;
• Select the “manage questionnaires” tab;
• Create a “new batch”;
• Select “add another staff member”;
• Enter staff name. Do not enter email addresses as automatically generated email may be blocked by “spam” filters;
Repeat these steps until the names of all the team members have been entered then select “save staff” under Section 2;
Next to each name there will be a text showing “not completed” and a link to download and / or print a paper copy of the survey;
Download each invitation and either print them or email them through your NHS email account;
Distribute to named individuals.

Each individual has a link to complete the survey and an automatically generated unique code to allow participants to participate in the survey. When staff members complete the survey, the text next to their names will change from “not completed” to “complete” to allow monitoring of response rates. Updates occur at each login.

Once all participants have completed their survey, login and select “manage questionnaires. Click on the “review” button for the current batch. Select “download report” twice and the report will automatically be generated. A copy may be saved in pdf format to aid further discussion.

The report should be disseminated to each member of the team that participated and a dedicated meeting to reflect on and discuss the findings should be held.

A guide to help practices maximise their use of the safety climate report is available at [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)

QS008.2(S) Reporting and Verification

Practices will submit a reflective summary of their action plan to improve the team safety culture based on practice discussion of the results of the survey. This will be submitted to the NHS Board no later than 31 March 2016.

### Section 6: Medicines management (MM) domain

Please note exception reporting does not apply to this domain.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
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<tbody>
<tr>
<td>MM001(S). The practice meets with the NHS Board prescribing adviser at least annually and agrees 3 actions related to prescribing.</td>
<td>4</td>
</tr>
<tr>
<td>MM002(S). The practices meets with the NHS Board prescribing adviser,</td>
<td>9</td>
</tr>
</tbody>
</table>
has agreed 3 actions related to prescribing and subsequently provided evidence of change.

The practice should also undertake an audit of an area of prescribing that is a clinical issue that has been agreed with the NHS Board prescribing adviser.

MM003(S). A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines. Standard 80 per cent.

**Guidance: Medicines Management 2015-16**

The common aim of the indicators within the medicines management domain is to consolidate and continually improve the quality and cost-effectiveness of prescribing in general practice.

This is achieved by promoting the supervision and review of repeat medication lists and the implementation and measurement of prescribing action plans and / or local formulary compliance. They encourage the use of medicines to maximise therapeutic benefit and improve safety by minimising adverse drug reactions and drug-to-drug interactions.

Recognised best practice includes the appropriate use of a risk and benefit discussion with the patient.

**MM indicator 001(S)**

The practice meets the NHS Board prescribing adviser at least annually and agrees 3 actions related to prescribing.

**MM001.1(S) Aim of the Indicator**

To consolidate and continually improve the quality and cost-effectiveness of prescribing in general practice by identifying by agreement between the NHS Board and the practice those actions most likely to have benefit in keeping with overarching aim of the domain.

**MM001.1(S) Practice guidance**

If the NHS Board prescribing adviser is unable to visit within the year and there has been no contact with another NHS Board recognised source of prescribing advice within the year then the practice will by default be considered to have achieved full points for MM001(S). In this circumstance, the practice should provide written confirmation from the NHS Board prescribing adviser that he or she has been unable to visit within the relevant year.

**MM001.2(S) Written evidence**
Three actions agreed with the NHS Board prescribing adviser should be produced, or written confirmation from the NHS Board prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A).

**MM001.3(S) Assessment visit**

The actions should be discussed.

**MM001.4(S) Assessors’ guidance**

This indicator will be considered to have been met if the NHS Board prescribing adviser and the practice have reached agreement on the 3 action points.

**MM indicator 002(S)**

The practice meets the NHS Board prescribing adviser at least annually, has agreed 3 actions related to prescribing and subsequently provided evidence of change.

In addition the practice agrees an audit project with the NHS Board prescribing adviser related to prescribing, to be completed and reported within the year.

**MM002.1(S) Aim of the Indicator**

To consolidate and continually improve the quality and cost-effectiveness of prescribing in general practice by identifying by agreement between the NHS Board and the practice those actions most likely to have benefit in keeping with overarching aim of the domain, implementing these actions and evidencing positive change.

An audit project will provide additional reflection and evidence of improvement in an area agreed with the NHS Board prescribing advisor/NHS Board.

**MM002.2(S) Practice guidance**

Normally, improvements should be demonstrated in all three areas and the prescribing audit project. 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 NHS Board prescribing adviser for its reasons for not achieving the areas in question.

National Education Scotland (NES) provide resource to produce an audit using the recommended format:


If the NHS Board prescribing adviser is unable to visit within the year, then the practice will by default be considered to have achieved full points for MM002(S). The
practice should provide written confirmation from the NHS Board prescribing adviser that he or she has been unable to visit within the relevant year.

Where suitable and appropriate the audit project may be considered for submission of written evidence for appraisal and revalidation.

**MM002.3(S) Written evidence**

A report should be written for the three agreed prescribing actions to include evidence of the change produced. If no change was produced then written support from the NHS Board prescribing adviser for the reason for this should be provided.

A report should be written for the prescribing audit using the format suggested by NES – see hyperlink below.


Completed audits should be submitted to NHS Boards as part of their end of year return by 15 March 2016.

**MM002.4(S) Assessment visit**

Actions and improvements should be discussed.

**MM002.5(S) Assessors’ guidance**

Normally, improvements should be demonstrated in all three areas and the audit. 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 to the NHS Board prescribing adviser for its reasons for not achieving the areas in question and/or audit.

**MM indicator 003(S)**

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 per cent).

**MM003.1(S) Aim of the Indicator**

To consolidate and continually improve the quality and cost-effectiveness of prescribing in general practice by supervising and reviewing repeat medication lists, ensuring that the prescription remains appropriate in the context of patient choice, expected benefit and co-existing prescriptions and medical conditions.

**MM003.2(S) Practice guidance**

Medication is by far the most common form of medical intervention. Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four or more. However, we also know that up to 50 per cent of drugs are not taken as
prescribed and adverse drug reactions are implicated in 5 to 17 per cent of hospital admissions.

Patient engagement with 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. This is defined as a review of medicines with patient’s full notes (not necessarily with patient present).

The underlying principles of any medication review include:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
4. Any changes resulting from the review are agreed with the patient.
5. The review is documented in the patient’s notes.
6. The impact of any change is monitored.

In addition, once reviewed, for those patients that are clinically stable, the Chronic Medication Service offered by community pharmacists can be considered to allow for pharmaceutical care, monitoring and serial dispensing.

**MM003.2(S) Written information**

A survey of medication review should be undertaken on request. This could be a computerised search and print out, or a survey of 50 records of patients on four or more medications.

**MM003.3(S) Assessment visit**

Inspection of records should be carried out.

**MM003.4(S) Assessors’ guidance**

The assessors should ask the staff to demonstrate how the system works in particular how an annual review is ensured.
Section 7. QOF queries

Queries can be divided into three main categories:

1. those which can be resolved by referring to the guidance and/or FAQs.
2. those which require interpretation of the guidance or Business Rules.
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, QMAS (up to and including 2013/14 QOF payments) and CQRS (from 2014/15 - England), clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas. CQRS was the replacement for QMAS in England, and in Scotland, QOF Calculator has been used since 2010.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where an issue relating to clinical indicators has arisen mid-year that cannot be resolved with simple clarification of the guidance, this will fall in to the NICE process of reviewing QOF indicators.

Scotland

In Scotland queries should be directed as follows:

Level one (NHS Boards):

Practices should send queries to their NHS Board Lead contact for resolution from agreed guidelines/ existing FAQs. Where there is uncertainty or it is not possible to resolve the query, it is escalated to level two.

Level two (Scotland):

The Board (or national body) escalates queries as necessary to the Scottish QOF queries portal at [ScottishQOFQueries@scotland.gsi.gov.uk](mailto:ScottishQOFQueries@scotland.gsi.gov.uk). Responses will be agreed between the Scottish Government (SG) and Scottish General Practitioners’ Committee (SGPC) in consultation.

Level three – Four Countries issues
NICE operate an online facility which allows stakeholders to comment on current QOF indicators. Comments will be used to review existing QOF indicators against set criteria which include:

- evidence of unintended consequences;
- significant changes to the evidence base;
- changes in current practice.

Comments are fed into a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be fed into negotiations between NHS Employers and the GPC. The online facility is available on the NICE website[^179].

[^179]: NICE website, QOF. [http://www.nice.org.uk/aboutnice/qof/qof.jsp](http://www.nice.org.uk/aboutnice/qof/qof.jsp)
Section 8: Exception reporting guidance

Purpose of guidance

Exception reporting was introduced into the QOF in 2004. It is intended to allow contractors to pursue the quality improvement agenda without being penalised for patient specific clinical circumstances or other circumstances beyond the contractor's control which lead to failure to achieve the indicator. For example, where a medication cannot be prescribed due to a contra-indication or side-effect, where patients do not attend for review or where secondary care services are not available.

Since 2004, it became clear that a variety of interpretations and applications of the nationally defined exception reporting criteria are possible. NHS Employers and the BMA published guidance in October 2006 regarding what constitutes good practice in exception reporting. The 2006 guidance was designed to provide additional clarity, to the information contained in the QOF guidance, in order to help maintain a consistent approach to exception reporting.

From April 2013, the exception reporting guidance has been updated and supersedes any previous guidance issued. It is supplementary to the paragraphs included in section one of this document.

Principles

The overriding principles to follow in deciding to except a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements;
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment i.e. to have continuing knowledge of health status and personal health goals;
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record;
• There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

**Definitions**

There is an important distinction to be made between “exclusions” and “exceptions”. This guidance is about “exceptions”.

**Exclusions** are patients on a particular clinical register, but who for definitional reasons are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

**Exceptions** are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the SFE (Scotland). Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

The criteria under which a patient may be excepted from a QOF indicator are set out in the SFE 2015 (Scotland) and also in section one of this document.

Although the SFE 2015 (Scotland) sets out nine reasons why a patient may be exception reported, the national QOF achievement analysis systems (CQRS) identifies exception reporting against a limited number of codes. For example, criteria A and G are both coded as “informed dissent” or "patient refused". Any patient is only excepted once by the system for a given indicator, but any patient’s clinical record could contain more than one type of exception reporting Read code entered by the contractor. It is therefore not possible to extract completely accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE 2015 (Scotland) from the national systems. Therefore the HSCIC only reports the total numbers of patients excepted for each indicator.

For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient’s clinical record. For example, where a patient has not tolerated
medication, the nature of the contraindication should be recorded in the patient’s notes as well as the exception reporting code applied.

**Detailed guidance on exception reporting**

Each of the nine criteria for exception reporting is detailed below:

**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.**

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient’s prescription requesting that they attend for review.

The three invitations need to have taken place within the 15 months related to the QOF ‘year’ in question (i.e. 1 January 2015 to 31 March 2016 if applying to the 2015-16 contract year). There should be three separate invitations at three unique periods of time. The only exception to this rule is indicator CS001(S), where the period in which the three invitations are sent reflects the timeframe of the indicator i.e. five years.

The telephone call invitation may lead to the application of exception criteria G, ‘informed dissent’, if the patient refuses to take up the invitation to attend.

The following are examples that are not acceptable as an invitation:

i. a generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. flu vaccination;

ii. a notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. flu vaccination).

**Influenza vaccination indicators**

Exception reporting for influenza vaccination has caused some confusion because flu vaccination is also remunerated through a Directed Enhanced Services (DES). For the DES, payment is based on the number of at-risk patients immunised. The DES nevertheless requires the contractor to develop a proactive approach and a robust call and reminder system for the at-risk groups.

For QOF, the payment is based on the percentage of patients immunised in each relevant disease area. Exception reporting rules apply to the QOF indicators and patients need to have been personally invited on at least three occasions that year to be excluded from the denominator for achievement under criteria A.
Cervical screening indicators

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before ‘informed dissent’ can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

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

The overriding principle is that blanket exception reporting is not acceptable and individual decisions based on clinical judgment should be made.

It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis e.g. dementia or cancer. However, age, diagnosis, co-morbidity, health and functional status should be taken into account when deciding whether to exception report individual patients under this criterion.

In each individual case there is a question of degree which requires clinical judgement to be exercised.
C. Patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.

Exception reporting is done automatically through the national achievement analysis system.

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.

Again, the over-riding principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment (see criteria B).

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out. The patient should not be exception reported on the basis that they are under the care of a consultant. The contractor should either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, exception reporting will be allowed. This should be noted in the patient record.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contra-indication or have experienced an adverse reaction.

The nature of the contra-indication, allergy or adverse drug reaction should be recorded in the patient record as well as the exception reporting code applied.

F. Where a patient has not tolerated medication:

The nature of the intolerance should be recorded in the patient record as well as the exception reporting code applied.

G. Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their medical records.
A personal contact or discussion should be documented in the patient records for this criteria to apply. This can include either face-to-face or telephone contact between a health professional and the patient.

Patients not responding to invitations to attend or failing to arrive at appointments cannot be exception reported under criteria G, i.e. DNA alone does not fulfil the criteria for informed dissent. Patients failing to respond after three invitations can be exception reported under criteria A.

The informed dissent should have been given in the period 1 April 2014 to 31 March 2015 if applying to the year 2014/15) (except cervical screening where a patient has withdrawn from the call and recall system).

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

The nature of the supervening condition should be recorded in the patient’s notes as well as the exception reporting code applied.

I. Where an investigative or secondary care service is unavailable.

The contractor would be expected to explore fully with their NHS Board whether or not a suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the services was unavailable.
### Section 9: Glossary of terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ABPI</td>
<td>Ankle Brachial Pressure Index</td>
</tr>
<tr>
<td>ABPM</td>
<td>Ambulatory Blood Pressure Monitoring</td>
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<tr>
<td>ACCORD</td>
<td>Action to Control Cardiovascular Risk in Diabetes</td>
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<tr>
<td>ACE-Inhibitor or ACE-I</td>
<td>Angiotensin Converting Enzyme Inhibitor</td>
</tr>
<tr>
<td>ACR</td>
<td>Albumin:Creatinine Ratio</td>
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<td>ACS</td>
<td>Acute Coronary Syndrome</td>
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<tr>
<td>ACTIVE-W</td>
<td>Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events</td>
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<td>ADA</td>
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<td>AF</td>
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<td>AMA</td>
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</tr>
<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
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<td>ARB</td>
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<td>Asthma</td>
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<td>mmHg</td>
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<td>mmol/l</td>
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<td>MR</td>
<td>Modified Release</td>
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<td>MRC</td>
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<td>MRI</td>
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<td>NEJM</td>
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<td>National Services Scotland</td>
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<td>OGTT</td>
<td>Oral Glucose Tolerance Test</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>Description</td>
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<td>OST</td>
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<td>OTC</td>
<td>Over The Counter</td>
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<td>PAD</td>
<td>Peripheral Arterial Disease</td>
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<td>PC</td>
<td>Palliative Care</td>
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<tr>
<td>PCR</td>
<td>Protein:Creatinine Ratio</td>
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<td>PE</td>
<td>Patient Experience</td>
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<td>PEF</td>
<td>Peak Expiratory Flow</td>
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<td>Nine Item Patient Health Questionnaire</td>
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<td>PCRJ</td>
<td>Primary Care Respiratory Journal</td>
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<tr>
<td>PSD</td>
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<td>PVD</td>
<td>Peripheral Vascular Disease</td>
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<tr>
<td>QMAS</td>
<td>Quality Management and Analysis System</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>QP</td>
<td>Quality and Productivity</td>
</tr>
<tr>
<td>RA</td>
<td>Rheumatoid Arthritis</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nurses</td>
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<td>RCTs</td>
<td>Randomised Controlled Trials</td>
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<td>Supportive Care Register</td>
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<td>SGPC</td>
<td>Scottish General Practitioners Committee</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>SIMD</td>
<td>Scottish Index of Multiple Deprivation</td>
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<td>SMOK</td>
<td>Smoking</td>
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<td>SPARRA</td>
<td>Scottish Patients at Risk of Readmission and Admission</td>
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<td>Selective Serotonin Reuptake Inhibitors</td>
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<tr>
<td>STIA</td>
<td>Stroke or Transient Ischemic Attack</td>
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<td>TIA</td>
<td>Transient Ischemic Attack</td>
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<td>Thyroid</td>
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<tr>
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<td>United Kingdom</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
Section 10: Appendices

Appendix A: Supporting Documentation, Guidance & Links

http://www.psd.scot.nhs.uk/professionals/medical/qof-guidance.html

Practice Continuous Quality Improvement Report (PCQIR) 2015 -16

Practice QOF Review Report 2015/16

Datasets

Appendix B: Summary of QOF changes for 2015-16

Summary of Changes
APPENDIX A

Practice Continuous Quality Improvement Report (PCQIR) 2015-16

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<th>Health Board:</th>
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<td>Practice List Size:</td>
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<tr>
<td>Practice Lead:</td>
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1. INDICATOR DESCRIPTION QS003(S)

The practice participates in a process of continuous quality improvement by undertaking a review of a data set, agreed between SGPC and SG, provided by the NHS Board. The practice provides an annual report, on a template agreed between the SG and SGPC, and participates in a 3 yearly peer review visit.

2. BACKGROUND

Across the healthcare system, there is increasing use of data and improvement tools to analyse, reflect upon and improve the quality of care that is provided to patients. These approaches are broad in technique, and involve familiar tools to general practice such as audit and significant event analysis, alongside newer techniques such as the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles.

Examples of these resources and tools can be found at the NHS Scotland Quality Hub website:


or at the NHS Education for Scotland website:

This commitment to improving the Quality of care is an intrinsic component of professionalism and a core requirement of appraisal and revalidation. The provision of useful and relevant data that enables and supports this activity will allow general practice to demonstrate continuous improvement in key areas of healthcare and should be underpinned by the following principles:

- Achieves consistent high quality, safe, effective and person-centred care across the country;
- Facilitates the continuous improvement of healthcare;
- Reduces bureaucracy;
- Does not result in disadvantaged groups of patients or drive inappropriate care;
- Stabilises funding into general practice;
- Maximises the opportunity for appropriate clinical input from the whole system;
- Is flexible to local health priority and need;
- Provides sufficient assurance around clinical governance and contract delivery.

The activity relating to this indicator should not be used for performance management purposes.

All work associated with this indicator would be eligible for inclusion in the process of appraisal and revalidation.

3. DATA REVIEW

Data review - national datasets and designated datasets
The Scottish Government and Scottish General Practitioners Committee will agree at least five national datasets. Two of the national datasets will be "designated datasets" (agreed between SG and SGPC) for discussion in all practices across Scotland.

Data review - local datasets
NHS boards and Local Medical Committees will agree between 2 and 4 datasets (both the number of datasets and the content to be agreed).

Annual quality report
Practices will be provided with the national and local data sets. Practices will discuss the 2 national designated datasets and one local dataset the NHS board will designate as being considered likely to be the most useful to have in the discussion with that practice. The practice will then choose:

- 1 additional national dataset
- 1 additional local datasets

This template, Annex A, has been agreed between SG and SGPC and should be used to structure practice analysis and report. Reports must be returned to the NHS board by 15 March 2015.
Please complete one reflection table for each dataset that you have analysed and discussed. Include any activity that the practice has identified which will assist in spreading good practice or actions which the practice wishes to undertake in order to develop care further.

### 1. National Dataset (designated)

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<tr>
<th>Area:</th>
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<tr>
<td>Areas for possible practice development</td>
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<td>Additional comments</td>
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<tr>
<td>Has the practice identified any actions?</td>
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<tr>
<td>If you have identified actions, how could you tell if these result in improvement?</td>
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### 2. National Dataset (designated)

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### 3. National Dataset (practice choice)

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4. Local Dataset (designated)

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5. Local Dataset (practice choice)

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<td>If you have identified actions, how could you tell if these result in improvement?</td>
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</table>

The purpose of this activity is to improve the quality of care that is provided to patients across the country through analysis, reflection and the introduction of new approaches. Please highlight any areas of good practice that you would be willing to share with other colleagues.
PRACTICE QOF REVIEW REPORT 2015/16

Practice Name: [ ] Practice Number: [ ] Visit Date: [ ]

QOF Visiting Team:

Lead GP
CHP Lead
Primary Care Service Representative

Practice Team:

Lead GP
Practice Manager

1. Introduction -

e.g. Thank you for allowing us the opportunity to visit the practice and meet with members of your team for the Quality Improvement peer review visit. The visit was conducted as part of your QOF, Quality and Safety domain.

Firstly, we would like to congratulate your team on their level of achievement, and hope the review visit has contributed in a constructive way to helping inform further opportunities for improvement in the coming years.

2. Areas Discussed:

<table>
<thead>
<tr>
<th>Area Discussed:</th>
<th>Local Datasets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Discussion:</td>
<td></td>
</tr>
</tbody>
</table>

Actions agreed:
Area Discussed: National Dataset
Summary of Discussion:

Actions agreed:

Area Discussed: Access
Summary of Discussion:

Actions agreed:

3. GENERAL FEEDBACK FROM QOF VISITING TEAM

4. PRACTICE FEEDBACK -

Please give us some brief feedback on your experience of the visit in the box below.
- Do you broadly agree with the reviewer comments and summary?
- Are there any aspects you would like to discuss further before the report is finalised?
- Do you have any suggestions of how the review visit/process could be improved?

Date of final report:

Signed and dated by Lead GP:

I agree to the accuracy of the report, signed and dated on behalf of Practice:

...........................................................................................................................................................................
(On Behalf of Drs:  )

Please return to:

Primary Care Manager
DATA FOR IMPROVEMENT

PRIMARY CARE INDICATORS – PRACTICE PROFILE INFORMATION REPORTS

Introduction

ISD’s Health and Social Care Pathways service area are working with Scottish Government, Health Boards and primary care leads to develop a suite of national indicators to support improvement in General Practice. The indicators aim to help Boards work with GP practices to identify waste, avoidable variation and areas for improvement, and offer the opportunity for national benchmarking.

Specific purposes:

- to allow objective benchmarking both between practices and over time, on particular parameters so as to identify variation and areas for improvement, in whatever part of the system they need to occur
- to allow for objective benchmarking between and within Board areas so as to identify any geographical variation
- to facilitate the collection of national data sets to inform national policy and practice

Who will use the data?

- Practice / individual contractor level
- Locality level
- CHP / Board level
- National / Government level
How will the data be used?

A few examples of how the data could be used include:

- **At practice / individual contractor level** – to review practice processes, provide reflection (analysis) at both individual and practice level as to why practices might be where they are in the spectrum of activity.
- **At locality level** – to inform debate about what the issues might be across practices within that locality.
- **At CHP/Board level** - to assist and more readily identify those issues that need support across practices and localities and show which practices might have something useful to share with/learn from other practices.
- **At National level** – allow Government to demonstrate delivery of the Quality Strategy and how it impacts on outcomes for patients and in turn potentially inform national policy going forward.

How and where to access

The data is drawn from a range of currently available but separate sources which is then uploaded in excel workbook format via a secure website aims to provide a single point of referencing the indicators together and to provide a consistently presented structure.

Access to these practice profile reports is controlled through authorised distribution lists and password protection which is renewed frequently. If colleagues within your practice / organisation require access, written requests with explicit approval from your Primary Care lead should be sent to NSS.isdPTIqueries@nhs.net
The current suite of indicators

1. The table below shows the indicators for which national data currently exists:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>Number of new first appointments standardised for age and sex, for All Scotland Top 10 high volume specialties.</td>
<td>SMR00</td>
</tr>
<tr>
<td>Referrals</td>
<td>Number of GP and GOP new first Ophthalmology appointments, standardised for age and sex.</td>
<td>SMR00</td>
</tr>
<tr>
<td>Admissions</td>
<td>Emergency admissions for patients with COPD and Heart Failure</td>
<td>SMR01</td>
</tr>
<tr>
<td>Admissions</td>
<td>7 day readmission rates (health board) and 28 day readmission rates (practice level).</td>
<td>SMR01</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Total antibiotic use</td>
<td>PRISMS</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Proton Pump Inhibitors (PPI)</td>
<td>PRISMS</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Overall experience of the practice</td>
<td>Patient Experience Survey</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Rating of overall arrangements to see a doctor</td>
<td>Patient Experience Survey</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Being treated with kindness and understanding</td>
<td>Patient Experience Survey</td>
</tr>
</tbody>
</table>

In most cases the data reflects the last five years and includes 2013/14.

2. A number of indicators have been identified for potential future inclusion as supporting national datasets are developed. These are listed below:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Source</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>Proportion of Patients with SPARRA risk&gt; 50% who have an anticipatory care plan</td>
<td>Not currently available</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>Number of ‘Advice Only’ referrals.</td>
<td>Not currently available</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>Avoidable referrals as a % of new first appointments.</td>
<td>Not currently available</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>Use of non-steroidal drugs</td>
<td>Not currently available</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>Part 7 Use</td>
<td>Not currently available</td>
<td></td>
</tr>
</tbody>
</table>
Quality and Safety Domain (QOF – QS003)

An additional and specific usage for General Practice was identified as part of 2014-15 GMS contract settlement where SG and Scottish General Practitioners Committee agreed to introduce an indicator that would promote and facilitate a practice approach to continuous quality improvement.

This will continue for 2015/16 and datasets have been refreshed.

(QS003) – the practice participates in a process of continuous improvement by undertaking a review of the datasets agreed between SGPC and SG, provided by the NHS Board. The practice provides an annual report, on a template agreed between SG and SGPC, and participates in a 3 yearly peer review visit.

Practices needed to review **FIVE** quality datasets in total as instructed by each Health Board and these differ between areas:

Two designated national datasets; one other national dataset; a designated local dataset; and one other local dataset – practices were instructed to reflect on these and complete the quality report for submission to PCCO by 15 March 2015.

The national datasets for 2015/16 are the same as for 2014/15: [select 1 and 2 (designated), plus one other]

1. Practice COPD prevalence (designated) – source QOF Dashboard
2. Emergency admissions for patients with COPD (designated) – source Primary Care Indicators (PCI)
3. Number of new first appointments for respiratory conditions (option) – source PCI
4. 28 day readmission rates at practice level (option) – source PCI
5. Patient experience: rating of overall arrangements to see a doctor (option) – source PCI – experience survey

It is the responsibility of each Health Board to communicate and support the process associated with QS003 to general practice.
What does it look like?

Here are a couple of screen shots which give a glimpse of the Primary Care Indicators secure webpage (a secure area within the main ISD website) and the other shows an aspect of one of the indicator workbooks.

The secure webpage

![Screen shot of the secure webpage](image-url)

The reports available on this web page are designed to aid the delivery of primary care services and contain information not available in the public domain. The reports are not for onward distribution.

Latest News

- **July 2014** - Outpatient attendance workbook updated to include quarterly and annual data up to the year ending 31st March 2013.
- **June 2014** - Workbook presenting Emergency Admissions and Emergency Bed Days (All, COPD and Heart Failure admissions) uploaded to website.
- Draft User Guidance document added to website.
- 7 & 28 day Emergency Readmissions workbook uploaded to website.
- Policy Background documents to set context for the indicators have also been added.
- **May 2014** - Patient Experience workbook version uploaded to website. As with the referrals workbook, Operational Group members can feedback any comments on design, layout and general functionality.
- **April 2014** - Referrals profile workbook version 0.3 uploaded to website. Operational Group members are now invited to review the referrals indicators and feedback any comments on design, layout and general functionality. Please note, the workbook is still in development and some bugs may remain. We would appreciate your feedback on any bugs encountered so we can rectify them as soon as possible.

ISD’s Health and Social Care Pathways service area are working with Scottish Government, health boards and primary care leads to develop a suite of indicators to support improvement in General Practice. The indicators aim to help Boards work with GP practices to identify waste, avoidable variation and areas for improvement, and offer the opportunity of national benchmarking.
**Indicator workbook**

To highlight a selected GP practice and specialty, use the filters below.

- Please select a Health Board or CHP: East Ayrshire Community Health Partnership
- Please select a Practice: [Practice Name]
- Please select a Specialty: [Specialty]
- Please select a Time Period: [Time Period]

<table>
<thead>
<tr>
<th>Practice</th>
<th>2012/13 Q1</th>
<th>2012/13 Q2</th>
<th>2012/13 Q3</th>
<th>2012/13 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Ayrshire CHP</td>
<td>55.5</td>
<td>54.4</td>
<td>59.6</td>
<td>55.3</td>
</tr>
<tr>
<td>GP Practice 1</td>
<td>54.0</td>
<td>55.7</td>
<td>59.2</td>
<td>55.5</td>
</tr>
<tr>
<td>Practice 2</td>
<td>54.7</td>
<td>51.2</td>
<td>52.7</td>
<td>50.0</td>
</tr>
<tr>
<td>Scotland</td>
<td>200.0</td>
<td>200.0</td>
<td>200.0</td>
<td>200.0</td>
</tr>
</tbody>
</table>

**Help at hand**

Further guidance, support and help is available. Feedback on ease of use and recommendations for future development is also welcomed and can be sent to the contacts listed below:

NSS.isdPTIqueries@nhs.net
APPENDIX B

Quality and Outcomes Framework - Changes for QOF 2015 -16

- AF004 will be renumbered AF002(S), indicator changed and the QOF Points increased: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc risk stratification scoring system in the preceding 15 months (excluding those whose previous CHA2DS2-VASc score of 2 or above).
  (8 QOF points, threshold 40 – 70%)

- AF005(S), indicator changed and QOF Points increased. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.
  (9 QOF Points, threshold 50 – 90%).

- CVD-PP003(S) is retired, 5 QOF Points (transferred to AF): The patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who require lifestyle advice on increasing physical activity, as identified in CVD-PP002(S), in the preceding 15 months, are given that advice utilising the Scottish Physical Activity Screening Questions (Scot-PASQ+).

- QS002(S) – continue the review of access, using the RCGP/ Productive General Practice tools. In addition GP practices will have the option to undertake a higher level Access Review – but this will be optional (and the option agreed in advance with SGPC);

- QS003(S) – continue with a review of respiratory practice based data agreed for 2014/15. We will jointly consider a new clinical area for review for the 2015/16 peer review visits. This will be agreed with SGPC before the end of March 2015, and will be based on availability of appropriate data sets;

- QS004/5/6(S) – remove the 2 year timescale and continue the service until 2017;