

# Quality and Outcomes Framework for 2012/13

Guidance for PCOs and practices

March 2012

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# Section 1. Introduction

The Quality and Outcomes Framework (QOF) rewards practices for the provision of 'quality care' and helps to standardise improvements in the delivery of clinical care. Practice participation in QOF is voluntary but most practices on General Medical Services (GMS) contracts, as well as many on Personal Medical Services (PMS) contracts, take part in QOF. It was introduced as part of the new GMS contract in 2004.

From May 2006, evidence was provided by an 'expert panel', co-ordinated by a consortium of academic bodies, including the Universities of Birmingham and Manchester, which informed negotiations between NHS Employers, on behalf of the four United Kingdom (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.

This document outlines changes in relation to QOF payments under the GMS contract for 2012/13 and replaces all guidance issued in previous years. The content of this document reflects the provisions of Annex D of the Statement of Financial Entitlements (SFE) Directions and forms part of the General Medical Services (GMS) Contract for 2012/13.

NICE operates 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 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: <http://www.nice.org.uk/aboutnice/qof/comment.jsp>

The term PCO (Primary Care Organisation) is used throughout the guidance, as the structures responsible for the organisation and management of primary care differ in the four countries e.g. primary care trusts in England and local health boards in Wales and 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.

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

Indicators across all domains are numbered. In the guidance they are prefixed by the disease category to which they belong e.g. chronic heart disease (CHD) indicator number one, becomes CHD1. Indicator 'identifiers' or 'references' are numbered sequentially except where indicators have been removed or amended. Where indicators have been amended, either in relation to the activity being measured, the frequency with which the activity should be completed or where a linked indicator has been changed, the indicator has been renumbered. For example, the 2009/10 diabetes DM23 HbA1c<sup>1</sup> target changed in 2011/12, therefore, the indicator identifier changed to DM26. For clarity DM24 and DM25 were also renumbered to keep the three target indicators grouped together.

The reason that indicators are renumbered is to avoid inappropriate cross-year comparisons between different indicators. Indicators have NOT been renumbered where the only change is in the threshold and range. Indicators that have been developed through the NICE process<sup>2</sup> are identified by the reference '*NICE [YEAR] Menu ID: NMXX*' for information.

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

- Where an age range is referred as "X to Y years" (i.e. 25 to 64 years) it means from the day the patient turns the former age (for example, their 25<sup>th</sup> birthday) until the day before the latter age (for example, the day before their 65<sup>th</sup> birthday)
- Where an age range is referenced as "X years and over" (i.e. 75 years and over) it means from the day the patient reaches that age and onwards (for example, from their 75<sup>th</sup> birthday)
- Where an age range is referred as "X years and under" (i.e. 25 years and under) it means until the day the patient exceeds the age of X (for example, the day before the patient's 26<sup>th</sup> birthday)
- Where an age range is referred as "under the age of X" (i.e. under the age of 25) it means until the day before the stated age (for example, the day before their 25<sup>th</sup> birthday)
- The phrase "in the preceding x months" means that the activity described is done every x months from the REF\_DAT. For payment purposes, it relates to the months preceding the 31 March of the relevant financial year in which the activity would be required, in order to measure achievement. Please note that in-year QOF data extractions would record a different result to an end year extraction as the REF\_DAT would be the date on which the extraction took place.
- References to "From [date]" (i.e. from 1 April) means 'on or after' that date ( for example 'on or after 1 April')

Further information about the development of the QOF is available on the NHS Employers website: '[Developing the QOF](#)'

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<sup>1</sup> From 1 June 2011 all HbA1c measurements should use only IFCC-HbA1c values (mmol/mol) – for conversions from DCCT values (%) please see explanation and table on pp.60-61

<sup>2</sup> For more information on the NICE menu of indicators please see <http://www.nice.org.uk/aboutnice/qof/indicators.jsp>

Reporting should be possible through the use of GP clinical systems and practices can run a report annually which can be submitted to the PCO. Separate guidance has been produced on the electronic queries which can be used to report on the QOF in England<sup>3</sup>.

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

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063>

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

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

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

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

## QOF Business Rules

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

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

The Logical Query Indicator Specification and the Dataset and Business Rules are updated twice a year and can be downloaded from [www.pcc.nhs.uk](http://www.pcc.nhs.uk)

Further information on the Business Rules process is available on the NHS Employers website: [‘Developing the QOF Business Rules’](#)

## Disease registers

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

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<sup>3</sup> <http://www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/qmas>

Some indicator sets (e.g. depression) do not have an indicator which relates to establishing a register. Where this is the case the underlying target population is stipulated in the Business Rules. Practices should ensure that their coding of such conditions supports this calculation.

## Exception reporting

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

The following criteria have been agreed for exception reporting:

- A. patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- B. patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty
- C. patients newly diagnosed or who have recently registered with the practice who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels
- D. patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- E. patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contraindication or have experienced an adverse reaction
- F. where a patient has not tolerated medication
- G. where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their medical records following a discussion with the patient
- H. where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease
- I. where an investigative service or secondary care service is unavailable.

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

In addition, practices may exception report patients from single indicators, for example a patient who has heart failure due to left ventricular dysfunction (LVD) but who is intolerant of angiotensin converting enzyme inhibitors (ACE inhibitors) could be exception reported. This would again be done by removing the patient from the denominator.

Practices should report the number of exceptions for each indicator set and individual indicator. Practices will not be expected to report why individual patients were exception reported. However, practices may be called on to justify why they have 'excepted' patients from an indicator during verification and this should be identifiable in the clinical record.

Exception reporting guidance can be found at the following location:

[www.pcc.nhs.uk/uploads/QOF/october\\_06/qof212\\_exception\\_reporting\\_guidance\\_final.pdf](http://www.pcc.nhs.uk/uploads/QOF/october_06/qof212_exception_reporting_guidance_final.pdf)

# Section 2. Summary of all indicators

## Clinical domain

### Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Payment stages
<b>Records</b>		
CHD1. The practice can produce a register of patients with coronary heart disease	4	
<b>Ongoing management</b>		
CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	17	40–75%
CHD8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	17	45–70%
CHD9. 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	7	50–90%
CHD10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker	7	40–65%
CHD14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin <i>NICE 2010 menu ID: NM07</i>	10	45–80%
CHD12. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March	7	50–90%

## Cardiovascular disease – primary prevention (PP)

Indicator	Points	Payment stages
<b>Initial diagnosis</b>		
PP1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool <i>NICE 2010 menu ID: NM06</i>	8	40–75%
<b>Ongoing management</b>		
PP2. The percentage of patients diagnosed with hypertension (diagnosed 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%

## Heart failure (HF)

Indicator	Points	Payment stages
<b>Records</b>		
HF1. The practice can produce a register of patients with heart failure	4	
<b>Initial diagnosis</b>		
HF2. The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	50–90%
<b>Ongoing management</b>		
HF3. The percentage of patients with a current diagnosis of heart failure due to left ventricular dysfunction (LVD) who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who can tolerate therapy and for whom there is no contraindication	10	45–80%
HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers	9	40–65%

## Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	45–80%
<b>Ongoing management</b>		
STROKE 6. 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 or less	5	40–75%
STROKE 7. The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 15 months	2	50–90%
STROKE 8. The percentage of patients with stroke or TIA whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	5	40–65%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken	4	50–90%
STROKE 10. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March	2	45–85%

## Hypertension (BP)

Indicator	Points	Payment stages
<b>Records</b>		
BP1. The practice can produce a register of patients with established hypertension	6	
<b>Ongoing management</b>		
BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	8	50–90%
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	55	45–80%

## Diabetes mellitus (DM)

Indicator	Points	Payment stages
<b>Records</b>		
DM32. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed <i>NICE 2011 menu ID: NM41</i>	6	
<b>Ongoing management</b>		
DM2. The percentage of patients with diabetes whose notes record BMI in the preceding 15 months	1	50–90%
DM26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months <i>NICE 2010 menu ID: NM14</i>	17	40–50%
DM27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	45–70%
DM28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10	50–90%
DM21. The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months	5	50–90%
DM29. The percentage of patients with diabetes 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 <i>NICE 2010 menu ID: NM13</i>	4	50–90%
DM10. The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months	3	50–90%
DM30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less <i>NICE 2010 menu ID: NM01</i>	8	45–71%
DM31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less <i>NICE 2010 menu ID: NM02</i>	10	40–65%

DM13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)	3	50–90%
DM22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months	1	50–90%
DM15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	45–80%
DM17. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less	6	40–75%
DM18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	45–85%

## Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Payment stages
<b>Records</b>		
COPD14. The practice can produce a register of patients with COPD	3	
<b>Initial diagnosis</b>		
COPD15. The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	45–80%
<b>Ongoing management</b>		
COPD10. The percentage of patients with COPD with a record of FEV <sub>1</sub> in the preceding 15 months	7	40–75%
COPD13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50–90%
COPD8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	45–85%

## Epilepsy

Indicator	Points	Payment stages
<b>Records</b>		
EPILEPSY 5. The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy	1	
<b>Ongoing management</b>		
EPILEPSY 6. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months	4	50–90%
EPILEPSY 8. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	6	45–70%
EPILEPSY 9. The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months <i>NICE 2010 menu ID: NM03</i>	3	50–90%

## Hypothyroidism

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
<b>Ongoing management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months	6	50–90%

## Cancer

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

<b>Ongoing management</b>		
CANCER 3. The percentage of patients with cancer, diagnosed within the preceding 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	50–90%

## Palliative care (PC)

Indicator	Points	Payment stages
<b>Records</b>		
PC3. The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
<b>Ongoing management</b>		
PC2. The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	

## Mental health (MH)

Indicator	Points	Payment stages
<b>Records</b>		
MH8. The practice can produce a register of patients with schizophrenia, bipolar affective disorder and other psychoses	4	
<b>Ongoing management</b>		
MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months <i>NICE 2010 menu ID: NM15</i>	4	50–90%
MH12. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months <i>NICE 2010 menu ID: NM16</i>	4	50–90%
MH13. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months <i>NICE 2010 menu ID: NM17</i>	4	50–90%

MH19. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months <i>NICE 2010 menu ID: NM18</i>	5	45–80%
MH20. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months <i>NICE 2011 menu ID: NM42</i>	5	45–80%
MH16. The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years <i>NICE 2010 menu ID: NM20</i>	5	45–80%
MH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months <i>NICE 2010 menu ID: NM21</i>	1	50–90%
MH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months <i>NICE 2010 menu ID: NM22</i>	2	50–90%
MH10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	30–55%

## Asthma

Indicator	Points	Payment stages
<b>Records</b>		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
<b>Initial management</b>		
ASTHMA 8. The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	45–80%

<b>Ongoing management</b>		
ASTHMA 10. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months	6	45–80%
ASTHMA 9. The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions <i>NICE 2011 menu ID: NM23</i>	20	45–70%

## Dementia (DEM)

Indicator	Points	Payment stages
<b>Records</b>		
DEM1. The practice can produce a register of patients diagnosed with dementia	5	
<b>Ongoing management</b>		
DEM2. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	15	35–70%
DEM4. The percentage of patients with a new diagnosis of dementia recorded between 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 6 months before or after entering on to the register <i>NICE 2010 menu ID: NM09</i>	6	45–80%

## Depression (DEP)

Indicator	Points	Payment stages
<b>Diagnosis and initial management</b>		
DEP1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on 1 occasion during the preceding 15 months using two standard screening questions	6	50–90%
DEP6. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care <i>NICE 2010 menu ID: NM10</i>	17	50–90%

DEP7. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care  <i>NICE 2010 menu ID: NM11</i>	8	45–80%
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## Chronic kidney disease (CKD)

Indicator	Points	Payment stages
<b>Records</b>		
CKD1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
<b>Initial management</b>		
CKD2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months	4	50–90%
<b>Ongoing management</b>		
CKD3. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less	11	45–70%
CKD5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB)	9	45–80%
CKD6. 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	6	45–80%

## Atrial fibrillation (AF)

Indicator	Points	Payment stages
<b>Records</b>		
AF1. The practice can produce a register of patients with atrial fibrillation	5	

<b>Ongoing management</b>		
AF5. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS <sub>2</sub> risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS <sub>2</sub> score is greater than 1) <i>NICE 2011 menu ID: NM24</i>	10	40-90%
AF6. In those patients with atrial fibrillation in whom there is a record of a CHADS <sub>2</sub> score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy <i>NICE 2011 menu ID: NM45</i>	6	50-90%
AF7. In those patients with atrial fibrillation whose latest record of a CHADS <sub>2</sub> score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy <i>NICE 2011 menu ID: NM46</i>	6	40-70%

## Obesity (OB)

<b>Indicator</b>	<b>Points</b>	<b>Payment stages</b>
<b>Records</b>		
OB1. The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months	8	

## Learning disability (LD)

<b>Indicator</b>	<b>Points</b>	<b>Payment stages</b>
<b>Records</b>		
LD1. The practice can produce a register of patients aged 18 years and over with learning disabilities	4	
LD2. The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register) <i>NICE 2010 menu ID: NM04</i>	3	45-70%

## Smoking

Indicator	Points	Payment stages
<b>Ongoing management</b>		
SMOKING 5. 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 <i>NICE 2011 menu ID: NM38</i>	25	50–90%
SMOKING 6. 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 smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months <i>NICE 2011 menu ID: NM39</i>	25	50–90%
SMOKING 7. The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months	11	50-90%
SMOKING 8. The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months <i>NICE 2011 menu ID: NM40</i>	12	40-90%

## Peripheral arterial disease (PAD)

Indicator	Points	Payment stages
<b>Records</b>		
PAD1. The practice can produce a register of patients with peripheral arterial disease <i>NICE 2011 menu ID: NM32</i>	2	
<b>Ongoing management</b>		
PAD2. 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 <i>NICE 2011 menu ID: NM33</i>	2	40-90%

PAD3. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less <i>NICE 2011 menu ID: NM34</i>	2	40-90%
PAD4. The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less <i>NICE 2011 menu ID: NM35</i>	3	40-90%

## Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Payment stages
<b>Records</b>		
OST1. The practice can produce a register of patients: 1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012 <i>NICE 2011 menu ID: NM29</i>	3	
<b>Ongoing management</b>		
OST2. The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent <i>NICE 2011 menu ID: NM30</i>	3	30-60%
OST3. The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent <i>NICE 2011 menu ID: NM31</i>	3	30-60%

## Organisational domain

### Records and information

	Indicator	Points
<b>Records 3</b>	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
<b>Records 8</b>	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
<b>Records 9</b>	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)  Minimum Standard 80%	4
<b>Records 11</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients	10
<b>Records 13</b>	There is a system to alert the out of hours service or duty doctor to patients dying at home	2
<b>Records 15</b>	The practice has up to date clinical summaries in at least 60% of patient records	25
<b>Records 17</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients	5
<b>Records 18</b>	The practice has up to date clinical summaries in at least 80% of patient records	8
<b>Records 19</b>	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
<b>Records 20</b>	The practice has up to date clinical summaries in at least 70% of patient records	12

### Information for patients

	Indicator	Points
<b>Information 5</b>	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2

## Education and training

	Indicator	Points
<b>Education 11</b>	There is a record of all practice-employed clinical staff and clinical partners having attended training/updating in basic life support skills in the preceding 18 months	4
<b>Education 5</b>	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
<b>Education 6</b>	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
<b>Education 7</b>	<p>The practice has undertaken a minimum of 12 significant event reviews in the preceding 3 years which could include:</p> <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• New cancer diagnoses</li> <li>• Deaths where terminal care has taken place at home</li> <li>• Any suicides</li> <li>• Admissions under the Mental Health Act</li> <li>• Child protection cases</li> <li>• Medication errors</li> <li>• A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)</li> </ul>	4
<b>Education 8</b>	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5
<b>Education 9</b>	All practice-employed non-clinical team members have an annual appraisal	3
<b>Education 10</b>	The practice has undertaken a minimum of 3 significant event reviews within the preceding year	6

## Practice management

	Indicator	Points
<b>Management 1</b>	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1

<b>Management 2</b>	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used	1
<b>Management 3</b>	The hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance	0.5
<b>Management 5</b>	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed with the PCO	3
<b>Management 7</b>	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> <li>• A defined responsible person</li> <li>• Clear recording</li> <li>• Systematic pre-planned schedules</li> <li>• Reporting of faults</li> </ul>	3
<b>Management 9</b>	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
<b>Management 10</b>	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access	2

## Medicines management

	Indicator	Points
<b>Medicines 2</b>	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
<b>Medicines 3</b>	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
<b>Medicines 4</b>	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)	3
<b>Medicines 6</b>	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
<b>Medicines 8</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)	6

<b>Medicines 10</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	4
<b>Medicines 11</b>	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%	7
<b>Medicines 12</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%	8

## Quality and productivity

	Indicator	Points
<b>QP6</b>	The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5
<b>QP7</b>	The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	5
<b>QP8</b>	The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2013	11
<b>QP9</b>	The practice meets internally to review the data on emergency admissions provided by the PCO	5
<b>QP10</b>	The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	15
<b>QP11</b>	The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2013	27.5
<b>QP12</b>	The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practices is appropriate, in light of the patterns on accident and emergency attendance	7

<b>QP13</b>	The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements to the PCO	9
<b>QP14</b>	The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013	15

## Patient experience domain

Indicator	Points
<p><b>PE1 Length of consultations</b></p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (if the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria</p>	33

## Additional services domain

For practices providing additional services, the following indicators will apply.

### Cervical screening (CS)

	Indicator	Points
<b>CS1</b>	The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical screening test has been performed in the preceding 5 years (Payment stages 45–80%)	11
<b>CS5</b>	The practice has a system for informing all women of the results of cervical smears	2
<b>CS6</b>	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
<b>CS7</b>	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates	7

### Child health surveillance (CHS)

	Indicator	Points
<b>CHS1</b>	Child development checks are offered at intervals that are consistent with national guidelines and policy	6

### Maternity services (MAT)

	Indicator	Points
<b>MAT1</b>	Antenatal care and screening are offered according to current local guidelines	6

### Contraception (SH)

	Indicator	Points
<b>SH1</b>	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS	4

<p><b>SH2</b></p>	<p>The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months (Payment stages 50–90%)</p>	<p>3</p>
<p><b>SH3</b></p>	<p>The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within 1 month of, the prescription (Payment stages 50–90%)</p>	<p>3</p>

# 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 ongoing 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 in a number of the four nations.

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

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

For each indicator, two descriptions are given – ‘rationale’ and ‘reporting and verification’.

### **‘xx.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 electronic version of this guidance) is provided. When available, national guidelines have been used as the main evidence source, individual papers are also quoted.

In some areas, more extensive information is provided. It is difficult to achieve a balance of providing helpful information without providing 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.

In many of the indicators additional time is factored in to the timeframe, either within the wording of the indicator (e.g. BP5) or through the supporting business logic (DEP6). The first recognises that in practice it may be difficult to ensure that all patients have attended for review and have completed the review process within any particular timescale. For example, in relation to indicator BP5, national guidance recommends that all patients with hypertension should have their blood pressure measured every six months. However, the indicator wording looks at the number of patients with hypertension who have had a blood pressure measured in the last nine months. The second recognises that QOF activity can span more than one QOF year thereby ensuring fair and consistent payments to practices and ensuring that patients who are diagnosed or newly registered within the last three months of the QOF year are identified.

### **‘xx.2 Reporting and verification’**

This section defines the audit information which practices will be required to submit annually.

The term ‘notes’ is used throughout to indicate either electronic or paper patient records.

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. As part of this process, NICE prioritise areas for new indicator development, develop and select indicators for inclusion on the NICE menu of indicators, make recommendations for the retirement of indicators and consult with individuals and stakeholder groups. The recommendations made by NICE are based on current clinical evidence and cost-effectiveness.

The NICE menu of indicators is published in July/August each year and the recommendations are used to inform national contract negotiations between NHS Employers and the GPC on changes to the QOF.

NHS Employers and the GPC use this menu and the associated guidance to agree which indicators should be implemented across the UK and what point value and threshold ranges should apply. The QOF guidance continues to be jointly produced and published by NHS Employers and the GPC and reflects the outcome of these negotiations.

## Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Payment stages
<b>Records</b>		
CHD1. The practice can produce a register of patients with coronary heart disease	4	
<b>Ongoing management</b>		
CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	17	40–75%
CHD8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	17	45–70%
CHD9. 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	7	50–90%
CHD10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker	7	40–65%
CHD14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin <i>NICE 2010 menu ID: NM07</i>	10	45–80%
CHD12. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March	7	50–90%

### CHD – Rationale for inclusion of indicator set

Coronary heart disease (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 in the four nations.

### CHD indicator 1

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

### **CHD 1.1 Rationale**

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

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

### **CHD 1.2 Reporting and verification**

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

Verification - may require a comparison of the expected prevalence with the reported prevalence.

## **CHD indicator 6**

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

### **CHD 6.1 Rationale**

This indicator measures the intermediate health outcome of a blood pressure of 150/90 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 (2011) sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the rationale for the hypertension domain. To summarise, patients with CHD and stage one hypertension are recommended drug therapy for hypertension.

The NICE clinical guideline on Hypertension (2011) recommends a target clinic blood pressure below 140/90 mmHg in patients aged under 80 years with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 years and over, with treated hypertension.

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

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<sup>4</sup>.

Further information

NICE clinical guideline CG127. Hypertension (2011).

<http://guidance.nice.org.uk/CG127>

### **CHD 6.2 Reporting and verification**

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

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<sup>4</sup> Collins et al. Lancet 1990; 335: 827-38

## CHD indicator 8

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

### CHD 8.1 Rationale

This indicator measures the intermediate health outcome of total cholesterol of 5mmol/l or less in patients with established coronary heart disease (CHD). Its intent is to promote the secondary prevention of CHD. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

The NICE clinical guideline CG67 on lipid modification (2007) states that statin therapy is recommended for adults with clinical evidence of CVD (this includes those with CHD). The guideline recommends that the decision whether to initiate statin therapy should be made after an informed discussion between the responsible clinician and the patient about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy. Initiation of therapy should not be delayed by management of modifiable risk factors (e.g. smoking status, blood pressure level). Blood tests and clinical assessment should be performed, and co-morbidities and secondary causes of dyslipidaemia should be treated.

The NICE clinical guideline CG67 (2007) recommends that treatment for the secondary prevention of CVD should be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen.

For patients taking statins for secondary prevention, NICE recommends that clinicians should consider increasing to simvastatin 80 mg or a drug of similar efficacy and acquisition cost if either a total cholesterol of less than 4 mmol/litre or an LDL cholesterol of less than 2 mmol/litre is not attained. Any decision to offer a higher intensity statin should take into account informed preference, co-morbidities, multiple drug therapy, and the benefit and risks of treatment. The guideline developers noted that the use of a target figure can be helpful in guiding increases of lipid lowering drugs as long as it is clear that this figure is intended to guide treatment rather than be a figure patients are expected to achieve.

The NICE clinical guideline (2007) recommends that an 'audit' level of total cholesterol of 5mmol/l should be used to assess progress in populations or groups of people with cardiovascular disease.

The guidance here is given in terms of total cholesterol.

### CHD 8.2 Reporting and verification

The practice reports the percentage of patients on the CHD register who have a record of total cholesterol in the preceding 15 months which is 5mmol/l or less.

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

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

## CHD indicator 9

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

### CHD 9.1 Rationale

Both NICE (2007/2011) and Scottish Intercollegiate Guidelines Network (SIGN) (2007) clinical guidelines recommend that aspirin (75 – 150 mg per day) should be 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. Aspirin should be avoided in patients who are anti-coagulated.

Further information

NICE clinical guideline 48. Secondary prevention in primary and secondary care for patients following a myocardial infarction (2007).

[www.nice.org.uk/CG048](http://www.nice.org.uk/CG048)

NICE clinical guideline 126. Management of stable angina (2011).

[www.nice.org.uk/guidance/CG126](http://www.nice.org.uk/guidance/CG126)

SIGN clinical guideline 96 and 97. Grade A Recommendation.

[www.sign.ac.uk/guidelines/fulltext/96/index.html](http://www.sign.ac.uk/guidelines/fulltext/96/index.html)

[www.sign.ac.uk/guidelines/fulltext/97/index.html](http://www.sign.ac.uk/guidelines/fulltext/97/index.html)

### CHD 9.2 Reporting and verification

The practice reports the percentage of patients on the CHD register who have been prescribed aspirin, clopidogrel or warfarin within the preceding 15 months or have a record of taking over the counter (OTC) aspirin updated in the preceding 15 months.

## CHD indicator 10

The percentage of patients with coronary heart disease who are currently treated with a beta-blocker.

### CHD 10.1 Rationale

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

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

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

SIGN clinical guidelines 96 and 97 (2007). Grade A Recommendation.

NICE clinical guideline 48. Secondary prevention in primary and secondary care for patients following a myocardial infarction (2007).

[www.nice.org.uk/CG048](http://www.nice.org.uk/CG048)

## CHD 10.2 Reporting and verification

The practice reports the percentage of patients on the CHD register who have been prescribed a beta-blocker in the preceding six months.

## CHD indicator 14 (NICE 2010 menu NM07)

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

### CHD 14.1 Rationale

There is evidence from meta-analyses and randomised controlled trials (level 1 evidence) for a range of relevant health outcomes, including mortality, to support all patients who have had an acute myocardial infarction (MI) being offered treatment with a combination of the following drugs:

- ACE (angiotensin converting enzyme) inhibitor (or angiotensin receptor blocker (ARB) if ACE intolerant)
- aspirin
- 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 48<sup>5</sup>.

#### ACE inhibitor (ACE-I)

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

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

#### Aspirin and alternative antiplatelet 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 antiplatelet therapy) have similar cardiovascular benefits.

#### Warfarin

Patients may be treated with anticoagulants when they are intolerant of aspirin and clopidogrel or for the management of co-morbid conditions such as atrial fibrillation and heart failure. Where a patient is treated with anticoagulant therapy, anti-platelet therapy may not be clinically appropriate. For the purpose of this indicator, anticoagulant 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.

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<sup>5</sup> NICE clinical guideline 48: Secondary prevention in primary and secondary care for patients following a myocardial infarction (2007).

## Statins

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

NICE clinical guideline 48 (2007). MI secondary prevention in primary and secondary care for patients following a myocardial infarction.

[www.nice.org.uk/guidance/CG48](http://www.nice.org.uk/guidance/CG48)

NICE technology appraisal 94 (2006). Statins for the prevention of cardiovascular events in patients at increased risk of developing CVD or those with established CVD.

[www.nice.org.uk/guidance/TA94](http://www.nice.org.uk/guidance/TA94)

NICE clinical guideline 67 (2007). Lipid modification.

[www.nice.org.uk/guidance/CG67](http://www.nice.org.uk/guidance/CG67)

## **CHD 14.2 Reporting and verification**

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

- an ACE inhibitor OR (if contraindicated) an ARB; and
- either aspirin OR an alternative anti-platelet or anticoagulant therapy; and
- a beta-blocker; and
- a statin.

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

- a. receiving an ACE AND receiving either aspirin or alternative anti-platelet or anticoagulant therapy AND receiving a beta-blocker AND receiving a statin
- b. the patient is contraindicated for an ACE BUT receiving an ARB AND receiving either aspirin or an alternative anti-platelet or anticoagulant therapy AND receiving a beta-blocker AND receiving a statin.

A patient will not be counted towards the target if they are:

- a. exception reported using one of the nine QOF exception reporting criteria (apart from if they have a contraindication as per b above but receiving the other drugs)
- b. receiving a drug from the last three groups but contraindicated for both an ACE and ARB.

A patient will be included in the denominator if they are:

- a. not appropriately exception coded
- b. not receiving the medicines described above.

The practice reports the percentage of patients who have had a myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet or anticoagulant therapy, beta-blocker and statin.

## CHD indicator 12

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

### **CHD 12.1 Rationale**

This is a current recommendation from the Department of Health (the Scottish Government for Scotland) and the Joint Committee on Vaccination and Immunisation (JCVI).

### **CHD 12.2 Reporting and verification**

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

From April 2012, the FLU\_COD cluster in the Business Rules has been replaced. Practices should note the change and use the new codes for recording purposes.

## Cardiovascular disease – primary prevention (PP)

Indicator	Points	Payment stages
<b>Initial diagnosis</b>		
PP1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool <i>NICE 2010 menu ID: NM06</i>	8	40–75%
<b>Ongoing management</b>		
PP2. The percentage of patients diagnosed with hypertension (diagnosed 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%

### Cardiovascular disease – primary prevention – 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 65 years). Moreover, of greater significance for the NHS, CVD is now the commonest cause of disability (through stroke and heart failure particularly) and hospital admission. This results in CVD being the major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

Primary prevention (PP) works and evidence-based interventions can dramatically reduce risk – in North Karelia which had the highest CVD rates in Europe 25 years ago, CVD mortality has reduced by 50 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, with 68 per cent of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in people without recognised CHD compared to 32 per cent in CHD patients<sup>6</sup>.

### Primary prevention (PP) indicator 1 (NICE 2010 menu NM06)

In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk

<sup>6</sup> Kabir Z., Bennett K., Shelley E., Unal B., Critchley J., Capewell S. *Comparing primary prevention with secondary prevention to explain decreasing Coronary Heart Disease death rates in Ireland, 1985-2000.* BMC Public Health 2007, 7:17

assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool.

### **Primary prevention 1.1 Rationale**

Primary prevention of CVD requires that patients at risk are identified before disease has become established. Risk assessment in those likely to be at high risk of CVD (for example, patients with hypertension) requires the use of a validated assessment tool that scores a range of modifiable and non-modifiable risk factors for CVD.

A number of risk tools can be used to assess cardiovascular risk for the purpose of QOF. These include:

- Framingham
- Joint British Societies' guidelines (JBS 2)
- QRISK
- Assessing cardiovascular risk using SIGN guidelines to assign preventive treatment (ASSIGN - Scotland only).

In February 2010, NICE withdrew its guidance recommending a particular method of CVD risk estimation (Framingham) so that the decision could be left to local NHS organisations to use the method best suited to their requirements. It should be noted that all four risk equations allow for a structured risk assessment to be undertaken.

In order to allow for all four risk assessment tools to be used (they each have different individual age thresholds), an upper and lower age range for this indicator has been set at 30 to 74 years. Practices will be expected to use one of the four age appropriate tools to risk assess their patients even if it is not a tool normally available on the practices clinical system.

Framingham<sup>7</sup> and JBS<sup>8</sup> are based on the American Framingham equations which are of limited use in the UK as they were developed in an historic American population. The Framingham equations overestimate risk by up to 50 per cent in contemporary northern European populations, particularly in people living in more affluent areas. They 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 dataset.

The newer risk scores, QRISK and ASSIGN, have the advantage of including other variables, such as measures of social deprivation, ethnicity and family history. QRISK uses data from UK general practice databases, whereas ASSIGN was developed using a Scottish cohort and has not been validated in a non-Scottish population.

#### **Framingham and JBS2**

The variables required for the estimation of risk using the Framingham risk assessment 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.

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<sup>7</sup> Anderson KM, Odell, PM, Wilson PW et al. (1991) CVD risk profiles. American Heart Journal 121: 293-8. Risk profile only. [www.framinghamheartstudy.org/risk/coronary.html](http://www.framinghamheartstudy.org/risk/coronary.html)

<sup>8</sup> British Cardiac Society. British Hypertension Society. Diabetes UK. HEART UK. Primary Care Cardiovascular Society. Stroke Association (2005). JBS guidelines on prevention of CVD in clinical practice. Heart, 91: 1.52.

JBS2 utilises the Framingham variables with the exception of the presence of left ventricular hypertrophy<sup>9</sup>.

Key to the use of Framingham is that it should be an assessment of actual as opposed to estimated risk. The values used should have been recorded no longer than six months before the date of the risk assessment and prior to any treatment for hypertension. Framingham should not be used in patients with pre-existing CVD (CHD or angina, stroke or TIA, or peripheral arterial disease), diabetes, chronic kidney disease (CKD) where the patient has an estimated glomerular filtration rate (eGFR) rate below 60 and familial hypercholesterolemia. The Framingham risk score is not appropriate for use in patients already taking lipid-lowering medication prior to a new diagnosis of hypertension.

The Framingham risk score can be used in patients aged 35 to 74 years. JBS2 can be used in patients aged 40 years and older.

#### QRISK

The QRISK CVD risk calculator was developed by doctors and academics working in the NHS and is based on routinely collected data from general practitioners (GPs) across the country. The current version of QRISK is QRISK2<sup>10</sup> (see [www.qrisk.org](http://www.qrisk.org)). QRISK2 utilises the following variables to calculate CVD risk: self assigned ethnicity, age, sex, smoking status, systolic blood pressure, total cholesterol, high density lipoprotein cholesterol, body mass index (BMI), family history of CHD in first degree relative under 60 years, Townsend deprivation score, treated hypertension, type 2 diabetes, renal disease, atrial fibrillation, and rheumatoid arthritis.

QRISK2 can be used in patients aged 30 to 84 years.

#### ASSIGN

The ASSIGN cardiovascular risk score<sup>11</sup> was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham-based risk scores for Scottish populations, and continues to be developed<sup>12</sup>. It is available via the internet to practices in Scotland and, like QRISK calculates deprivation-related risk due to postcode. ASSIGN utilises the following variables to calculate CVD risk: age, sex, Scottish Index of Multiple Deprivation (SIMD), family history of CHD and/or stroke, diabetes, smoking status, systolic blood pressure, total cholesterol and high density lipoprotein cholesterol. Scottish practices should use the ASSIGN risk score or the Framingham 1991 10-year risk equations for the purposes of this indicator.

The ASSIGN risk score can be used in patients aged 30 to 74 years.

### **Primary prevention 1.2 Reporting and verification**

The practice reports the number of patients with a new diagnosis of hypertension (excluding those with a pre-existing diagnosis of CHD, diabetes, stroke or TIA) in the preceding 1 April to 31 March and the percentage of these patients aged 30 to 74 years who have had a face to face CVD risk assessment within three months before and after the date of diagnosis using an agreed risk assessment tool.

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<sup>9</sup> NICE clinical guideline 67 (2008). Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. [www.nice.org.uk/guidance/CG67](http://www.nice.org.uk/guidance/CG67)

<sup>10</sup> Hippisley-Cox J, Coupland C, Vinogradova Y et al. (2008) Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2. *BMJ* 336: 1475–82

<sup>11</sup> ASSIGN cardiovascular risk score. [www.assign-score.com](http://www.assign-score.com)

<sup>12</sup> SIGN clinical guideline 97 (2007). Risk estimation and the prevention of CVD. [www.sign.ac.uk/guidelines/fulltext/97](http://www.sign.ac.uk/guidelines/fulltext/97)

The denominator for this indicator is calculated over the preceding 15 months to ensure that patients diagnosed with hypertension in the last three months of the QOF year are included.

This risk equation should not be used for the following groups of people and as such these groups have been excluded from the denominator:

- Coronary heart disease or angina
- Stroke or TIA
- Peripheral vascular disease
- Familial hypercholesterolemia
- Diabetes
- Chronic kidney disease where the patient has an eGFR value of below 60

Verification – may require randomly selecting a number of case records of patients in which a risk assessment has been recorded as taking place to confirm that the key risk factors have been addressed and that biochemical and other clinical data used to inform the risk assessment are up to date. Practices may also be required to demonstrate that an age appropriate risk assessment tools have been used for different patients.

## Primary prevention (PP) indicator 2

The percentage of patients diagnosed with hypertension (diagnosed 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.

### Primary prevention 2.1 Rationale

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

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

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

This advice should be reiterated on an annual basis.

Further information

NICE public health guidance 10 (2008): Smoking cessation services in primary care, pharmacies, local authorities and NICE. <http://guidance.nice.org.uk/PH10/Guidance/pdf/English>

NHS Health Scotland (2010). A guide to smoking cessation in Scotland. <http://www.healthscotland.com/documents/4661.aspx>

NICE public health guidance 6 (2007). Behaviour change at population, community and individual levels. <http://guidance.nice.org.uk/PH6/Guidance/pdf/English>

NICE public health guidance 25 (2010). Prevention of cardiovascular disease. <http://guidance.nice.org.uk/PH25/Guidance/pdf/English>

NICE public health guidance 24 (2010). Alcohol use disorders - preventing harmful drinking. <http://guidance.nice.org.uk/PH24/Guidance/pdf/English>

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

Scottish Government (2009). Changing Scotland's Relationship with Alcohol: A Framework for Action. <http://www.scotland.gov.uk/Publications/2009/03/04144703/0>

Scottish Government (2010). Preventing Overweight and Obesity in Scotland: A Route Map towards Healthy Weight. <http://www.scotland.gov.uk/Publications/2010/02/17140721/0>

Scottish Government (2008). Diet and physical activity. Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity. <http://www.scotland.gov.uk/Publications/2008/06/20155902/10>

NICE public health guidance 2 (2006). Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. <http://guidance.nice.org.uk/PH2/Guidance/pdf/English>

NICE clinical guideline 67 (2008). Management of lifestyle factors can be found in Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of CVD. <http://guidance.nice.org.uk/CG67/NICEGuidance/pdf/English>

### **Primary prevention 2.2 Reporting and verification**

The practice reports the percentage of patients diagnosed with hypertension on or after 1 April 2009 who have been given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

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

# Heart failure (HF)

Indicator	Points	Payment stages
<b>Records</b>		
HF1. The practice can produce a register of patients with heart failure	4	
<b>Initial diagnosis</b>		
HF2. The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	50–90%
<b>Ongoing management</b>		
HF3. The percentage of patients with a current diagnosis of heart failure due to left ventricular dysfunction (LVD) who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who can tolerate therapy and for whom there is no contraindication	10	45–80%
HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers	9	40–65%

## Heart failure – rationale for inclusion of indicator set

Heart Failure (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 heart failure unless specified otherwise.

### Heart failure (HF) indicator 1

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

#### Heart failure 1.1 Rationale

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

#### Heart failure 1.2 Reporting and verification

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

### Heart failure (HF) indicator 2

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

### **Heart failure 2.1 Rationale**

This indicator requires that all patients with suspected heart failure should be investigated<sup>13</sup> 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 heart failure need referral for echocardiography and their use is recommended as below. Specialists may include GPs identified by their PCO as having a special clinical interest in heart failure. Many heart failure patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintigraphy or angiography rather than echocardiography.

Current NICE guidance (2010/2011) recommends that patients with suspected heart failure should receive both echocardiography and specialist assessment. Serum natriuretic peptides should be measured in patients with suspected heart failure without previous MI. Patients with suspected heart failure 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. Current SIGN guidance (2007) recommends that echocardiography is performed in patients with suspected heart failure who have either a raised serum natriuretic peptide or abnormal electrocardiograph result to confirm the diagnosis and establish the underlying cause.

Further information

<http://guidance.nice.org.uk/CG108/NICEGuidance/pdf/English> (2010)

<http://www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp> (2011)

<http://www.sign.ac.uk/guidelines/fulltext/95/index.html> (2007)

### **Heart failure 2.2 Reporting and verification**

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

## **Heart failure (HF) indicator 3**

The percentage of patients with a current diagnosis of heart failure due to left ventricular dysfunction (LVD) who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who can tolerate therapy and for whom there is no contraindication.

### **Heart failure 3.1 Rationale**

There is strong clinical and cost effectiveness evidence to support the use of ACE inhibitors in all patients with heart failure with LVD. ACE inhibitors improve symptoms, reduce hospitalisation rate, and improve survival rate. This is applicable in all age groups. ARBs are also effective in the treatment of patients with heart failure and LVD but, as recommended below, they should be used only in patients intolerant of ACE inhibitors.

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

Current NICE (2010/2011) and SIGN (2007) guidance recommends that ACE inhibitors should

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<sup>13</sup> Senni et al. *J Am Coll Cardiol*. 1999; 33(1): 164 – 70; NICE clinical guideline 5 (2003).

be used as first-line therapy in all patients with heart failure due to left ventricular systolic dysfunction and that ARBs are used in patients who are intolerant of ACE inhibitors.

Further information

<http://guidance.nice.org.uk/CG108/NICEGuidance/pdf/English> (2010)

<http://www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp> (2011)

<http://www.sign.ac.uk/guidelines/fulltext/95/index.html> (2007)

### **Heart failure 3.2 Reporting and verification**

The practice reports the number of patients on their heart failure register with heart failure due to LVD.

The practice reports the percentage of these patients whose records show they have been prescribed an ACE inhibitor or an ARB in the preceding six months.

## **Heart failure (HF) indicator 4**

The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or angiotensin receptor blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

### **Heart failure 4.1 Rationale**

The evidence base for treating heart failure due to LVD with beta-blockers<sup>14,15</sup> is at least as strong as the evidence base guiding the HF3 indicator on ACE inhibitors (Level 1a), with a 34 per cent reduction in major endpoints of beta-blockers on top of ACE inhibitors compared to placebo, and is a standard recommendation in all heart failure guidelines including NICE. The belief that beta-blockers are contraindicated in heart failure was disproved, at least for the licensed beta-blockers, in the late 1990s and in some countries (especially Scandinavia) beta-blockers have never been contraindicated in heart failure. Furthermore, there are no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised patients over 75 years with significant benefits and no safety signal) and there are no contraindications for use in patients with chronic obstructive pulmonary disease (COPD).

However, this strategy is more difficult in clinical practice than initiating ACE (more contraindications, less tolerated, with a need for slower but more dose titration steps). Furthermore, there are negative trials of beta-blockers in heart failure<sup>16</sup> and concerns over the effectiveness of atenolol in reducing vascular risk generally. Therefore the beta-blocker used should be one licensed for heart failure, which is also in line with NICE recommendations. The only such agents in the UK are carvedilol, bisoprolol and nebivolol.

Practices should be aware that patients already prescribed an unlicensed beta-blocker prior to diagnosis of heart failure due to LVD should not have their drug therapy changed to meet the

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<sup>14</sup> Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrandt P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J; MERIT-HF Study Group. Efficacy, safety and tolerability of metoprolol CR/XL in patients with diabetes and chronic heart failure: experiences from MERIT-HF. *Am Heart J.* 2005; 49 (1):159-67.

<sup>15</sup> CIBIS-II Investigators and Committees. The Cardiac Insufficiency Bisoprolol Study II. *Lancet* 1999; 353: 9-13.

<sup>16</sup> Anderson JL, Krause-Steinrauf H, Goldman S, Clemson BS, Domanski MJ, Hager WD, Murray DR, Mann DL, Massie BM, McNamara DM, Oren R, Rogers WJ; Beta-Blocker Evaluation of Survival Trial (BEST) Investigators. Failure of benefit and early hazard of bucindolol for Class IV heart failure. *J Card Fail.* 2003; 9 (4): 266-77

criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded from the achievement calculator.

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

The British National Formulary (BNF) states that "the beta-blockers bisoprolol and carvedilol are of value in any grade of stable heart failure and left ventricular systolic dysfunction; nebivolol is licensed for stable mild to moderate heart failure in patients over 70 years. Beta-blocker treatment should be started by those experienced in the management of heart failure, at a very low dose and titrated very slowly over a period of weeks or months. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy"<sup>17</sup>.

Current NICE (2010/2011) and SIGN (2007) guidance recommends that beta-blockers licensed for heart failure are used as first line therapy in all patients with heart failure due to left ventricular systolic dysfunction. NICE (2010) makes it clear that beta-blockers should be used in patients with defined co-morbidities such as older adults and those with peripheral vascular disease, erectile dysfunction, diabetes mellitus, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contraindication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

Further information

<http://guidance.nice.org.uk/CG108/NICEGuidance/pdf/English> (2010)

<http://www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp> (2011)

<http://www.sign.ac.uk/guidelines/fulltext/95/index.html>

#### **Heart failure 4.2 Reporting and verification**

The practice reports the percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or ARB, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

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<sup>17</sup><http://bnf.org/bnf/bnf/current/119651.htm> (password protected site)

# Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	45–80%
<b>Ongoing management</b>		
STROKE 6. 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 or less	5	40–75%
STROKE 7. The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 15 months	2	50–90%
STROKE 8. The percentage of patients with stroke or TIA whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	5	40–65%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken	4	50–90%
STROKE 10. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 September to 31 March	2	45–85%

## Stroke/TIA - rationale for inclusion of indicator set

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

### Stroke indicator 1

The practice can produce a register of patients with stroke or TIA.

#### Stroke 1.1 Rationale

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

For patients diagnosed prior to April 2003 it is accepted that various diagnostic criteria may have been used. For this reason the presence of the diagnosis of stroke or TIA in the records will be acceptable. Generally patients with a diagnosis of transient global amnesia or vertebro-basilar insufficiency should not be included in the retrospective register. However, practices

may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.

As with other conditions, it is up to the practice to decide, on clinical grounds, when to include a patient, e.g. when a 'dizzy spell' becomes a TIA. Medical records coded with 'Amaurosis fugax' but without a code for TIA are excluded from the register.

### **Stroke 1.2 Reporting and verification**

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

Verification - may require a comparison of the expected prevalence with the reported prevalence.

## **Stroke indicator 13**

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

### **Stroke 13.1 Rationale**

The original indicator, Stroke 2 suggested that patients needed to be referred for confirmation of the diagnosis by CT or MRI scan. However, specialist investigations are often only accessible by a referral to secondary care services and therefore this indicator has been changed to reflect referral activity rather than confirmation by specific scanning investigations.

The National Audit Office (NAO) Report<sup>18</sup> highlights that UK national guidelines recommend that all patients with suspected TIA should be assessed and investigated within seven days, but notes that only a third of 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.

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

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

### **Stroke 13.2 Reporting and verification**

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

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of records of patients with stroke or TIA diagnosed after 1 April 2008 to look at the proportion referred for further investigation

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<sup>18</sup> National Audit Office report. The Stationary Office (2005). Reducing brain damage: faster access to better stroke care. [http://www.nao.org.uk/publications/0506/reducing\\_brain\\_damage.aspx](http://www.nao.org.uk/publications/0506/reducing_brain_damage.aspx)

- inspection of a sample of records of patients for whom a record of investigations such as CT or MRI scan is claimed, to see if there is evidence of this in the medical records.

## Stroke indicator 6

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 or less.

### Stroke 6.1 Rationale

This indicator measures the intermediate health outcome of a blood pressure of 150/90 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 35 - 40 per cent less stroke over five years<sup>19</sup>. The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in patients with prior stroke or TIA<sup>20</sup>.

The NICE clinical guideline on Hypertension (2011) sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the rationale for the hypertension domain. To summarise, all patients aged under 80 years with CVD and 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) are recommended drug therapy for hypertension.

The SIGN clinical guideline (2008) recommends that patients who have had a stroke or TIA and have hypertension should be treated to less than 140/85 mm Hg.

The NICE clinical guideline on Hypertension (2011) recommends a target clinic blood pressure below 140/90 mmHg in patients aged under 80 years with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 years and over, with treated hypertension.

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

Further information

SIGN guideline 108 (2008). The Management of patients with stroke or TIA.  
<http://www.sign.ac.uk/guidelines/fulltext/108/index.html>

RCP Stroke Guideline (2008).  
<http://bookshop.rcplondon.ac.uk/details.aspx?e=250>

NICE clinical guideline CG127 (2011). Hypertension.  
<http://guidance.nice.org.uk/CG127>

### Stroke 6.2 Reporting and verification

The practice reports the percentage of patients on the stroke or TIA register whose last recorded blood pressure was 150/90 or less. This blood pressure reading should have been taken in the preceding 15 months.

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<sup>19</sup> Collins et al. *Lancet* 1990; 335: 827-38

<sup>20</sup> PROGRESS Collaborative Group, *Lancet* 2001; 358:1033-41

## Stroke indicator 7

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

### Stroke 7.1 Rationale

The NICE clinical guideline 67<sup>21</sup> on lipid modification recommends statin therapy for patients with clinical evidence of CVD. The guideline recommends that the decision on whether to initiate statin therapy should be made after an informed discussion between the responsible clinician and the patient about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

The NICE clinical guideline (2007) recommends that treatment for the secondary prevention of CVD should be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen.

For patients taking statins for secondary prevention, NICE recommends that clinicians should consider increasing to simvastatin 80 mg or a drug of similar efficacy and acquisition cost if a total cholesterol of less than 4 mmol/litre or an LDL cholesterol of less than 2 mmol/litre is not attained. Any decision to offer a higher intensity statin should take into account informed preference, co-morbidities, multiple drug therapy and the benefit and risks of treatment.

The SIGN clinical guideline 108<sup>22</sup> on the management of patients with stroke or TIA, states that statin therapy after haemorrhagic stroke is not routinely recommended unless the risk of further vascular events outweighs the risk of further haemorrhage.

The Royal College of Physicians' (RCP) stroke guideline states that treatment with statin therapy should be avoided or used with caution (if required for other indications) in individuals with a history of haemorrhagic stroke, particularly those with inadequately controlled hypertension.

### Stroke 7.2 Reporting and verification

The practice reports the percentage of patients on the stroke or TIA register who have a record of total cholesterol in the preceding 15 months.

In verifying that this information has been correctly recorded, an inspection of the output from a computer search that has been used to provide information on this indicator could be used.

## Stroke indicator 8

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

### Stroke 8.1 Rationale

See Stroke 7.

This indicator measures the intermediate health outcome of total cholesterol of 5mmol/l or less in patients with established stroke or TIA (cerebrovascular disease, one of the main causes of CVD). Its intent is to promote the secondary prevention of CVD. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

The cholesterol level set by this indicator is consistent with that recommended by NICE.

<sup>21</sup> NICE clinical guideline 67 (2010). <http://www.nice.org.uk/nicemedia/live/11982/40689/40689.pdf>

<sup>22</sup> SIGN clinical guideline 108 (2008) <http://www.sign.ac.uk/guidelines/fulltext/108/index.html>

NICE clinical guideline 67 on lipid modification recommends that an 'audit' level of total cholesterol of 5mmol/l should be used to assess progress in populations or groups of people with cardiovascular disease.

### **Stroke 8.2 Reporting and verification**

The practice reports the percentage of patients on the stroke or TIA register that have a record of total cholesterol in the preceding 15 months which is 5mmol/l or less.

In verifying that this information has been correctly recorded, an inspection of the output from a computer search that has been used to provide information on this indicator could be used.

## **Stroke indicator 12**

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

### **Stroke 12.1 Rationale**

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

The British National Formulary (62) makes the following treatment 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 contraindicated, 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 atrial fibrillation - see below), clopidogrel 75 mg once daily is recommended as long-term treatment. 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, then aspirin alone is recommended.

Patients with stroke associated with atrial fibrillation should be reviewed for long-term treatment with warfarin or an alternative anti-coagulant (see management of atrial fibrillation indicator).

Further information

The British National Formulary (62).

<http://bnf.org/bnf/index.htm>

NICE technology appraisal guidance 210. Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events (review of technology appraisal guidance 90) (2010).

[www.nice.org.uk/guidance/TA210](http://www.nice.org.uk/guidance/TA210)

### **Stroke 12.2 Reporting and verification**

The practice reports the percentage of patients with non-haemorrhagic stroke or TIA who have a record in the preceding 15 months of prescribed aspirin, clopidogrel, dipyridamole MR or warfarin, or of taking over the counter aspirin updated in the preceding 15 months.

## **Stroke indicator 10**

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

### **Stroke 10.1 Rationale**

While there have been no randomised controlled trials (RCTs) looking at the impact of flu vaccination specifically in patients with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke<sup>23</sup>.

### **Stroke 10.2 Reporting and verification**

The practice reports the percentage of patients on the stroke or TIA register who have had an influenza vaccination administered in the preceding 1 September to 31 March.

From April 2012, the FLU\_COD cluster in the Business Rules has been replaced. Practices should note the change and use the new codes for recording purposes.

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<sup>23</sup> Lavallee et al. *Stroke* 2002; 33: 513-518; Nichol et al. *NEJM* 2003; 348:1322-32

# Hypertension (BP)

Indicator	Points	Payment stages
<b>Records</b>		
BP1. The practice can produce a register of patients with established hypertension	6	
<b>Ongoing management</b>		
BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	8	50–90%
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	55	45–80%

## Hypertension – rationale for inclusion of indicator set

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

## Hypertension (BP) indicator 1

The practice can produce a register of patients with established hypertension.

### BP 1.1 Rationale

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

The NICE clinical guideline on Hypertension (CG127) 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 on three separate occasions have generally been used to confirm sustained high blood pressure. However, the recently updated NICE clinical guideline on Hypertension now recommends the use of ambulatory blood pressure monitoring (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 significant change in practice and may take time to be integrated into routine clinical practice.

For patients aged under 40 years with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes, the NICE guideline recommends 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 clinical guideline 127 (2011). Hypertension. Management of hypertension in adults in primary care.

<http://guidance.nice.org.uk/CG127>

NICE public health guidance 25 (2010). Prevention of CVD.

<http://guidance.nice.org.uk/PH25/Guidance/pdf/English>

### **BP 1.2 Reporting and verification**

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

Verification – may require a comparison of the expected prevalence with the reported prevalence. PCOs may wish to discuss with practices their plans for ensuring that new diagnoses are confirmed using ABPM or HBPM as appropriate.

## **Hypertension (BP) indicator 4**

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

### **BP 4.1 Rationale**

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

For the purposes of the contract it is assumed that blood pressure monitoring in people with hypertension will be undertaken at least six monthly with the audit standard being set at nine months.

### **BP 4.2 Reporting and verification**

The practice reports the percentage of patients on their hypertension register who have had a blood pressure measurement recorded in the preceding 9 months.

## **Hypertension (BP) indicator 5**

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

### **BP 5.1 Rationale**

This indicator measures the intermediate health outcome of a blood pressure of 150/90 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 (CG 127) on Hypertension recommends drug therapy in patients who are aged under 80 years with **stage 1** hypertension who have one or more of the following:

- target organ damage
- established cardiovascular disease
- renal disease
- diabetes
- a 10-year cardiovascular risk equivalent to 20 per cent or greater.

The NICE guideline recommends that antihypertensive drug treatment for patients of any age with **stage 2** hypertension.

For patients aged under 40 years with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes, the NICE guideline recommends that general 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.

The frequency of follow up for treated patients after adequate blood pressure control is attained depends upon factors such as the severity of the hypertension, variability of blood pressure, complexity of the treatment regime, patient compliance and the need for non-pharmacological advice. For the purposes of the contract it is assumed that repeat blood pressure measurements will be undertaken at least six monthly with the audit standard being set at nine months.

The NICE clinical guideline on Hypertension recommends that patients with hypertension should have their care reviewed annually to monitor blood pressure, provide support and discuss lifestyle, symptoms and medication.

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

For the purpose of QOF an audit standard of 150/90 has been adopted. For patients with diabetes mellitus, see indicators DM30 and DM31. For patients with chronic kidney disease, see indicator CKD3.

Further information

NICE clinical guideline 127 (2011). Hypertension: management of hypertension in adults in primary care.

<http://guidance.nice.org.uk/CG127>

NICE public health guidance 25 (2010). Prevention of CVD.

<http://guidance.nice.org.uk/PH25/Guidance/pdf/English>

### **BP 5.2 Reporting and verification**

The practice reports the percentage of patients on their hypertension register whose last recorded blood pressure is 150/90 or less. This blood pressure reading must have been measured in the preceding nine months.

## Diabetes mellitus (DM)

Indicator	Points	Payment stages
<b>Records</b>		
DM32. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed <i>NICE 2011 menu ID: NM41</i>	6	
<b>Ongoing management</b>		
DM2. The percentage of patients with diabetes whose notes record BMI in the preceding 15 months	1	50–90%
DM26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol or less in the preceding 15 months <i>NICE 2010 menu ID: NM14</i>	17	40–50%
DM27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64mmol/mol or less in the preceding 15 months	8	45–70%
DM28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 15 months	10	50–90%
DM21. The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months	5	50–90%
DM29. The percentage of patients with diabetes 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 <i>NICE 2010 menu ID: NM13</i>	4	50–90%
DM10. The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months	3	50–90%
DM30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less <i>NICE 2010 menu ID: NM01</i>	8	45–71%
DM31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less <i>NICE 2010 menu ID: NM02</i>	10	40–65%

DM13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)	3	50–90%
DM22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months	1	50–90%
DM15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	45–80%
DM17. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less	6	40–75%
DM18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	45–85%

## Diabetes – rationale for inclusion of indicator set

Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the 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<sup>24</sup> 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

NICE clinical guideline 10 (2004). Type 2 Diabetes – Footcare.  
<http://guidance.nice.org.uk/CG10/NICEGuidance/pdf/English>

NICE clinical guideline 87 (2010). Type 2 diabetes: The management of type 2 diabetes.  
<http://guidance.nice.org.uk/CG87>

NICE clinical guideline 15 (2004). Type 1 Diabetes.  
<http://guidance.nice.org.uk/CG15>

SIGN clinical guideline 116 (2010). Management of diabetes.  
<http://www.sign.ac.uk/guidelines/fulltext/116/index.html>

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

<sup>24</sup> [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en)

From April 2012 this set of indicators relates to all types of diabetes where a diagnosis has been confirmed. The type of diabetes should still where possible be recorded. Although the care of patients with Type 1 diabetes may be shared with specialists, the GP would still be expected to ensure that appropriate annual checks had been carried out.

## Diabetes (DM) indicator 32 (NICE 2011 menu NM41)

The practice can produce a register of all patients aged 17 years and over with diabetes mellitus which specifies the type of diabetes where a diagnosis has been confirmed.

### Diabetes 32.1 Rationale

A register of patients with diabetes, which forms the basis of a recall system, is essential to undertake planned systematic care and audit care for patients with diabetes.

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<sup>25</sup>. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes (see [www.diabetes.nhs.uk](http://www.diabetes.nhs.uk)). Following publication of this report, the QOF diabetes register indicator has been expanded to include all types of diabetes within the proposed algorithm. Gestational diabetes will continue to be excluded from this indicator set.

If it is too early in the clinical course to diagnose the specific type of diabetes, or if the specific diagnosis is uncertain, practices are asked to code diabetes using the parent term 'Diabetes Mellitus'. Practices are expected to update these patient's records when their specific type of diabetes is confirmed. This should generally be within 6-12 months of the initial diagnosis of Diabetes Mellitus.

The QOF indicator does not specify how the diagnosis of diabetes should be 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. Practices are therefore encouraged to adopt a systematic approach to the diagnosis of diabetes.

The World Health Organisation (WHO) 2006<sup>26</sup> states that fasting plasma glucose  $\geq 7.0$ mmol/l (126mg/dl) or 2-h plasma glucose  $\geq 11.1$ mmol/l (200mg/dl) should be used as criteria for diagnosing diabetes.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of HbA1c in diagnosing diabetes mellitus<sup>27</sup>. 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

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<sup>25</sup> The Royal College of General Practitioners and NHS diabetes (2011) Coding, Classification and Diagnosis of Diabetes. Available from [www.diabetes.nhs.uk/our\\_work\\_areas/classification\\_of\\_diabetes/www.diabetes.nhs.uk](http://www.diabetes.nhs.uk/our_work_areas/classification_of_diabetes/www.diabetes.nhs.uk)

<sup>26</sup> World Health Organisation (2006) Definition and diagnosis of diabetes mellitus and intermediate hyperglycaemia. Available from [www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes\\_new.pdf](http://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf)

<sup>27</sup> World Health Organisation (2011) Use of glycosylated haemoglobin (HbA1c) in the diagnosis of diabetes mellitus. Abbreviated report of a WHO consultation. Available from [www.who.int/diabetes/publications/report-hba1c\\_2011.pdf](http://www.who.int/diabetes/publications/report-hba1c_2011.pdf)

international reference values, and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5%)<sup>28</sup> is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5%) 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%).

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 should not be 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 OGTT.

### **Diabetes 32.2 Reporting and verification**

The practice separately reports the numbers of patients on their diabetes register (aged 17 years and over) with diabetes and the numbers of patients with each type of diabetes i.e. Type 1, Type 2, genetic, other and uncertain.

Verification – may require randomly selecting a number of case records of patients coded with the parent term 'diabetes mellitus' and requesting information about how long the specific diagnosis has been unknown. Practices are expected to demonstrate that they have processes in place to ensure that patient records are updated once a specific diagnosis has been made. This should normally occur within 6-12 months of the initial diagnosis.

## **Diabetes (DM) indicator 2**

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

### **Diabetes 2.1 Rationale**

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

### **Diabetes 2.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register who have had a BMI recorded in the preceding 15 months.

## **Diabetes (DM) indicator 26 (NICE 2010 menu NM14)**

The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol or less in the preceding 15 months.

### **Diabetes 26.1 Rationale**

The three target levels for HbA1c (59, 64 and 75 mmol/mol) in the 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. Also practitioners should note that in the 2009 guideline for Type 2 diabetes, NICE advises against pursuing highly intensive management to levels below 48mmol/mol in certain patient subgroups<sup>29</sup>.

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<sup>28</sup> 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

<sup>29</sup> NICE clinical guideline 87 (2009). Type 2 diabetes: the management of type 2 diabetes.  
[www.nice.org.uk/guidance/CG87](http://www.nice.org.uk/guidance/CG87)

There is a near linear relationship between glycaemic control and death rate in patients with type 2 diabetes<sup>30</sup>. 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 suggest that, as with blood pressure and cholesterol, over the longer term at least, the lower the HbA1c the better<sup>31</sup>.

However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial has highlighted the risks of adopting an aggressive treatment strategy for patients at risk of cardiovascular disease. 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<sup>32</sup>. However, a recent meta-analysis did not confirm such an increase in risk<sup>33</sup> and reassuringly, the ADVANCE study<sup>34</sup> and the Veteran Affairs Diabetes Trial<sup>35</sup> 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<sup>36</sup>.

A newly published retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim<sup>37</sup>. 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 59mmol/l, 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%; median = 6.4%). 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 the management of 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 person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.
- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.
- When setting a target glycated haemoglobin (HbA1c):
  1. involve the person 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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<sup>30</sup> Khaw KT, Wareham N, Luben R et al. (2001) Glycated haemoglobin, diabetes, and mortality in men in Norfolk cohort of European prospective investigation of cancer and nutrition (EPIC-Norfolk). *BMJ*; 322: 15–18 – see also next footnote

<sup>31</sup> Elley CR, Kenealy T, Robinson E et al. (2008) Glycated haemoglobin and cardiovascular outcomes in people with type 2 diabetes: a large prospective cohort study. *Diabetic Medicine*; 25: 1295–1301

<sup>32</sup> Action to Control Cardiovascular Risk in Diabetes Study Group (2008) Effects of intensive glucose lowering in type 2 diabetes. *N Engl J Med*; 358: 2545–59

<sup>33</sup> Ray KK, Seshasai SR, Wijesuriya S et al. (2009) Effect of intensive control of glucose on cardiovascular outcomes and death in patients with diabetes mellitus: a meta-analysis of randomised controlled trials. *Lancet*; 373:1765-72

<sup>34</sup> ADVANCE Collaborative Group (2008) Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. *N Engl J Med*; 358: 2560–72

<sup>35</sup> Duckworth W, Abraira C, Moritz T et al. (2009) Glucose control and vascular complications in veterans with type 2 diabetes. *N Engl J Med*; 360: 129–39

<sup>36</sup> Holman RR, Paul SK, Bethel MA et al. (2008) 10-year follow-up of intensive glucose control in type 2 diabetes. *N Engl J Med*; 359: 1577–89

<sup>37</sup> Currie CJ, Peters JR, Tynan A, et al. (2010) Survival as a function of HbA1c in people with type 2 diabetes: a retrospective cohort study. *The Lancet*; 375: 481–9

2. encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life
3. offer therapy (lifestyle and medication) to help achieve and maintain the HbA1c target level
4. inform a person with a 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 48mmol/mol

The NICE and SIGN clinical guidelines are consistent<sup>38</sup>.

Given that there is strong evidence to support tight glycaemic control in Type 1 diabetes, which is reflected in current NICE and SIGN guidance, the revised 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 cardiovascular disease, those with a history of hypoglycaemia, or those requiring multiple medications or insulin to achieve a NICE suggested target HbA1c of 48mmol/mol.

From June 2009 the way in which HbA1c results are reported in the UK has changed. A standard specific for HbA1c was prepared by the International Federation of Clinical Chemistry and Laboratory Medicine (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 will be reported only as IFCC-HbA1c mmol/mol (see table 1 below).

### **Diabetes 26.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register in which the last HbA1c measurement was 59mmol/mol or less. The test must have been carried out in the preceding 15 months.

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of records of patients with diabetes to look at the proportion with a last recorded HbA1c of 59mmol/mol or less
3. inspection of a sample of records of patients for whom a record of HbA1c of 59mmol/mol or less is claimed, to see if there is evidence of this in the medical records.

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<sup>38</sup> The American Diabetes Association, European Association for the Study of Diabetes, International Federation of Clinical Chemistry and Laboratory Medicine, and the International Diabetes Federation (2007) Consensus Statement on the Worldwide Standardization of the Hemoglobin A1C Measurement. *Diabetes Care*; 30: 2399-2400

**Table 1: IFCC values expressed as mmol/mol**

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

## Diabetes (DM) indicator 27

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

### Diabetes 27.1 Rationale

See DM 26.1.

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

### Diabetes 27.2 Reporting and verification

The practice reports the percentage of patients on the diabetic register in which the last HbA1c measurement was 64mmol/mol or less. The test must have been carried out in the preceding 15 months.

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 64mmol/mol or less
3. inspection of a sample of records of patients for whom a record of HbA1c 64mmol/mol or less is claimed, to see if there is evidence of this in the medical records.

## Diabetes (DM) indicator 28

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

### Diabetes 28.1 Rationale

See DM 26.1

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

### Diabetes 28.2 Reporting and verification

The practice reports the percentage of patients on the diabetic register in which the last HbA1c measurement was 75mmol/mol or less. The test must have been carried out in the preceding 15 months.

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of records of patients with diabetes to look at the proportion with last recorded HbA1c 75 mmol/mol or less
3. inspection of a sample of records of patients for whom a record of HbA1c 75 mmol/mol or less is claimed, to see if there is evidence of this in the medical records.

## Diabetes (DM) indicator 21

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

### Diabetes 21.1 Rationale

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

SIGN clinical guideline 116 (2010). Management of diabetes. Grade B Recommendation.  
<http://www.sign.ac.uk/guidelines/fulltext/116/index.html>

In order to be effective, screening must be carried out by a skilled professional as part of a formal and systematic screening programme to detect sight-threatening diabetic retinopathy. Practices should ensure that the screening received by patients meets national standards (where local services meet those standards) or PCO standards otherwise.

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

### Diabetes 21.2 Reporting and verification

The practice reports the percentage of patients on the diabetic register who have had retinal screening performed in the preceding 15 months. To meet this indicator practices must now demonstrate that patients have received retinal screening to the required standard.

Verification – proof of attendance at an approved retinal screening service may be required.

## Diabetes (DM) indicator 29 (NICE 2010 menu NM13)

The percentage of patients with diabetes 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.

### Diabetes 29.1 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 should include:

- identifying the presence of sensory neuropathy (loss of the 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 guideline on Type 2 diabetes: the prevention and management of foot problems<sup>39</sup> advises that foot risk should be 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 should:

- 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 purpose of QOF the Read codes for 'moderate risk' are used to record the concept of 'increased risk'.

In NHS Scotland, foot risk can be calculated by using the SCI-DC electronic foot risk screening tool which is based on the SIGN clinical guideline 116 foot risk algorithm and as such is recognised as best practice and encouraged for use in Scotland.

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<sup>39</sup> NICE clinical guideline 10 (2004). Type 2 diabetes: prevention and management of foot problems. [www.nice.org.uk/guidance/CG10](http://www.nice.org.uk/guidance/CG10)

### **Diabetes 29.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register who have had a foot examination within the preceding 15 months that classifies the level of risk as follows: 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 or previous ulcer) or 4) ulcerated foot.

## **Diabetes (DM) indicator 10**

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

### **Diabetes 10.1 Rationale**

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

It is very important that correct testing for sensory neuropathy is carried out using the appropriate equipment. The foot inspection and assessment should include identifying the presence of sensory neuropathy (loss of the ability to feel a monofilament, vibration or sharp touch) and/or the abnormal build up of callus.

Both vibration perception threshold measurement using a biothesiometer and sensation threshold measurement using a 10g monofilament accurately predict neuropathic patients at raised risk of ulceration. The 10g monofilament is convenient and easy to use. Longevity and recovery testing suggests that each monofilament will survive usage on approximately ten patients before needing a recovery time of 24 hours (to restore buckling strength) before further use. Identification of neuropathy based on insensitivity to a 10g monofilament is convenient and appears cost-effective.

Further information

NICE clinical guideline 10 (2004). Type 2 diabetes: prevention and management of foot problems. <http://guidance.nice.org.uk/CG10>

SIGN clinical guideline 116 (2010). Management of diabetes, 2010. <http://www.sign.ac.uk/guidelines/fulltext/116/index.html>

### **Diabetes 10.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register with a record of neuropathy testing in the preceding 15 months.

## **Diabetes (DM) indicator 30 (NICE 2010 menu NM01)**

The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less.

### **Diabetes 30.1 Rationale**

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

DM31 sets a target of 140/80 mmHg as per the target recommended by NICE<sup>40</sup> while the target of 150/90 mmHg has been set for those patients who cannot manage this, such as those with retinopathy, microalbuminuria or cerebrovascular disease.

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<sup>40</sup> NICE clinical guideline 87 (2008). Type 2 Diabetes - newer agents (partial update of CG66). [www.nice.org.uk/CG87](http://www.nice.org.uk/CG87)

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.

### **Diabetes 30.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register in which the last blood pressure measurement was 150/90 or less. The blood pressure measurement must have been recorded in the preceding 15 months.

## **Diabetes (DM) indicator 31 (NICE 2010 menu NM02)**

The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less.

### **Diabetes 31.1 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.

### **Diabetes 31.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register in which the last blood pressure measurement was 140/80 or less. The blood pressure measurement must have been recorded in the preceding 15 months.

## **Diabetes (DM) indicator 13**

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

### **Diabetes 13.1 Rationale**

Diabetic patients are at risk of developing nephropathy. Measurements of urinary albumin loss and serum creatinine are the best screening tests for diabetic nephropathy. Urinary microalbuminuria has been identified as an independent risk factor for cardiovascular complications. Its presence is therefore a pointer to the need for more rigorous management of all cardiovascular risk factors. All patients with diabetes should have their urinary albumin concentration and serum creatinine measured at diagnosis and at regular intervals, usually annually.

Further information

SIGN clinical guideline 116 (2010). Management of diabetes.

<http://www.sign.ac.uk/guidelines/fulltext/116/index.html>

NICE clinical guideline 87 (2010). Type 2 Diabetes: The management of Type 2 diabetes.

<http://guidance.nice.org.uk/CG87>

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

### **Diabetes 13.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register who have a record of microalbuminuria testing in the preceding 15 months and the percentage of patients on the diabetic register who have proteinuria who have not therefore been tested for microalbuminuria.

## Diabetes (DM) indicator 22

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

### Diabetes 22.1 Rationale

See DM 13.1

eGFR based on serum creatinine is reported as a better means to detect and monitor early renal disease and has been routinely reported since 2006.

### Diabetes 22.2 Reporting and verification

The practice reports the percentage of patients on the diabetic register who have a record of eGFR or serum creatinine in the preceding 15 months. In verifying that this information has been correctly recorded, a number of approaches could be taken:

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

## Diabetes (DM) indicator 15

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

### Diabetes 15.1 Rationale

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

Patients with a diagnosis of microalbuminuria or proteinuria should be commenced on an ACE inhibitor or considered for A2 antagonist therapy.

Further information

SIGN clinical guideline 116 (2010). Management of diabetes.

<http://www.sign.ac.uk/guidelines/fulltext/116/index.html>

### Diabetes 15.2 Reporting and verification

The practice reports the number of patients with a prescription for ACE inhibitors or A2 antagonist in the preceding six months as a percentage of patients on the diabetic register who have microalbuminuria or proteinuria.

## Diabetes (DM) indicator 17

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

### Diabetes 17.1 Rationale

In patients whose total cholesterol is greater than 5.0mmol/l, statin therapy to reduce cholesterol should be initiated and titrated as necessary to reduce total cholesterol to less than

5mmol/l. There is ongoing debate concerning the intervention levels of serum cholesterol in diabetic patients who do not apparently have CVD.

The age when a statin should be initiated is unclear. It is pragmatically suggested that the prescription of a statin should be considered for all diabetic patients over the age of 40 years, particularly if their cholesterol is greater than 5.0mmol/l. Below the age of 40 years a decision needs to be reached between the doctor and the patient and may involve assessment of other risk factors and the actual age of the patient.

Further information

Heart Protection Study Collaborative Group. MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial<sup>41</sup>.

Mortality from CHD in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction Haffner et al<sup>42</sup>.

SIGN clinical guideline 97 (2007). Risk estimation and the prevention of CVD.

<http://www.sign.ac.uk/guidelines/fulltext/97/index.html>

### **Diabetes 17.2 Reporting and verification**

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

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

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

## **Diabetes (DM) indicator 18**

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

### **Diabetes 18.1 Rationale**

This is a current recommendation from the Department of Health (the Scottish Government for Scotland) and the JCVI.

### **Diabetes 18.2 Reporting and verification**

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

From April 2012, the FLU\_COD cluster in the Business Rules has been replaced. Practices should note the change and use the new codes for recording purposes.

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<sup>41</sup> *Lancet* 2003; 361:2005-2016

<sup>42</sup> *NEJM* 1998; 339: 229-234

# Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Payment stages
<b>Records</b>		
COPD14. The practice can produce a register of patients with COPD	3	
<b>Initial diagnosis</b>		
COPD15. The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	45–80%
<b>Ongoing management</b>		
COPD10. The percentage of patients with COPD with a record of FEV <sub>1</sub> in the preceding 15 months	7	40–75%
COPD13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50–90%
COPD8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	45–85%

## COPD – rationale for inclusion of indicator set

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

The majority of patients with COPD are managed by 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.

## COPD indicator 14

The practice can produce a register of patients with COPD.

### COPD 14.1 Rationale

A register is a prerequisite for monitoring patients with COPD.

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

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

NICE clinical guideline 101 recommended a change to the diagnostic threshold for COPD (see table 2). As this may lead to an increase in the recorded prevalence of COPD, this indicator has been renumbered from April 2011 in recognition of this.

**Table 2: Gradation of severity of airflow obstruction**

		NICE clinical guideline 12 (2004)	ATS/ERS <sup>43</sup> 2004	GOLD 2008 <sup>44</sup>	NICE clinical guideline 101 (2010)
Post-bronchodilator FEV <sub>1</sub> /FVC	FEV <sub>1</sub> % predicted	Severity of airflow obstruction			
			Post-bronchodilator	Post-bronchodilator	Post-bronchodilator
< 0.7	≥ 80%		Mild	Stage 1 – Mild	Stage 1 – Mild*
< 0.7	50–79%	Mild	Moderate	Stage 2 – Moderate	Stage 2 – Moderate
< 0.7	30–49%	Moderate	Severe	Stage 3 – Severe	Stage 3 – Severe
< 0.7	< 30%	Severe	Very severe	Stage 4 – Very severe**	Stage 4 – Very severe**

\*Symptoms should be present to diagnose COPD in patients with mild airflow obstruction (see recommendation 1.1.1.1).

\*\*Or FEV<sub>1</sub> (Forced expiratory volume in one second) < 50% with respiratory failure.

#### **COPD 14.2 Reporting and verification**

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

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

Verification – may require a comparison of the expected prevalence with the reported prevalence.

<sup>43</sup> Celli BR, MacNee W (2004) Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *European Respiratory Journal* 23(6): 932–46.

<sup>44</sup> Global Initiative for Chronic Obstructive Lung Disease (GOLD) (2008). Global strategy for the diagnosis, management, and prevention of COPD.

## COPD indicator 15

The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry.

### COPD 15.1 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.

NICE clinical guidelines provide the following definition of COPD:

- airflow obstruction is defined as a reduced FEV<sub>1</sub>/FVC ratio (where FEV<sub>1</sub> is forced expired volume in one second and FVC is forced vital capacity), such that FEV<sub>1</sub>/FVC is less than 0.7
- if FEV<sub>1</sub> is greater than or equal to 80 per cent predicted normal a diagnosis of COPD should only be made in the presence of respiratory symptoms, for example breathlessness or cough.

The NICE guidelines require 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<sup>45</sup>. Spirometry should be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400mcg salbutamol).

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

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 should be managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FEV<sub>1</sub> of less than 80 per cent of predicted normal as well as an appropriate medical history.

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

The NICE clinical guideline on COPD recommends that all health professionals involved in the care of patients with COPD should 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 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.

Further information

NICE clinical guideline 101 (2010). Chronic obstructive pulmonary disease.

<http://guidance.nice.org.uk/CG101/NICEGuidance/pdf/English>

NICE quality standard on COPD (2011). Chronic obstructive pulmonary disease (COPD) quality standard.

<http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp>

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<sup>45</sup> Johannessen et al. *Thorax* 2005; 60(10): 842-847

From April 2011 the diagnostic codes for this indicator have been updated to include new codes for post bronchodilator spirometry. The previous codes for reversibility testing will no longer be acceptable for QOF purposes.

### **COPD 15.2 Reporting and verification**

The practice reports the percentage of patients diagnosed after 1 April 2011 who are on their COPD register, who have a record that the diagnosis has been confirmed by post bronchodilator spirometry.

For the purposes of the QOF, post bronchodilator spirometry undertaken between three months before and 12 months after a diagnosis of COPD being made would be considered as meeting the requirements of this indicator.

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

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

## **COPD indicator 10**

The percentage of patients with COPD with a record of FEV<sub>1</sub> in the preceding 15 months.

### **COPD 10.1 Rationale**

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

NICE clinical guideline 101 recommends that FEV<sub>1</sub> and inhaler technique should be assessed at least annually for patients with mild/moderate/severe COPD (and in fact at least twice a year for patients with very severe COPD). The purpose of regular monitoring is to identify patients with increasing severity of disease who may benefit from referral for more intensive treatments/diagnostic review.

Further information

NICE clinical guideline 101 – see table 6.

Practices should identify those patients who could benefit from long term oxygen therapy and pulmonary rehabilitation.

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

The long-term administration of oxygen (more than 15 hours per day) to patients with chronic respiratory failure has been shown to increase survival and improve exercise capacity. Referral for consideration for long-term oxygen therapy and/or pulmonary rehabilitation should be made to those with appropriate training and expertise. This may include a respiratory physician, a general physician or a GP with a special interest (GPwSI) in respiratory disease. The

specific clinical criteria for referral for long term oxygen therapy and pulmonary rehabilitation are set out in NICE clinical guideline 101.

### **COPD 10.2 Reporting and verification**

The practice reports the percentage of patients on the COPD register who have had spirometry performed in the preceding 15 months.

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

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

## **COPD indicator 13**

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

### **COPD 13.1 Rationale**

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management should be based on NICE clinical guideline 101 and international The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines in terms of both drug and non-drug therapy.

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

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

A tool such as the Clinical COPD Questionnaire could be used to assess current health status<sup>46</sup>.

Additionally there is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. Where a patient is prescribed an inhaled therapy their technique should be assessed during any review.

The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available under Section 1.1, Diagnosing COPD, in table one of the NICE clinical guideline 101 on COPD.

### **COPD 13.2 Reporting and verification**

The practice reports the percentage of patients on the COPD register who have had a review of their COPD by a healthcare professional which included an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.

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<sup>46</sup> Clinical COPD Questionnaire. <http://www.ccg.nl/>

Verification - may require randomly selecting a number of case records of patients in which the review has been recorded as taking place to confirm that the defined elements are recorded as having been addressed, if applicable.

## **COPD indicator 8**

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

### **COPD 8.1 Rationale**

This is a current recommendation from the Departments of Health (the Scottish Government for Scotland) and the JCVI.

### **COPD 8.2 Reporting and verification**

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

From April 2012, the FLU\_COD cluster in the Business Rules has been replaced. Practices should note the change and use the new codes for recording purposes.

# Epilepsy

Indicator	Points	Payment stages
<b>Records</b>		
EPILEPSY 5. The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy	1	
<b>Ongoing management</b>		
EPILEPSY 6. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months	4	50–90%
EPILEPSY 8. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	6	45–70%
EPILEPSY 9. The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months <i>NICE 2010 menu ID: NM03</i>	3	50–90%

## Epilepsy – rationale for inclusion of indicator set

Epilepsy is the most common serious neurological condition, affecting about five to ten per 1000 of the population at any one time. Few epilepsies are preventable, but appropriate clinical management can enable most patients with epilepsy to lead a full and productive life. For the purposes of the QOF, epilepsy is defined as 'recurrent unprovoked seizures'.

## Epilepsy indicator 5

The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy.

### Epilepsy 5.1 Rationale

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

Patients who have a past history of epilepsy who are not on drug therapy should be excluded from the register. Drugs on repeat prescription will be picked up on search.

It is proposed that the disease register includes patients aged 18 years and over as care for younger patients is generally undertaken outside of primary care.

### **Epilepsy 5.2 Reporting and verification**

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

Verification - may require a comparison of the expected prevalence with the reported prevalence recognising that reported prevalence will be reduced as the register is limited to those patients receiving drug treatment.

## **Epilepsy indicator 6**

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

### **Epilepsy 6.1 Rationale**

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

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

NICE clinical guideline 137 suggests that 'all individuals with epilepsy should have a regular structured review ...in adults this review should be carried out at least yearly by either a generalist or a specialist'.

Good quality structured reviews for patients with epilepsy are recommended and an assessment of seizure frequency should take place via a face-to-face or telephone review. Seizure frequency cannot be established in a satisfactory way solely from a review of the medical records.

Further information

NICE clinical guideline 137 (2012). The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care.

<http://guidance.nice.org.uk/CG137>

SIGN clinical guideline 70 (2003). Diagnosis and management of epilepsy in adults.

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

### **Epilepsy 6.2 Reporting and verification**

The practice reports the percentage of patients on the epilepsy register who have a record of seizure frequency in the preceding 15 months.

Verification - there should be evidence of a consultation with the patient (either face to face or telephone) where seizure frequency was recorded

## **Epilepsy indicator 8**

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

### **Epilepsy 8.1 Rationale**

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

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

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

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

[http://www.epilepsyscotland.org.uk/patient-information/info\\_163.html](http://www.epilepsyscotland.org.uk/patient-information/info_163.html)

### **Epilepsy 8.2 Reporting and verification**

The practice reports the percentage of patients with epilepsy who have been seizure free in the last 12 months, recorded in patients in the preceding 15 months.

## **Epilepsy indicator 9 (NICE 2010 menu NM03)**

The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months.

### **Epilepsy 9.1 Rationale**

It is estimated that in the UK 131,000 women with epilepsy are of child bearing age (12 – 50 years). Approximately 25 per cent of all patients with epilepsy are women of reproductive age and 1 in 200 women attending antenatal clinics are receiving antiepileptic drugs (AEDs)<sup>47</sup>. Around 2500 women with epilepsy will have a baby each year in the UK.

Antiepileptic drugs taken during pregnancy are associated with an increased risk of major congenital malformations (MCMs). Women in the general population have a one to two per cent chance of having a baby with an MCM. Women with epilepsy taking one AED have a chance of having a baby with an MCM of slightly over 3.5 per cent, while for women taking two or more AEDs the average chance increases to 6 per cent<sup>48</sup>. The risk of MCMs occurring can relate to having epilepsy and to taking AEDs while pregnant.

In a survey of women with epilepsy, only 28 per cent of participants aged 19 – 34 years have received information about oral contraception and epilepsy medication<sup>49</sup>. In the same group, 71 per cent said that the risk of epilepsy and/or an AED affecting the unborn child is an important issue. Only 46 per cent of women with epilepsy who have had children had been told before conceiving or during pregnancy that their medication might affect their unborn child.

NICE clinical guideline 20 on epilepsy made the following recommendation as a key priority for implementation:

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<sup>47</sup> Royal Society of Medicine (2004). Primary care guidelines for the management of females with epilepsy. [www.rsm.org.uk/epilepsy\\_web.pdf](http://www.rsm.org.uk/epilepsy_web.pdf)

<sup>48</sup> Morrow J, Russell A, Guthrie E et al. (2006) Malformation risks of antiepileptic drugs in pregnancy: a prospective study from the UK Epilepsy and Pregnancy Register. *Journal of Neurology, Neurosurgery and Psychiatry* 77: 193–8

<sup>49</sup> Crawford P, Hudson S (2003) Understanding the information needs of women with epilepsy at different lifestages: results of the 'Ideal World' survey. *Seizure* 12: 502–7

Women with epilepsy and their partners, as appropriate, must be given accurate information and counseling about contraception, conception, pregnancy, caring for children, breastfeeding and menopause.

SIGN clinical guideline 70 on epilepsy states:

Advice on contraception should be given before young women are sexually active. Women with epilepsy should be advised to plan their pregnancies.

Clinicians should use their judgment as well as the evidence base presented in this guidance to ensure that appropriate advice is given and is tailored to the women's individual needs. Not all three pieces of advice (contraception, conception and pregnancy) need to be given at the same time but may be given separately at any point over the 15 month period.

Advice must be given in the context of a face-to-face consultation.

### **Epilepsy 9.2 Reporting and verification**

The practice reports the percentage of women on the epilepsy register from 18 to 55 years who have been given information and advice in the preceding 15 months for contraception, conception and pregnancy (unless not clinically necessary e.g. post hysterectomy and early menopause).

Practices are required to deliver all three pieces of advice as outlined in this indicator in order for the patient to be included in the target. Where one or more of these elements of advice are not clinically appropriate, for example if the patient is already pregnant, then normal exception reporting rules apply.

Practices should demonstrate how patients are given such advice e.g. provide examples of leaflets and any specific practice protocols. Evidence that the advice has been given in the context of a face-to-face consultation can be demonstrated by a print out or summary of appointment bookings.

# Hypothyroidism

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
<b>Ongoing management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months	6	50–90%

## Hypothyroidism – rationale for inclusion of indicator set

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

There is a clear consensus on how hypothyroidism should be treated. Monitoring of hypothyroidism is almost entirely undertaken in primary care.

## Thyroid indicator 1

The practice can produce a register of patients with hypothyroidism.

### Thyroid 1.1 Rationale

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

### Thyroid 1.2 Reporting and verification

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

Verification – may require a comparison of the expected prevalence with the reported prevalence.

## Thyroid indicator 2

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

### Thyroid 2.1 Rationale

There is no clear evidence on the appropriate frequency of thyroid stimulating hormone (TSH)/T4 measurement. However, the consensus group on thyroid disease recommended an annual

check of TSH/T4 levels in all patients treated with thyroxine. In addition they recommend an annual check in patients previously treated with radio-iodine or partial thyroidectomy<sup>50</sup>.

### **Thyroid 2.2 Rationale**

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

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

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

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<sup>50</sup> Consensus statement for good practice and audit measures in the management of hypothyroidism and hyperthyroidism. *BMJ* 1996; 313: 539-544

# Cancer

Indicator	Points	Payment stages
<b>Records</b>		
CANCER 1. The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'	5	
<b>Ongoing management</b>		
CANCER 3. The percentage of patients with cancer, diagnosed within the preceding 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	50–90%

## Cancer – rationale for inclusion of indicator set

Cancer is a clinical priority in all four countries. It is recognised that the principal active management of cancers occurs in the secondary care setting. General 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 indicator 1

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

### Cancer 1.1 Rationale

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

### Cancer 1.2 Reporting and verification

The practice reports the number of patients added to its cancer register in the preceding 12 months and the number of patients added to its cancer register in the preceding 12 months as a proportion of total list size.

Verification – may require a comparison of the expected prevalence of new cases with the reported prevalence.

## Cancer indicator 3

The percentage of patients with cancer, diagnosed within the preceding 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis.

### Cancer 3.1 Rationale

Most practices will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting.

Whilst the indicator suggests that this should occur within six months of receiving confirmation of the diagnosis, good practice would suggest that a review should occur between three to six months.

A cancer review is an opportunity to cover the following issues:

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

Further information

Better Cancer Care: An Action Plan.

<http://www.scotland.gov.uk/Publications/2008/10/24140351/0>

### **Cancer 3.2 Reporting and verification**

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

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

## Palliative care (PC)

Indicator	Points	Payment stages
<b>Records</b>		
PC3. The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
<b>Ongoing management</b>		
PC2. The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	

### Palliative care – rationale for inclusion of indicator set

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

In Scotland, “Living and Dying Well, a national action plan for palliative and end of life care in Scotland”<sup>51</sup> places great emphasis on the role of primary care in providing palliative care for all patients with such needs, regardless of diagnosis. The action plan uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland.

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

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

The National EOLC Strategy and “Living and Dying Well” suggest that all practices should adopt a systematic approach to end of life care and work to develop measures and markers of good care. They recommend the Gold Standards Framework (GSF) and the associated After Death Analysis (ADA) as examples of good practice. Evidence suggests that over 60 per cent of

<sup>51</sup> Living and Dying Well, a national action plan for palliative and end of life care in Scotland (2008). <http://www.scotland.gov.uk/Publications/2008/10/01091608/0>

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 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 practices to focus on implementing high quality patient-centred care.

<http://www.goldstandardsframework.org.uk/>

## Palliative care (PC) indicator 3

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

### Palliative care 3.1 Rationale

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 of patients have a sudden death. It should be possible therefore 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 over pessimism. However, the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them and anticipating need.

**Identifying** patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. 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<sup>52</sup>.

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

1. Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask themselves 'the surprise question' – 'Would I be surprised if this patient were still alive in 12 months?')
2. They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of GSF website<sup>53</sup>).
3. They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months)

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

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<sup>52</sup> NAO End of Life Care report (November 2008). 'In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month'

<sup>53</sup> <http://www.goldstandardsframework.org.uk/>

### **Palliative care 3.2 Reporting and verification**

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

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

## **Palliative care indicator 2**

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

### **Palliative care 2.1 Rationale**

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

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

Many practices find use of a checklist during the meeting helpful, as it helps to ensure all aspects of care are covered e.g. supportive care register (SCR) templates SCR1 and 2 and the assessment tools on the GSF website.

Scottish practices have access to the Electronic Palliative Care Summary (or equivalent as described in annex D of the Palliative Care DES) that can be used as a template for this indicator.

### **Palliative care 2.2 Reporting and verification**

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

## Mental health (MH)

Indicator	Points	Payment stages
<b>Records</b>		
MH8. The practice can produce a register of patients with schizophrenia, bipolar affective disorder and other psychoses	4	
<b>Ongoing management</b>		
MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months <i>NICE 2010 menu ID: NM15</i>	4	50–90%
MH12. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months <i>NICE 2010 menu ID: NM16</i>	4	50–90%
MH13. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months <i>NICE 2010 menu ID: NM17</i>	4	50–90%
MH19. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months <i>NICE 2010 menu ID: NM18</i>	5	45–80%
MH20. The percentage of patients aged 40 years and older with schizophrenia, bipolar affective disorder and other psychoses who have a record blood glucose or HbA1c in the preceding 15 months <i>NICE 2011 menu ID: NM42</i>	5	45–80
MH16. The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years <i>NICE 2010 menu ID: NM20</i>	5	45–80%

MH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months <i>NICE 2010 menu ID: NM21</i>	1	50–90%
MH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months <i>NICE 2010 menu ID: NM22</i>	2	50–90%
MH10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	30–55%

## Mental health – 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 MH11, MH12, MH13, MH16, M19 and MH20 relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders. Indicators MH17 and MH18 relate to the care of patients who are currently prescribed lithium. Indicator MH8 requires practices to maintain a register of individuals with a diagnosis of serious mental illness (SMI) i.e. schizophrenia, bipolar or other affective disorders. Within the Business Rules there is a second component to the MH register which relates to those who are currently receiving treatment with lithium.

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.

Mental health problems are also included in some of the organisational indicators. These include significant event audits which focus specifically on mental health problems and methods of addressing the needs of carers. This indicator set focuses on patients with serious mental illness. There are separate indicator sets that focus on patients with depression and dementia.

### Mental health indicators MH11, MH12, MH13, MH16, MH19 and MH20

It is recommended that patients should 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 NICE clinical guideline on schizophrenia<sup>54</sup>.

NICE clinical guideline 38 on bipolar disorder<sup>55</sup> recommends that patients with bipolar disorder should have an annual physical health review, normally in primary care, to ensure that the following are assessed each year:

- lipid levels, including cholesterol in all patients over 40 years even if there is no other indication of risk

<sup>54</sup> NICE clinical guideline 82 (2009). Schizophrenia. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. [www.nice.org.uk/guidance/CG82](http://www.nice.org.uk/guidance/CG82)

<sup>55</sup> NICE clinical guideline 38 (2006). Bipolar disorder. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. [www.nice.org.uk/guidance/CG38](http://www.nice.org.uk/guidance/CG38)

- plasma glucose levels
- 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 and dyslipidaemia), which is a predictor of Type 2 diabetes and CHD<sup>56</sup>.

## Mental health (MH) indicator 8

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

### Mental health 8.1 Rationale

The register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses to avoid a generic phrase that is open to variations in interpretation. The notion of regular follow-up is not referenced in the indicator to acknowledge the variation in interpretation of this clause.

### Remission from serious mental illness

Historically, patients have been added to the QOF mental health register for schizophrenia, bipolar affective disorder and other psychoses, but over time it has become apparent that it may 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 judgment. A recent 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<sup>57</sup> is used.

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

Practices may record patients as being in remission. 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 mental health indicators MH11, MH12, MH13, MH16, MH19 and MH20.

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<sup>56</sup> Mackin P, Bishop D, Watkinson H et al. (2007) Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *Br J Psychiatry* 191: 23–9

<sup>57</sup> Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. et al. (2001) Recovery from psychotic illness: A 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178:506-517

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 medical record.

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

### **Mental health 8.2 Reporting and verification**

The practice reports the number of patients on its mental health register for schizophrenia, bipolar affective disorder and other psychoses and the number of patients on its lithium therapy register as a proportion of total list size. This will include both patients with a current condition and those recorded as being in remission.

Verification – may require randomly selecting a number of case records of patients in which a 'remission code' has been recorded and request evidence as to why it was appropriate for that patient to be considered 'in remission'. Practices are expected to have a protocol to guide their clinicians as to how this would work and who would be suitable to make the decision. It would not be appropriate for non clinical members of the practice to make the decision as to when to enter this code. Practices will be expected to demonstrate that patients coded as being in remission have received no anti-psychotic medications, mental health in-patient admissions or mental health secondary or community care for at least five years prior to the entry of the remission code in their record.

## **Mental Health (MH) indicator 11 (NICE 2010 menu 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.

### **Mental health 11.1 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<sup>58</sup>. 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<sup>59, 60</sup>. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse<sup>61</sup>.

### **Mental health 11.2 Reporting and verification**

The practice reports the percentage of patients on its mental health register for schizophrenia, bipolar affective disorder and other psychoses that have a record of alcohol consumption in the preceding 15 months.

## **Mental Health (MH) indicator 12 (NICE 2010 menu NM16)**

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

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<sup>58</sup> Banerjee S, Clancy C, Crome I, editors (2001) Co-existing problems of mental disorder and substance misuse (dual diagnosis). An information manual. London: Royal College of Psychiatrists' Research and Training Unit

<sup>59</sup> Meltzer H, Gill B, Pettigrew M et al. (1996) OPCS Survey of Psychiatric Morbidity in Great Britain. Report 3: Economic activity and social functioning of adults with psychiatric disorders. London: HMSO

<sup>60</sup> Farrell M, Howes S, Taylor C et al. (1998) Substance misuse and psychiatric comorbidity: an overview of the OPCS National Psychiatric Morbidity Survey. *Addictive Behaviors* 23: 909–18

<sup>61</sup> Kessler RC, Rubiow DR, Holmes C et al. (1997) The epidemiology of DSM-III-R bipolar I disorder in a general population survey. *Psychological Medicine* 27: 1079–89

### **Mental health 12.1 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 mellitus. Superimposed on this are lifestyle issues (not all actively chosen) for people with psychosis, generating an escalation of cardiovascular risks<sup>62</sup>.

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<sup>63</sup>. In addition to lifestyle factors, 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, and dyslipidaemia), which is a predictor of Type 2 diabetes and CHD<sup>64</sup>.

Approximately 40 per cent of patients with schizophrenia are obese<sup>65</sup> and obesity is also common in people with bipolar disorders<sup>66</sup>.

NICE clinical guideline 43 (2006). Obesity. The prevention, identification, assessment and management of overweight and obesity in adults and children.

<http://www.nice.org.uk/CG043>

SIGN guideline 115 (2010). Management of obesity.

<http://guidance.nice.org.uk/CG115>

### **Mental health 12.2 Reporting and verification**

The practice reports the percentage of patients on its mental health register for schizophrenia, bipolar affective disorder and other psychoses that have had their BMI calculated in the preceding 15 months.

## **Mental Health (MH) indicator 13 (NICE 2010 menu 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.

### **Mental health 13.1 Rationale**

Patients with schizophrenia have a mortality of 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 the cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population<sup>67</sup>. The NICE clinical guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may

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<sup>62</sup> Heiskanen T, Niskanen L, Lyytikäinen R et al. (2003) Metabolic syndrome in patients with schizophrenia. *J Clin Psychiatry* 64: 575–9

<sup>63</sup> McCreadie R, MacDonald E, Blacklock C et al. (1998) Dietary intake of schizophrenic patients in Nithsdale, Scotland: case-control study. *BMJ* 317: 784–5

<sup>64</sup> Mackin P, Bishop D, Watkinson H et al. (2007) Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *Br J Psychiatr* 191: 23–9

<sup>65</sup> Hennekens C, Hennekens A, D Hollar (2005) Schizophrenia and increased risks of cardiovascular disease. *Am Heart J* 150: 1115–21

<sup>66</sup> Elmsie JL, Silverstone JT, Mann JI et al. (2000) Prevalence of overweight and obesity in bipolar patients. *Journal of Clinical Psychiatry* 61: 179–84

<sup>67</sup> Brown S, Kim M, Mitchell C et al. (2010) 25 year mortality of a community cohort with schizophrenia. *Br J Psychiatr* 196:116–21

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<sup>68</sup>. 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<sup>69</sup>.

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 practices were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups<sup>70</sup>.

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

### **Mental health 13.2 Reporting and verification**

The practice reports the percentage of patients on its mental health register for schizophrenia, bipolar affective disorder and other psychoses that have had their blood pressure measured in the preceding 15 months.

## **Mental Health (MH) indicator 19 (NICE 2010 menu NM18)**

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

### **Mental health 19.1 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<sup>71</sup>. Patients with schizophrenia also have a much higher risk of raised total cholesterol:hdl ratio than the general population<sup>72</sup>.

### **Mental health 19.2 Reporting and verification**

The practice reports the percentage of patients aged 40 years and over on its mental health register for schizophrenia, bipolar affective disorder and other psychoses that have had their total cholesterol:hdl ratio measured in the preceding 15 months.

A new exclusion cluster has been included in the Business Rules from April 2012 for patients with established CVD. The rationale for this is that the intent of the indicator is to help manage CVD risk in patients with SMI without established CVD. If a patient already has CVD, then the cholesterol:HDL ratio test is not required.

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<sup>68</sup> Hennekens C, Hennekens A, Hollar D (2005) Schizophrenia and increased risks of cardiovascular disease. *Am Heart J* 150: 1115-21

<sup>69</sup> Kilbourne AM, Cornelius JR, Han X et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disorder* 6: 368-73

<sup>70</sup> Roberts L, Roalfe A, Wilson S et al. (2007) Physical health care of patients with schizophrenia in primary care: a comparative study. *Fam Pract* 24: 34-40

<sup>71</sup> Kilbourne AM, Cornelius JR, Han X et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disorder* 6: 368-73

<sup>72</sup> Oud M, Meyboom-de Jong B (2009) Somatic diseases in patients with schizophrenia in general practice: their prevalence and health care. *BMC Family Practice* 10: 32

## Mental Health (MH) indicator 20 (NICE 2011 menu NM42)

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

### Mental health 20.1 Rationale

This indicator supports annual case finding for diabetes through the use of random or fasting blood glucose or HbA1c measurement. This indicator replaces MH15 to allow the additional use of HbA1c.

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%<sup>73</sup>. The relative risk of developing diabetes mellitus is reported to be two to three times higher in people with schizophrenia than in the general population<sup>74</sup>.

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 years or above has been applied to this indicator.

The WHO 2006<sup>75</sup> states that fasting plasma glucose  $\geq 7.0$ mmol/l (126mg/dl) or 2-h plasma glucose  $\geq 11.1$ mmol/l (200mg/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 diabetes mellitus<sup>76</sup>. 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. An HbA1c of 48 mmol/mol<sup>74</sup> is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol 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.

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).

Patients in whom diabetes has already been diagnosed will be excluded from the denominator for this indicator as they should be managed according to the diabetes indicator set.

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<sup>73</sup> Kilbourne AM, Cornelius JR, Han X et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar disorders* 6: 368-73

<sup>74</sup> Oud M, Meyboom-de Jong B (2009) Somatic diseases in patients with schizophrenia in general practice: their prevalence and health care. *BMC Family practice* 10: 32

<sup>75</sup> World Health Organisation (2006) Definition and diagnosis of diabetes mellitus and intermediate hyperglycemia. Available from

[www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes\\_new.pdf](http://www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf)

<sup>76</sup> World Health Organisation (2011) Use of glycosylated haemoglobin (HbA1c) in the diagnosis of diabetes mellitus: abbreviated report of a WHO consultation. Available from [www.who.int/diabetes/publications/report-hba1c\\_2011.pdf](http://www.who.int/diabetes/publications/report-hba1c_2011.pdf)

### **Mental health 20.2 Reporting and Verification**

The practice reports the percentage of patients on its mental health register with schizophrenia, bipolar affective disorder or other psychoses, aged 40 years and over who have had a their blood glucose levels or HbA1c measured and recorded in the preceding 15 months.

## **Mental Health (MH) indicator 16 (NICE 2010 menu NM20)**

The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.

### **Mental health 16.1 Rationale**

A recent 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 previous five years (63 per cent) compared with the general population (73 per cent). This did not apply to patients with bipolar affective disorder<sup>77</sup>. This finding may reflect an underlying attitude that such screening is less appropriate for women with schizophrenia. This indicator therefore encourages practices to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to devolved national guidelines.

### **Mental health 16.2 Reporting and verification**

The practice reports the percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding five years.

## **Mental Health (MH) indicator 17 (NICE 2010 menu NM21)**

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

### **Mental health 17.1 Rationale**

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

The NICE clinical guideline on bipolar disorder recommends that practitioners should 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 should be carried out every six months and more often if there is evidence of impaired renal function.

### **Mental health 17.2 Reporting and verification**

The practice reports the percentage of patients on lithium therapy with a record of TSH in the preceding nine months. Practices should report the percentage of patients on lithium therapy with a record of serum creatinine in the preceding nine months.

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

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<sup>77</sup> Hippisley-Cox J, Pringle M (2005). Health inequalities experienced by people with schizophrenia and manic depression: Analysis of general practice data in England and Wales. Nottingham: QRESEARCH. [www.qresearch.org/SitePages/publications.aspx](http://www.qresearch.org/SitePages/publications.aspx)

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

## **Mental Health (MH) indicator 18 (NICE 2010 menu NM22)**

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

### **Mental health 18.1 Rationale**

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

The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium treatment for bipolar disorder, which demonstrated that wrong or unclear dose or strength, and monitoring were key issues for lithium therapy<sup>78</sup>. 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<sup>79</sup>.

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

- monitor serum lithium 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 lithium levels.

The aim should be to maintain serum lithium levels between 0.6 and 0.8 mmol/litre 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/litre should be considered. If the range differs locally, the PCO will be required to allow for this.

Where a practice is prescribing, it has responsibility for checking that routine blood tests have been done (not necessarily by the practice) and for following up patients who default.

### **Mental health 18.2 Reporting and verification**

The practice reports the percentage of patients on lithium whose last serum lithium level is in the therapeutic range. The level should have been undertaken in the preceding four months.

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

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<sup>78</sup> NPSA. Patient safety alert 0921(2009). Safer lithium therapy. [www.nrls.npsa.nhs.uk/alerts](http://www.nrls.npsa.nhs.uk/alerts)

<sup>79</sup> Prescribing Observatory for Mental Health (2009). Topic 7 baseline report. Monitoring of patients prescribed lithium: baseline.

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

## Mental Health (MH) indicator 10

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

### Mental health 10.1 Rationale

This indicator reflects good professional practice and supported by NICE clinical guidelines<sup>80</sup>.

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

Up to 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 ongoing mental health problems had no social contacts outside mental health services<sup>81</sup>.
3. Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received.
4. Occupational status. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (ONS Labour Force Survey, Autumn 2003). People with mental health problems also earn only two thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities amongst users of mental health services with up to 90 per cent wishing to go into or back to work<sup>82</sup>.

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<sup>80</sup> NICE clinical guideline 82 (2009). Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.

<http://guidance.nice.org.uk/CG82/NICEGuidance/pdf/English>

<sup>81</sup> See Ford et al. *Psychiatric Bulletin* 1993; 17(7): 409-411 and Office of the Deputy Prime Minister, *Mental health and social exclusion (Social Exclusion Unit Report)*. London, ODPM, 2004

<sup>82</sup> See Grove and Drurie. *(Social firms: an instrument for social and economic inclusion)*. Redhill, Social Firms UK, 1999

5. "Early warning signs" from the patient's perspective that may indicate a possible relapse<sup>83</sup>. 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.

A care plan should be 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 should have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of the 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.

Further information

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

[www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1)

### **Mental health 10.2 Reporting and verification**

The practice reports the percentage of patients on the mental health register for schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan recorded.

Verification – may require randomly selecting a number of care plans to ensure that they are being maintained annually.

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<sup>83</sup> See Birchwood et al. *Advances in Psychiatric Treatment* 2000; 6: 93-101 and Birchwood and Spencer. *Clinical Psychology Review* 2001; 21(8): 1211-26

# Asthma

Indicator	Points	Payment stages
<b>Records</b>		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
<b>Initial Management</b>		
ASTHMA 8. The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	45–80%
<b>Ongoing management</b>		
ASTHMA 10. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months	6	45–80%
ASTHMA 9. The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions <i>NICE 2011 menu ID: NM23</i>	20	45-70%

## Asthma – rationale for inclusion of indicator set

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

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

### Asthma indicator 1

The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.

#### Asthma 1.1 Rationale

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

The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most 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 (FEV<sub>1</sub>) but which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma must be in doubt.

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

#### Children

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

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

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.

SIGN clinical guideline 101 (2009). SIGN and BTS. British Guideline on the Management of Asthma. <http://www.sign.ac.uk/pdf/qrg101.pdf>

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

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

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

## **Asthma 1.2 Reporting and verification**

### Asthma 1.2.1

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

### Asthma 1.2.2

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

Verification – may require a comparison of the expected prevalence with the reported prevalence.

## Asthma indicator 8

The percentage of patients aged 8 years and over, diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility.

### Asthma 8.1 Rationale

Accurate diagnosis is fundamental in order to avoid untreated symptoms as a result of under-diagnosis, and inappropriate treatment as a result of over-diagnosis. Both scenarios have implications both to the health of the patient and the cost of providing healthcare. National and international guidelines emphasise the importance of demonstrating variable lung function in order to confirm the diagnosis of asthma. Variability of PEF and FEV<sub>1</sub>, either spontaneously over time or in response to therapy is a characteristic feature of asthma.

SIGN Guideline 101 states: "...measurements of airflow limitation, its reversibility and its variability are considered critical in establishing a clear diagnosis of asthma" (Global Initiative for Asthma <http://www.ginasthma.org>). One peak flow measurement provides no information about variability and therefore can neither confirm, nor refute, the diagnosis.

Objective measurement of variability either spontaneously over time or in response to therapy is thus fundamental to the diagnosis of asthma and may be conveniently achieved in primary care with serial peak flow measurements. Significant variability in peak flow is defined as a change of 20 per cent or greater with a minimum change of at least 60l/min ideally for three days in a week for two weeks seen over a period of time and may be demonstrated by monitoring diurnal variation, demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks inhaled steroids, two weeks oral steroids) or a reduction after exercise or when the patient next meets their trigger. Spirometry (greater than 15 per cent and 200ml change in FEV<sub>1</sub>) may still be used to confirm variability, though the limitation imposed by a surgery based measurement means that changes over time may be missed.

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

It is of note that a proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400mls or more on FEV<sub>1</sub> – but do not return to over 80 per cent predicted, and a significant smoking history. Evidence would suggest that this should not usually be more than 15 per cent of the overall COPD population.

### Asthma 8.2 Reporting and verification

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

## Asthma indicator 10

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

### Asthma 10.1 Rationale

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

Studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control<sup>84</sup>.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity<sup>85</sup>.

### Asthma 10.2 Reporting and verification

The practice reports the percentage of patients on the asthma register between the ages of 14 and 19 years where smoking status has been recorded in the preceding 15 months.

## Asthma indicator 9 (NICE menu 2011 NM23)

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

### Asthma 9.1 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 guideline<sup>86</sup> proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

The BTS/SIGN guideline<sup>86</sup> recommends the use of standard questions for the monitoring of asthma. Proactive structured review, rather than opportunistic or unscheduled review, is associated with reduced exacerbation rate and fewer days lost from normal activity.

The QOF now explicitly requires that the following three RCP questions are used as an effective way of assessing symptoms<sup>87</sup>:

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)?

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<sup>84</sup> See Price et al. Clin Exp Allergy 2005; 35: 282-287.

<sup>85</sup> Thomson et al. Eur Respir J 2004; 24: 822 – 833

<sup>86</sup> British Thoracic Society and the Scottish Intercollegiate Guidelines Network (2008, revised May 2011). British guideline on the management of asthma (101): a national clinical guideline.

<http://www.sign.ac.uk/pdf/qrg101.pdf>

<sup>87</sup> Pearson MG, Bucknall CE, editors (1999) Measuring clinical outcomes in asthma: a patient focused approach. London: Royal College of Physicians

- Has your asthma interfered with your usual activities (for example, housework, work/school, etc.)?

The questions must 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<sup>88</sup>.

If the asthma appears to be uncontrolled, the following should 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. Practices may wish to follow the advice of the BTS/SIGN guideline<sup>89</sup> 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 older than 18 years 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<sup>89</sup>. For patients aged 18 years and younger the peak flow will be changing; therefore it is recommended that the best peak flow should be re-assessed annually. Inhaler technique should be reviewed regularly. The BTS/SIGN guideline<sup>89</sup> emphasises the importance of assessing ability to use inhalers before prescribing, and regularly reviewing technique, especially if control is inadequate. Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique. Reassess inhaler technique as part of the structured asthma review.

During an asthma review the following should take 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.

### **Asthma 9.2 Reporting and verification**

Practices should report the percentage of patients on the asthma register who have had an asthma review incorporating the three RCP questions at least once in the preceding 15 months. Practices must code the review and the responses to the three RCP questions separately and on the same day in order to comply with this indicator.

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<sup>88</sup> Thomas M, Gruffydd-Jones K, Stonham C et al. (2009) Assessing asthma control in routine clinical practice: use of the Royal College of Physicians '3 Questions'. *Primary Care Respiratory Journal* 18: 83-8

<sup>89</sup> British Thoracic Society and the Scottish Intercollegiate Guidelines Network (2008, revised May 2011). British guideline on the management of asthma (101): a national clinical guideline. <http://www.sign.ac.uk/pdf/qrg101.pdf>

## Dementia (DEM)

Indicator	Points	Payment stages
<b>Records</b>		
DEM1. The practice can produce a register of patients diagnosed with dementia	5	
<b>Ongoing management</b>		
DEM2. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	15	35–70%
DEM4. The percentage of patients with a new diagnosis of dementia recorded between 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 6 months before or after entering on to the register <i>NICE 2010 menu ID: NM09</i>	6	45–80%

### Dementia – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic, progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at 80 years of age. The annual incidence of vascular dementia is 1.2/100 overall person years at risk and is the same in all age groups. Alzheimer's disease accounts for 50 - 75 per cent of cases of dementia.

The annual incidence of dementia of the Alzheimer type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is an indicator of dementia especially when there is altered functioning in terms of activities of daily living.

### Dementia (DEM) indicator 1

The practice can produce a register of patients diagnosed with dementia.

#### Dementia 1.1 Rationale

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

## **Dementia 1.2 Reporting and verification**

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

## **Dementia (DEM) indicator 2**

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

### **Dementia 2.1 Rationale**

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

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

A series of well-designed cohort and case control studies have demonstrated that 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 should therefore include the assessment of any behavioural changes caused by:

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

Depression should also be considered since it is more common in patients with dementia than those without<sup>90</sup>.

Further information

The Audit Commission Report (2002). Forget Me Not. <http://www.audit-commission.gov.uk/nationalstudies/health/mentalhealth/Pages/forgetmenot2002.aspx>

The NSF for Older People.

[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH\\_4003066](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066)

Both recommend that patients and carers should be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia<sup>91</sup>. 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

<sup>90</sup> Burt et al. *Psychol Bull* 1995; 117: 285-305

<sup>91</sup> Eccles et al. *BMJ* 1998; 317: 802-808

concerned about issues raised in the consultation, then with appropriate permissions, they should contact the carer's own GP for further support and treatment<sup>92</sup>.

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

Further information

NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers in health and social care. <http://guidance.nice.org.uk/CG42/NICEGuidance/pdf/English>

No decision has been taken on the endorsement of clinical guideline 42 in Northern Ireland but the position is under review. Information on NICE guidance endorsed in NI may be found at: <http://www.dhsspsni.gov.uk/sqsd-guidance-nice-guidance>

NICE public health guidance 16 (2008). Mental wellbeing in older people. <http://publications.nice.org.uk/occupational-therapy-interventions-and-physical-activity-interventions-to-promote-the-mental-ph16>

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

Coping with Dementia – a Handbook for Carers (2008). <http://www.healthscotland.com/uploads/documents/7632-CopingWithDementia2008.pdf>

## **Dementia 2.2 Reporting and verification**

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

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

## **Dementia (DEM) 4 (NICE 2010 menu NM09)**

The percentage of patients with a new diagnosis of dementia recorded between 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 6 months before or after entering on to the register.

### **Dementia 4.1 Rationale**

There is no universal consensus on the appropriate diagnostic tests that should be undertaken in those with suspected dementia. However, a review of 14 guidelines and consensus statements found considerable similarity in recommendations<sup>93</sup>. 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).

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<sup>92</sup> see Eccles et al. *BMJ* 1998; 317: 802-808

<sup>93</sup> Beck C, Cody M, Souder E et al. (2000) Dementia diagnostic guidelines: methodologies, results, and implementation costs. *Journal of the American Geriatrics Society* 48: 1195–1203

The NICE clinical guideline on dementia<sup>94</sup> states that a basic dementia screen should be performed at the time of presentation, usually within primary care. It should include:

- routine haematology
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function)
- thyroid function tests
- serum vitamin B12 and folate levels.

#### **Dementia 4.2 Reporting and verification**

The practice reports the percentage of patients on the dementia register diagnosed between 1 April and 31 March who have had tests for FBC, calcium, glucose, renal, liver and thyroid function, and have serum vitamin B12 and folate levels, recorded up to six months before or six months after entering on to the register. 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) for successful completion of this indicator. Where the test is declined by the patient, then the patient should be exception reported.

The original DEM3 indicator (now renumbered DEM4) was introduced in April 2011 and applied to all patients diagnosed after 1 April 2011. For April 2012 the indicator has been changed so that it only applies to patients with a new diagnosis in the QOF year. However the workload has the potential to span more than one QOF year (in a similar way to DEP 6 and 7). The associated Business Rules therefore cover 18 months to capture patients whose care could span more than one QOF year and to ensure fair and consistent payment to practices.

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<sup>94</sup> NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers in health and social care. [www.nice.org.uk/CG42](http://www.nice.org.uk/CG42)

## Depression (DEP)

Indicator	Points	Payment stages
<b>Diagnosis and initial management</b>		
DEP1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on 1 occasion during the preceding 15 months using two standard screening questions	6	50–90%
DEP6. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care <i>NICE 2010 menu ID: NM10</i>	17	50–90%
DEP7. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care <i>NICE 2010 menu ID: NM11</i>	8	45-80%

### Depression – rationale for inclusion of the indicator set

Depression is common and disabling.

In 2000, the estimated point prevalence for a depressive episode among 16 – 74-year-olds 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 cent<sup>95</sup>). It contributes 12 per cent of the 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<sup>96</sup>. 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.

### Depression (DEP) indicator 1

The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on 1 occasion during the preceding 15 months using two standard screening questions.

<sup>95</sup> NICE clinical guideline 90 (2009). The treatment and management of depression in adults.  
<http://guidance.nice.org.uk/CG90>

<sup>96</sup> Murray CJL and Lopez AD. *The global burden of disease*. Boston, Mass: WHO and Harvard University Press, 1996

## Depression 1.1 Rationale

Depression is more common in patients with CHD and presence of depression is associated with poorer outcomes. Up to 33 per cent of patients develop depression after a myocardial infarction<sup>97</sup>.

The presence of depression in patients with CHD is associated with reduced compliance with treatment, increased use of health resources, increased social isolation and poorer outcomes<sup>98</sup>.

A meta-analysis of 20 trials<sup>99</sup> found that depressive symptoms and clinical depression in patients with CHD increased mortality for all follow-up periods even after adjustment for other risk factors. In other words, depression was an independent risk factor for mortality in patients with CHD. There is Grade A evidence from two randomised controlled trials that selective serotonin reuptake inhibitor (SSRI) antidepressant treatment in patients with CHD is safe and effective in reducing depression, at least among those with a prior history of depression and more severe symptoms<sup>100</sup>. Patients treated with an SSRI were also found to have a 42 per cent reduction in death or recurrent MI in a sub-group analysis of outcomes in a trial of cognitive behavioural therapy (CBT), although this was a post-hoc observation, and assignment to antidepressants was not randomised<sup>101</sup>.

There is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus<sup>102</sup> a prevalence rate three times higher than the general population. A recent meta-analysis of 42 studies found that depression is clinically relevant in nearly one in three patients with diabetes<sup>103</sup>. Patients with both diabetes and depression are less physically and socially active<sup>104</sup> and less likely to comply with diet and treatment than patients with diabetes alone, leading to worse long term complications and higher mortality. It may also be that practitioners provide poorer care to patients with co-morbid depression and diabetes because depression impairs communication with patients<sup>105</sup>. There is good evidence from five randomised controlled trials that effective treatment with either antidepressants or CBT improves the outcome of depression in patients with diabetes<sup>106</sup>. While treatment has not been shown consistently to improve glycaemic control, psychological well-being has been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

NICE guidance on depression suggests that “screening should be undertaken in primary care ...for depression in high-risk groups” and that “screening for depression should include the use of at least two questions concerning mood and interest:

- during the last month, have you often been bothered by feeling down, depressed or hopeless?; and
- during the last month, have you often been bothered by having little interest or pleasure in doing things?”

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<sup>97</sup> Davies et al. *BMJ* 2004; 328: 939-943

<sup>98</sup> Carney et al, *American Journal of Cardiology* 2003;92(11): 1277-81

<sup>99</sup> Barth et al. *Psychosomatic Medicine* 2004; 66: 802-13

<sup>100</sup> Glassman et al. *Journal of the American Medical Association* 2002; 288: 701-709; Taylor et al. *Archives of General Psychiatry* 2005; 62: 792-798

<sup>101</sup> Lesperance et al. *Journal of the American Medical Association* 2007; 297: 367-379

<sup>102</sup> Goldney et al. *Diabetes Care* 2004; 27(5): 1066-70

<sup>103</sup> Anderson et al. *Diabetes Care* 2001; 24: 1069-78

<sup>104</sup> Von Korf et al. *Psychosomatic Medicine* 2005; 67: 233-40

<sup>105</sup> Piette et al. *American Journal of Managed Care* 2004; 10: 152-162

<sup>106</sup> Lustman et al. *Psychosomatic Medicine* 1997; 59: 241-50; Lustman et al. *Annals of Internal Medicine* 1998; 129: 613-621; Lustman et al. *Diabetes Care* 2000; 23: 618-23; Katon et al. *Archives of General Psychiatry* 2004; 61: 1042-49; Williams et al. *Annals of Internal Medicine* 2004; 140: 1015-24

A “yes” answer to either question is considered a positive test. A “no” response to both questions makes depression highly unlikely. These two brief questions could be asked as part of a diabetes or CHD review and patients who answer “yes” to either questions could be referred to the GP for further assessment of other symptoms such as tiredness, guilt, poor concentration, change in sleep pattern and appetite and suicidal ideation to confirm a diagnosis of depression. This assessment should be informed by using a questionnaire measure of severity such as the Patient Health Questionnaire (PHQ-9), Hospital Anxiety and Depression Scale (HADS), or Beck Depression Inventory (BDI-II), as used for the DEP6 indicator<sup>107</sup>.

The specificity of screening has been shown to be improved by the addition of a third ‘help’ question asked of patients answering ‘yes’ to either of the first two questions: Is this something with which you would like help?<sup>108</sup>. This third question has three possible responses: ‘no’, ‘yes, but not today’, or ‘yes’. A ‘no’ response to this third question makes major depression highly unlikely (negative predictive value (NPV) of 94 per cent). It is important to stress therefore that a negative result to the two to three item screen can usually be taken to indicate that the patient doesn’t have depression.

### **Depression 1.2 Reporting and verification**

The practice reports the percentage of patients on their diabetes and CHD registers whose records show that they have been screened for depression using the two standard questions. This screening will have been recorded in the preceding 15 months. These questions should be asked as part of a consultation and should not be posted to patients.

Verification – may require randomly selecting a number of case records of patients in whom screening has been undertaken to ensure that the two standard questions are being used. There should be evidence that this has been recorded in the context of a clinical consultation.

## **Depression (DEP) indicator 6 (NICE 2010 menu NM10)**

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

### **Depression 6.1 Rationale**

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

Assessment of severity in patients with depression is essential to decide on appropriate interventions and improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression described in the NICE clinical guideline 90. The guideline states, for example, that antidepressants are not recommended for the initial treatment of mild depression but should be routinely considered for all patients with moderate or severe depression.

Further information

NICE clinical guideline 90 (2009). Depression in adults (update).

<http://guidance.nice.org.uk/CG90>

NICE clinical guideline 91 (2009). Depression with a chronic physical health problem.

<http://guidance.nice.org.uk/CG91>

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<sup>107</sup> see also Whooley et al. *Journal of General Internal Medicine* 1997; 12 (7): 439-45

<sup>108</sup> Arroll et al. *British Medical Journal* 2005; doi:10.1136/bmj.38607.464537.7c

The three suggested severity measures validated for use in a primary care setting are the nine item PHQ-9, the BDI-II and the HADS. It is advisable for a practice to choose one of these measures and become familiar with its questions and scoring systems.

#### Patient Health Questionnaire

The PHQ-9 is a nine-question self-report measure of severity that takes approximately three minutes to complete. It uses the 'Diagnostic and Statistical Manual of Mental Disorders, fourth edition' (DSM-IV) criteria for depression and scores are categorised as minimal (1–4), mild (5–9), moderate (10–14), moderately severe (15–19) and severe depression (20–27). It was developed and validated in the United States and can be downloaded free of charge:

<http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

#### Hospital Anxiety and Depression Scale

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

The HADS allows the severity of both anxiety and depression to be established simultaneously. Separate scores are given for anxiety and depression, which are independent measures. The HADS can be ordered from: <http://shop.glassessment.co.uk/home.php?cat=417&gclid=CPr3fjJhpkCFQ6wQwodl2Krlw>

The HADS depression subscale (HAD-D) has 90 per cent sensitivity and 86 per cent specificity for depression compared to the gold standard of a structured diagnostic interview<sup>109,110</sup>.

#### Beck Depression Inventory, second edition

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

[http://www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultMentalHealth/BeckDepressionInventory-II\(BDI-II\)/BeckDepressionInventory-II\(BDI-II\).aspx](http://www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultMentalHealth/BeckDepressionInventory-II(BDI-II)/BeckDepressionInventory-II(BDI-II).aspx)

#### Revised thresholds for intervention

A study in which the PHQ-9 and HAD-D were administered together to a single sample of patients also found that a greater proportion of the sample was classified as depressed according to the PHQ-9 compared with the HAD-D<sup>111</sup>. Validation studies against more extensive 'gold standard' diagnostic assessments have suggested that the validity of the measures in terms of identifying major depressive disorder could be improved by using a more conservative cut-off score of 12 rather than ten on the PHQ-9 and a less conservative cut-off of ten rather than 11 on the HAD-D<sup>112, 113</sup>. Changing the recommended threshold scores for

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<sup>109</sup> Zigmond AS, Snaith RP (1983) The hospital anxiety and depression scale. *Acta Psychiatr Scand* 67: 361–70

<sup>110</sup> Wilkinson MJ, Barczak P (1988) Psychiatric screening in general practice: comparison of the general health questionnaire and the hospital anxiety depression scale. *Journal of the RCGP* 38:311-3

<sup>111</sup> Cameron I, Crawford J, Lawton K et al. (2008) Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *British Journal of General Practice* 58: 32–6

<sup>112</sup> Löwe B, Spitzer RL, Gräfe K et al. (2004) Comparative validity of three screening questionnaires for DSM-IV depressive disorders and physicians' diagnoses. *J Affect Disord* 78: 131–40

<sup>113</sup> Gilbody S, Richards D, Barkham M (2007) Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ-9 and CORE-OM. *British Journal of General Practice* 57: 650–2

intervention would therefore make these measures more valid against longer assessments, more consistent with each other, and more consistent with practitioners' clinical judgment.

The revised recommended thresholds for considering intervention are therefore:

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

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

It is also important for clinicians to consider family and previous history as well as the degree of associated disability and patient preference in making an assessment of the need for treatment, rather than relying completely on a single symptom count at one point in time.

Decisions about treatment and referral should take into account the:

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

In addition, the PHQ-9 and the BDI-II have not been validated in terms of their cultural sensitivity and it is important to bear this in mind if using them with black and minority ethnic populations.

### **Depression 6.2 Reporting and verification**

The practice reports the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity at the time of diagnosis, defined as within 28 days of the initial diagnosis. New diagnoses are those which have been made between the preceding 1 April to 31 March. The practice should also report in each patient record which of the three assessment tools they used.

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

#### **Timeframe**

The original DEP2 indicator was introduced to QOF in April 2006. From April 2009 the associated Business Rules were revised to deal with a cross-year indicator where workload spans more than one QOF year, to:

- ensure fair and consistent payments to all practices
- ensure that patients who were diagnosed in the last three months of the QOF year are identified

The QOF is set up to support annual activity that is completed in one QOF calendar year, which runs from 1 April to 31 March. Prior to the business rule change in April 2009, any patient newly diagnosed with depression between January and February would have been removed from the denominator, due to the new diagnosis exception criteria. Furthermore, because the indicator specifically relates to a new diagnosis, the same patient would not be picked up in the following QOF year.

The depression indicator Business Rules were therefore revised, from 1 April 2009, to cover 15 months so as to address this issue.

From April 2012 the prevalence calculation for the DEP6 indicator has changed and will now apply to all patients diagnosed with depression post April 2006. Practices should code patients as 'depression resolved' where appropriate.

The above explanation for the timeframe and the Business Rules applies to the current depression indicator DEP6.

## **Depression (DEP) indicator 7 (NICE 2010 menu NM11)**

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

### **Depression 7.1 Rationale**

The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived<sup>114</sup>.

The change to the wording of this indicator, from 4-12 weeks to 2-12 weeks, recognises that the clinical guideline development group for NICE clinical guideline 90 noted that there is an assumption by practitioners that antidepressants have a delayed onset of action. This is now recognised as incorrect and it has been shown from clinical trial data that improvement can start immediately, with the greatest degree of improvement occurring in the first week; the improvement curve begins to flatten off thereafter, with a smaller degree of improvement as time goes on.

The NICE clinical guideline 90 on depression in adults, recommends that 'for people started on antidepressants who are not considered to be at increased risk of suicide, normally see them after two weeks. See them regularly thereafter, for example at intervals of two to four weeks in the first three months and then at longer intervals if the response is good.' Early cessation of treatment is associated with a greater risk of relapse.

The NICE guideline also states that further assessment should normally take place within two weeks in the following groups of people: those who, in the judgement of the practitioner, may recover with no formal intervention, those with mild depression who do not want an intervention, or those with subthreshold depressive symptoms who request an intervention.

The guideline also suggests that a patient who has benefited from taking an antidepressant should continue medication for at least six months after remission of an episode of depression. However, one study showed that only up to one-third of patients prescribed antidepressants were still receiving medication at four to six months<sup>115</sup>.

Analysis of the GP Research Database for the years 1993 to 2005 has confirmed this finding: more than half of patients treated with antidepressants for a new diagnosis of depression

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<sup>114</sup> Kates N, Mach M (2007) Chronic disease management for depression in primary care: a summary of the current literature and implications for practice. *Canadian Journal of Psychiatry* 52: 77-85

<sup>115</sup> Donoghue J (2000) Antidepressant use patterns in clinical practices: comparisons among tricyclic antidepressants and selective serotonin reuptake inhibitors. *Acta Psychiatrica Scandinavica* 101: (suppl 403): 57-61

during those years received prescriptions for only one or two months of treatment, and that this pattern had not changed over the 13 year period<sup>116</sup>.

### **Depression 7.2 Reporting and verification**

The practice reports the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity 2 – 12 weeks (inclusive) after the initial recording of the assessment of severity related to a new diagnosis of depression.

To be included in the denominator for DEP7, patients will have a record of an initial severity assessment within 28 days of the initial diagnosis, as defined in DEP6. This is an update to the previous rule set for this indicator. Previous definitions within the rules did not require an initial assessment to be included in the denominator for this indicator. New diagnoses are those which have been made between the preceding 1 April to 31 March. To be included in the numerator for this indicator a patient needs to have had both an initial and a subsequent severity assessment.

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

From April 2012 the prevalence calculation for the DEP7 indicator has changed and will now apply to all patients diagnosed with depression post April 2006. Practices should code patients as 'depression resolved' where appropriate.

Verification – may require randomly selecting a number of case records of patients with a new diagnosis of depression to verify that their notes record a follow-up assessment of severity 2 – 12 weeks after the initial assessment of severity.

#### **Timeframe**

The DEP3 (now DEP 7) indicator was introduced to QOF in April 2009 and for that reason, the first line of the supporting Business Rules excluded patients newly diagnosed before April 2009. The Business Rules for DEP3, were structured to take account of the cross-year issue which ensures fair and consistent payment to practices and good patient care. The Business Rules therefore look back 68 weeks to address this issue.

The above explanation for the timeframe and the Business Rules applies to the current depression indicator DEP 7.

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<sup>116</sup> Moore M, Yuen HM, Dunn N et al. (2009) Explaining the rise in antidepressant prescribing: a descriptive study using the GPRD. *BMJ* 339: b3999

## Chronic kidney disease (CKD)

Indicator	Points	Payment stages
<b>Records</b>		
CKD1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
<b>Initial management</b>		
CKD2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months	4	50–90%
<b>Ongoing management</b>		
CKD3. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less	11	45–70%
CKD5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB)	9	45–80%
CKD6. 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	6	45–80%

### Chronic kidney disease – rationale for inclusion of indicator set

The international classification developed by the US National Kidney Foundation describes five stages of CKD using an eGFR to measure kidney function (see table three). Patients with CKD stages three to five have, by definition, less than 60 per cent of their kidney function. Stage three is a moderate decrease in 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 3). Stage four is a severe decrease in GFR with or without other evidence of kidney damage and stage five is established renal failure. The QOF indicator set refers to 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<sup>117</sup>. The prevalence in females was higher than in males (6.9 per cent versus 4.9 per cent). In the fully adjusted model, the prevalence of low GFR was strongly associated with diagnosed diabetes (OR, 1.54; 95% CI, 1.28-1.80) and hypertension (OR, 1.98; 95% CI, 1.73-2.67) as well as higher BMI (OR, 1.08; 95% CI, 1.02-1.15 per 5-unit increment of BMI).

<sup>117</sup> Coresh et al *JAMA*. 2007;298(17):2038-2047

In the UK the prevalence of CKD stage 3–5 was 8.5 per cent and was higher in females, 10.6 per cent in females versus 5.8 per cent in males<sup>118</sup>. 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:

<http://www.apho.org.uk/resource/item.aspx?RID=65647>  
<http://www.apho.org.uk/resource/item.aspx?RID=63798>

The NHS Information Centre reports a prevalence of CKD for 2009/10 of 4.3 per cent using QMAS returns suggesting that, to date, CKD is under-reported in English GP practices.

**Table 3: Estimated glomerular filtration rate (eGFR) to measure kidney function**

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

\* All GFR values are normalized to an average surface area (size) of 1.73m<sup>2</sup>

Further information

National service framework for Renal Services (2005).

<http://www.kidney.org.uk/campaigns/Renal-nsf/nsf-pt2.pdf>

This indicator set applies to patients with stage three, four and five CKD (eGFR <60mL/min/1.73m<sup>2</sup> 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 one or two CKD go on to develop more advanced disease and symptoms do not usually appear until stage four. Where eGFR has persistently been recorded below 60 (<60) the CKD (stage 3) label should continue to apply, even if future management may lead to an improvement in eGFR.

Early identification of CKD is important as it allows appropriate measures to be taken not only to slow or prevent the progression to more serious CKD but also to combat the major risk of illness or death due to cardiovascular disease. The presence of proteinuria is a key risk multiplier

<sup>118</sup> Stevens et al. *Kidney International* 2007; 72: 92-9

at all stages of CKD and CKD is an independent risk factor for CVD and a multiplier of other risk factors<sup>119</sup>.

Further information

NICE clinical guideline 73 (2008). Early identification and management of CKD in adults in primary and secondary care. <http://www.nice.org.uk/CG73>

SIGN clinical guideline 103 (2008). Diagnosis and management of CKD in adults. <http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

These indicators reflect both of the guidance documents:

- Albumin:creatinine ratio (ACR) is the preferred measure of proteinuria
- NICE suggests blood pressure should be kept below 140 (systolic) and 90 (diastolic) with a target for systolic of between 120 and 139 mmHg. There is a tougher standard for diabetes. This compares with a blood pressure audit standard of 145/85 in this guidance for 40 to 70 per cent of the CKD population
- NICE recommends that the use of ACE inhibitors when there is hypertension and an ACR of  $\geq 30$ mg/mmol. However, when ACR  $\geq 70$ mg/mmol NICE recommends ACE inhibitors even in the absence of hypertension. As with BP there are stricter standards in diabetes
- NICE divides stage three into stage 3a and 3b. They recommend testing for bone disease and anaemia in stage 3b (eGFR 30 to 44), as well as stages four and five
- 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)

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

## Chronic kidney disease (CKD) indicator 1

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

### Chronic kidney disease 1.1 Rationale

Patients aged 18 years and over with a persistent estimated GFR or GFR of  $<60$ ml/min/1.73m<sup>2</sup> should be included in the register. From 2006, eGFR has been reported automatically when serum creatinine concentration is measured. Studies of general practice computerised medical records show that it is feasible to identify people with CKD<sup>120</sup> and that computer records are a valid source of data<sup>121</sup>.

The compilation of a register 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.

### Chronic kidney disease 1.2 Reporting and verification

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

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<sup>119</sup> Wali and Henrich. *Cardiol Clin* 2005; 23(3): 343-62

<sup>120</sup> de Lusignan et al. *Fam Pract* 2005; 22(3): 234-41

<sup>121</sup> Anandarajah et al. *Nephrol Dial Transplant* 2005; 20(10): 2089-96

## Chronic kidney disease (CKD) indicator 2

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

### Chronic kidney disease 2.1 Rationale

Studies show that reducing blood pressure in patients with CKD reduces the rate of deterioration of their kidney function whether or not they have hypertension or diabetes.<sup>122</sup>

### Chronic kidney disease 2.2 Reporting and verification

The practice reports the percentage of patients on its CKD register who have had a blood pressure measurement recorded in the preceding 15 months.

## Chronic kidney disease (CKD) indicator 3

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

### Chronic kidney disease 3.1 Rationale

Studies have shown that in people over 65 years and in people with diabetes, normal blood pressure is hard to achieve but is important<sup>123</sup>.

The NICE CKD guideline recommends that in people with CKD the clinician should aim to keep the systolic blood pressure below 140 mmHg (target range 120-139 mmHg) and the diastolic blood pressure below 90 mmHg. In people 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/24h or more) the clinician should aim to keep the systolic blood pressure below 130 mmHg (target range 120-129 mmHg) and the diastolic blood pressure below 80 mmHg.

The SIGN CKD guideline recommends that blood pressure be controlled to slow the deterioration of the glomerular filtration rate and reduce proteinuria. Patients with >1g/day of proteinuria (approximately equivalent to a protein/creatinine ratio of 100 mg/mmol) should have a target maximum systolic blood pressure of 130 mmHg.

The lower the blood pressure achieved the better for patient care; 140/85 mmHg is used here as an audit standard for this indicator.

Further information

NICE clinical guideline 73 (2008). CKD in adults in primary and secondary care.

<http://www.nice.org.uk/Guidance/CG73>

SIGN clinical guideline 103 (2008). Diagnosis and management of CKD in adults.

<http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

### Chronic kidney disease 3.2 Reporting and verification

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

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<sup>122</sup> Jafar et al. *Ann Int Med* 2003; 139: 244-52

<sup>123</sup> Anderson et al. *American Journal of Kidney Disease* 2005; 45(6): 994-1001

## Chronic kidney disease (CKD) indicator 5

The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB).

### Chronic kidney disease 5.1 Rationale

ACE inhibitors and ARBs are generally more effective than other anti-hypertensives in minimising deterioration in kidney function and this effect is most marked where there is significant proteinuria. Such treatment is both clinically and cost-effective<sup>124</sup>.

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 protein:creatinine ratio (PCR) in the urine or to use a stick test.

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

Further information

NICE clinical guideline 73 (2008). CKD in adults in primary and secondary care.

SIGN clinical guideline 103 (2008). Diagnosis and management of CKD in adults.

Thus, patients with non-diabetic stage 3 to 5 CKD should have an annual test of proteinuria ideally using ACR, or PCR according to local guidance. 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<sup>125</sup>. Practitioners should only go on to send off a midstream urine or perform another test to look for infection if there are symptoms.

It is not possible to derive a simple correction factor that allows the conversion of ACR values to PCR or 24 hour urinary protein excretion rates because the relative amounts of albumin and other proteins will vary depending on the clinical circumstances; however, the following table of approximate equivalents will allow clinicians unfamiliar with ACR values to see the approximate equivalent PCR and 24-hour urinary protein excretion rates (see table 4).

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

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

### Chronic kidney disease 5.2 Reporting and verification

The practice reports the percentage of patients on its CKD register with hypertension and proteinuria whose records show they have been prescribed an ACE inhibitor or an ARB in the preceding six months.

<sup>124</sup> Kent et al JASN 2007;18:1959-1965. See also: Lewis et al. NEJM 1993; 329:1456-1462; Brenner et al. NEJM 2001; 345:861-869; Ruggenenti et al. Lancet 1999; 354: 359-364

<sup>125</sup> Carter JL et al Nephrol Dial Transplant. 2006 Nov; 21(11):3031-7

## Chronic kidney disease (CKD) indicator 6

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

### Chronic kidney disease 6.1 Rationale

Quantitative measurement of proteinuria will enable appropriate management of patients with CKD. There is good observational evidence linking proteinuria to adverse outcome.<sup>126</sup>

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

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

As with 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.

### Chronic kidney disease 6.2 Reporting and verification

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

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<sup>126</sup> Foster M. Arch Intern Med. 2007; 167(13):1386–92. Hallan S. Arch Intern Med. 2007; 167(22):2490–2496. Cirillo M. Arch Intern Med. 2008; 168(6):617–24. Brantsma A, J. Am Soc Nephrol. 2008; 19(9):1785-91

## Atrial fibrillation (AF)

Indicator	Points	Payment stages
<b>Records</b>		
AF1. The practice can produce a register of patients with atrial fibrillation	5	
<b>Initial diagnosis</b>		
AF5. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS <sub>2</sub> risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS <sub>2</sub> score is greater than 1) <i>NICE menu ID: NM24</i>	10	40-90%
<b>Ongoing management</b>		
AF6. In those patients with atrial fibrillation in whom there is a record of a CHADS <sub>2</sub> score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy <i>NICE 2011 menu ID: NM45</i>	6	50-90
AF7. In those patients with atrial fibrillation whose latest record of a CHADS <sub>2</sub> score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy <i>NICE 2011 menu ID: NM46</i>	6	40-70%

### Atrial fibrillation – rationale for inclusion of indicator set

Atrial fibrillation is common, and an important cause of morbidity and mortality. The age specific prevalence of atrial fibrillation is rising, presumably due to improved survival of patients with CHD (the commonest underlying cause of atrial fibrillation<sup>127</sup>). One percent of a typical practice population will be in atrial fibrillation; five per cent of over 65s, and nine per cent of over 75 year olds. Atrial fibrillation is associated with a five-fold increase in risk of stroke.<sup>128</sup>

SIGN clinical guideline 94 (2007). Cardiac Arrhythmias in coronary heart disease.  
[www.sign.ac.uk/guidelines/fulltext/94/index.html](http://www.sign.ac.uk/guidelines/fulltext/94/index.html)

### Atrial fibrillation (AF) indicator 1

The practice can produce a register of patients with atrial fibrillation.

#### AF 1.1 Rationale

This is good professional practice and is consistent with other clinical domains within the QOF as a building block for further evidence based interventions. A register makes it possible to call

<sup>127</sup> Psaty et al. Circulation 1997; 96: 2455-61

<sup>128</sup> Wolf et al. Stroke 1991; 22: 983-88

and recall patients effectively to provide systematic care and to audit care. A register should include all patients with an initial event; paroxysmal; persistent and permanent atrial fibrillation.

### AF 1.2 Reporting and verification

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

## Atrial fibrillation (AF) indicator 5 (NICE 2011 menu NM24)

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS<sub>2</sub> risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS<sub>2</sub> score is greater than 1).

### AF 5.1 Rationale

A cornerstone of managing atrial fibrillation is deciding whether or not to use an anti-coagulant. Despite strong evidence supporting the efficacy of anti-coagulants in preventing thromboembolism related to atrial fibrillation<sup>129</sup>, many patients with atrial fibrillation who would benefit from their use are not prescribed them<sup>130</sup>.

In order to decide whether or not a patient with atrial fibrillation needs anti-coagulation it is necessary for the clinician to assess their future risk of stroke. This indicator therefore incentivises the use of a stroke risk stratification tool in general practice for patients with atrial fibrillation.

To help clinicians decide which management path to choose, several tools have been developed to estimate the risk of stroke on the basis of clinical factors<sup>131,132,133,134</sup>. The scoring system recommended for QOF is CHADS<sub>2</sub>, which is validated and particularly suitable for identifying high-risk atrial fibrillation patients, while also being relatively simple to use<sup>135</sup>. The CHADS<sub>2</sub> system is based on the Atrial Fibrillation Investigators I study (AF1) and Stroke Prevention in Atrial Fibrillation I study (SPAF1) risk criteria<sup>136,137</sup>.

The revised CHADS<sub>2</sub> system scores 1 point, up to a maximum of 6, for each of the following risk factors (except previous stroke or TIA, which scores double, hence the '2'):

- C - congestive heart failure (1 point)

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<sup>129</sup> Aguilar M, Hart R, Pearce L (2007) Oral anticoagulants versus antiplatelet therapy for preventing stroke in patients with non-valvular atrial fibrillation and no history of stroke or transient ischemic attacks. Cochrane Database of Systematic Reviews Issue 3: CD006186

<sup>130</sup> Ogilvie IM, Newton N, Welner S et al. (2010) Underuse of oral anticoagulants in atrial fibrillation: a systematic review. *American Journal of Medicine* 123: 638-45

<sup>131</sup> National Collaborating Centre for Chronic Conditions (2006) Atrial fibrillation: national clinical guideline for management in primary and secondary care. London: Royal College of Physicians

<sup>132</sup> Fang MC, Go AS, Chang Y et al. (2008) Comparison of risk stratification schemes to predict thromboembolism in people with nonvalvular atrial fibrillation. *Journal of the American College of Cardiology* 51: 810-5

<sup>133</sup> Van Staa TP, Setakis E, Di Tanna GL et al. (2011) A comparison of risk stratification schemes for stroke in 79,884 atrial fibrillation patients in general practice. *Journal of Thrombosis Haemostasis* 9: 39-48

<sup>134</sup> Olesen JB, Lip GYH, Hansen ML et al. (2011) Validation of risk stratification schemes for predicting stroke and thromboembolism in patients with atrial fibrillation: nationwide cohort study. *British Medical Journal* 342: d124

<sup>135</sup> Gage BF, Waterman AD, Shannon W et al. (2001) Validation of clinical classification schemes for predicting stroke: results from the National Registry of Atrial Fibrillation. *Journal of the American Medical Association* 285: 2864-70

<sup>136</sup> Laupacis A, Boysen G, Conolly S et al. (1994) Risk factors for stroke and efficacy of antithrombotic therapy in atrial fibrillation: analysis of pooled data from five randomized controlled trials. *Archives of Internal Medicine* 154: 1449-57

<sup>137</sup> The Stroke Prevention in Atrial Fibrillation Investigators (1992) Predictors of thromboembolism in atrial fibrillation: I. Clinical features of patients at risk. *Annals of Internal Medicine* 116: 1-5

- H - hypertension (1 point)
- A - age 75 years or over (1 point)
- D - diabetes mellitus (1 point)
- S<sub>2</sub> - previous stroke or TIA (2 points).

A score of 0 is classified as low risk, 1 moderate risk, and 2 or more high risk.

The expectation behind this indicator is that all patients with atrial fibrillation on the practice register will be assessed. The risk score can be calculated through a notes review.

### **AF 5.2 Reporting and verification**

The practice reports the percentage of patients on the atrial fibrillation register that have had a CHADS<sub>2</sub> score calculated in the preceding 15 months. PCOs may wish to discuss with practices the processes they have in place for performing this calculation and how any results indicating that anti-coagulation may be required are acted upon.

## **Atrial fibrillation (AF) indicator 6 (NICE 2011 menu NM45)**

In those patients with atrial fibrillation in whom there is a record of a CHADS<sub>2</sub> score of 1 (latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy.

### **AF 6.1 Rationale**

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

There is evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction)<sup>138</sup> and less so by aspirin (approximately 22 per cent risk reduction<sup>138</sup>).

Evidence from the Birmingham Atrial Fibrillation Treatment of the Aged (BAFTA)<sup>139</sup> and Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE-W)<sup>140</sup> studies suggests that not only is warfarin more effective than aspirin, but that it is not as unsafe (in terms of risk of serious haemorrhage) as previously thought. For example, in the BAFTA trial, the relative risk (RR) for stroke for patients treated with anti-coagulation versus aspirin was 0.46 (95% confidence interval [CI] 0.26 to 0.79). The same study showed no significant difference in the rate of haemorrhage between the warfarin and aspirin arms of the study (RR 0.88, 95% CI 0.46 to 1.63), which suggests a shift in the balance between the risks and benefits of warfarin compared with aspirin. However, to date no meta-analysis has been identified combining the results of studies comparing the two treatments for the outcome of haemorrhage.

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

This indicator uses the CHADS<sub>2</sub> risk stratification scoring system to inform treatment options.

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<sup>138</sup> No authors listed (1994) Risk factors for stroke and efficacy of antithrombotic therapy in atrial fibrillation: analysis of pooled data from five randomized clinical trials. *Archives of Internal Medicine* 154: 1449-57

<sup>139</sup> Mant J, Hobbs FD, Fletcher K et al. (2007) Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 370: 493-503

<sup>140</sup> Healey JS, Hart RG, Pogue J et al. (2008) Risks and benefits of oral anticoagulation compared with clopidogrel plus aspirin in patients with atrial fibrillation according to stroke risk: the Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE-W). *Stroke* 39: 1482-6

The use of a risk stratification scoring system is in line with recent European Society of Cardiology (2010) guidance that states that recommendations for therapy should be based on the presence (or absence) of risk factors for stroke and thromboembolism.

Where the CHADS<sub>2</sub> score is 0 (low risk), then the patient can be offered treatment with aspirin<sup>141</sup>. Where the CHADS<sub>2</sub> score is 1 (moderate risk) then either aspirin or anti-coagulants can be offered.

For the purposes of the QOF, acceptable anti-coagulants are warfarin, phenindione and dabigatran. In Scotland, Healthcare Improvement Scotland (HIS) consensus recommends that warfarin remains the anticoagulation of clinical choice for moderate and high-risk atrial fibrillation patients with good international normalised ratio (INR) control but that dabigatran can be used under certain specific clinical circumstances<sup>142</sup>. NICE has a technology appraisal in progress (as of January 2012) on the use of dabigatran for the prevention of stroke or systemic embolism in people with atrial fibrillation.

For the purposes of the QOF, acceptable anti-platelets are aspirin, dipyridamole and clopidogrel.

### **AF 6.2 Reporting and verification**

The practice reports the percentage of patients on the atrial fibrillation register with a CHADS<sub>2</sub> score of 1 who are currently treated with an anticoagulant or an alternative anti-platelet .

## **Atrial fibrillation (AF) indicator 7 (NICE 2011 menu NM 46)**

In those patients with atrial fibrillation whose latest record of a CHADS<sub>2</sub> score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy.

### **AF 7.1 Rationale**

See AF 6.1.

Where the CHADS<sub>2</sub> score is greater than 1 the patient is at high risk of having a future stroke and the patient should be offered treatment with anti-coagulation drug therapy<sup>143</sup>.

For the purposes of the QOF, acceptable anticoagulants are warfarin and phenindione. In Scotland HIS consensus recommends dabigatran under certain circumstances<sup>144</sup>.

### **AF 7.2 Reporting and Verification**

The practice reports the percentage of patients on the atrial fibrillation register with a CHADS<sub>2</sub> score of greater than 1 who are currently treated with an anticoagulant i.e. who have been given a prescription in the last six months of the QOF year.

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<sup>141</sup> Guidelines for the management of atrial fibrillation The Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC) (2010). European Heart Journal 31: 2369-429. Available from [www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/guidelines-afib-FT.pdf](http://www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/guidelines-afib-FT.pdf)

<sup>142</sup> [http://www.healthcareimprovementscotland.org/programmes/cardiovascular\\_disease/dabigatran\\_consensus\\_statement/dabigatran\\_consensus\\_statement.aspx](http://www.healthcareimprovementscotland.org/programmes/cardiovascular_disease/dabigatran_consensus_statement/dabigatran_consensus_statement.aspx)

<sup>143</sup> Guidelines for the management of atrial fibrillation The Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC) (2010) Guidelines for the management of atrial fibrillation. European Heart Journal 31: 2369-429. Available from [www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/guidelines-afib-FT.pdf](http://www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/guidelines-afib-FT.pdf)

<sup>144</sup> [http://www.healthcareimprovementscotland.org/programmes/cardiovascular\\_disease/dabigatran\\_consensus\\_statement/dabigatran\\_consensus\\_statement.aspx](http://www.healthcareimprovementscotland.org/programmes/cardiovascular_disease/dabigatran_consensus_statement/dabigatran_consensus_statement.aspx)

## Obesity (OB)

Indicator	Points	Payment stages
<b>Records</b>		
OB1. The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months	8	

### Obesity - rationale for inclusion of indicator set

The prevalence of obesity is a major public health challenge for the United Kingdom. In England, for example, 23 per cent of adults are obese<sup>145</sup>. In Scotland in 2010, 27.4% of the adult population aged between 16 and 64 were obese (BMI >30).

There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes. In addition to the obvious associated disease burden such as inactivity, degenerative joint disease, lower employment and mood disorders, obesity is also a major contributory factor for some of the commonest causes of death and disability in developed economies, most notably greater rates of diabetes mellitus<sup>146</sup> and accelerated onset of cardiovascular disease<sup>147</sup>. Obesity has therefore become a major health issue for the United Kingdom. The Foresight UK Tackling Obesities report 2007 estimated the cost to the UK of obesity to be £50 billion in 2050 at today's prices. <http://www.bis.gov.uk/foresight/our-work/projects/current-projects/tackling-obesities/reports-and-publications>

NICE clinical guideline 43 (2008). Prevention, identification, assessment and management of overweight and obesity in adults and children. <http://www.nice.org.uk/Guidance/CG43>

Tackling obesity is a high priority for the four UK health departments.

For England, the Government published "A call to action on obesity in England" in October 2011. This sets out new national ambitions for tackling excess weight in children and adults and calls on a range of partners to play their part.

In Northern Ireland this is happening through the draft Obesity Prevention Framework for NI 2011-2021 – A fitter Future for All<sup>148</sup>.

In Scotland this will be achieved through the Scottish Government and COSLA long term obesity strategy, published in February 2010, 'Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight'<sup>149</sup>.

To assist individuals, the Scottish Government supports NHS weight management programmes including "Counterweight" which is an evidence-based approach to managing weight in primary care that helps obese patients achieve a healthier lifestyle and lose weight. The route map however recognises that obesity cannot be viewed simply as a health issue, nor will it be solved exclusively by reliance on individual behaviour change. A successful approach will require

<sup>145</sup> Health Survey for England 2009 <http://www.ic.nhs.uk/pubs/hse09report>

<sup>146</sup> Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603

<sup>147</sup> Gregg et al. JAMA 2005; 293 (15): 1868-74

<sup>148</sup> <http://dhsspsni.gov.uk/show/consultations?xtid=44910>

<sup>149</sup> Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight. <http://www.scotland.gov.uk/Topics/Health/health/healthyweight>

actions by individuals concerned, as well as cross-portfolio and cross-sector collaboration and investment to make deep, sustainable changes to our living environment in order to shift it from one that promotes weight gain to one that supports healthy choices and healthy weight for all.

In Wales this is happening through the All Wales Obesity Pathway<sup>150</sup>, published in June 2010. This is intended for use as a tool for Local Health Boards to map provision for the prevention and treatment of obesity, to identify gaps and to implement and manage activity across the full range of determinants which cause obesity and overweight patients in Wales.

Further information

NICE public health guidance 2 (2006). Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.

<http://guidance.nice.org.uk/PH2>

NICE public health guidance 6 (2007). Behaviour change at population, community and individual levels. <http://guidance.nice.org.uk/PH6/Guidance/pdf/English>

## Obesity (OB) indicator 1

The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months.

### OB 1.1 Rationale

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

### OB 1.2 Reporting and verification

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

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<sup>150</sup> All Wales Obesity Pathway. <http://Wales.gov.uk/topics/health/improvement/index/pathway/?lang=en>

## Learning disabilities (LD)

Indicator	Points	Payment stages
<b>Records</b>		
LD1. The practice can produce a register of patients aged 18 years and over with learning disabilities	4	
LD2. The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register) <i>NICE 2010 menu ID: NM04</i>	3	45–70%

### Learning disabilities - rationale for inclusion of indicator set

People with learning disabilities are among the most vulnerable and socially excluded in our society. It is estimated that there are approximately 20/1,000 people with mild learning disabilities and 3–4/1000 people with severe and profound learning disabilities in the UK. Over the past three decades, almost all the long stay NHS beds for people with learning disabilities have closed, and virtually all people with learning disabilities are now living in the community and depend on their practice for their primary health care needs.

Further information

Royal College of Nursing learning disabilities guidance.

[http://www.rcn.org.uk/development/practice/social\\_inclusion/learning\\_disabilities/guidance](http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities/guidance)

Department of Health (2009). 'Valuing People Now' a new three-year strategy for people with learning disabilities, sets out the Government's strategy for people with learning disabilities for the next three years following consultation.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093377](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377)

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

<http://www.scotland.gov.uk/Topics/Health/care/adult-care-and-support/learning-disability/Resources/sameasyou>

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

[http://www.healthscotland.com/uploads/documents/LD\\_summary.pdf](http://www.healthscotland.com/uploads/documents/LD_summary.pdf)

Northern Ireland Strategy on Learning Disability. <http://www.rmhdni.gov.uk/index/published-reports.htm>

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

[http://www.wales.nhs.uk/sites3/Documents/480/SP\\_response\\_guide-e.pdf](http://www.wales.nhs.uk/sites3/Documents/480/SP_response_guide-e.pdf)

Department of Health (2008). Independent Inquiry into Access to Healthcare for People with Learning Disabilities.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_099255](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099255)

## Learning disability (LD) indicator 1

The practice can produce a register of patients aged 18 years and over with learning disabilities.

### Learning disability 1.1 Rationale

The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike<sup>151</sup>.

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

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

The definition encompasses people with a broad range of disabilities. It includes adults with autism who also have learning disabilities, but not people with a higher level autistic spectrum disorder who may be of average or above average intelligence. The presence of an Intelligence Quotient below 70, should not, in isolation, be used in deciding whether someone has a learning disability.

The definition does not include all those people who have a "learning difficulty", i.e. specific difficulties with learning, such as dyslexia.

For many people, there is little difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multidisciplinary specialist learning disability team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality Community Learning Disability Teams, working along with PCOs, have provided expertise and data about and for people with learning disabilities. Practices should liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where employed by PCOs to assist in the construction of a primary care database<sup>152</sup>.

Further information

British Institute of Learning Disabilities. <http://www.bild.org.uk/>

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

The creation of a full register of patients aged 18 years and over with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

### Learning disability 1.2 Reporting and verification

The practice reports the number of patients aged 18 years and over on its learning disability register and the number of patients with learning disabilities as a proportion of total list size.

## Learning disability (LD) indicator 2 (NICE 2010 menu NM04)

The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register).

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<sup>151</sup> See Treat Me Right, Mencap (2004). [www.mencap.org.uk](http://www.mencap.org.uk)

<sup>152</sup> see Martin and Martin. Journal of Learning Disabilities, 2000; 4(1): 37-48

### **Learning disability 2.1 Rationale**

Children and adults with Down's Syndrome are at increased risk of thyroid dysfunction, particularly hypothyroidism, compared with the general population, and the incidence of thyroid dysfunction increases with age<sup>153</sup>. Poor thyroid function can impair an individual's quality of life. Earlier intervention and management can help to improve health outcomes.

### **Learning disability 2.2 Reporting and verification**

The practice reports the percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over with a record of blood TSH (thyroid stimulating hormone) in the preceding 15 months. Patients with a diagnosis of hypothyroidism should be excluded from this indicator as these patients should be managed according to the hypothyroid indicator set.

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<sup>153</sup> Rooney S, Walsh E (1997) Prevalence of abnormal thyroid function in a down's syndrome population. International Journal of Medical Science 166: 80–2.

# Smoking

Indicator	Points	Payment stages
<b>Ongoing management</b>		
SMOKING 5. 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 <i>NICE 2011 menu ID: NM38</i>	25	50-90%
SMOKING 6. 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 smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months <i>NICE 2011 menu ID: NM39</i>	25	50-90%
SMOKING 7. The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months	11	50-90%
SMOKING 8. The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months <i>NICE 2011 menu ID: NM40</i>	12	40-90%

## Smoking indicator 5 (NICE 2011 menu NM38)

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.

### Smoking 5.1 Rationale

#### Coronary heart disease

Smoking is known to be associated with an increased risk of CHD.

SIGN clinical guideline 97 (2007). European Task Force European Society of Cardiology.

[www.sign.ac.uk/guidelines/fulltext/97/index.html](http://www.sign.ac.uk/guidelines/fulltext/97/index.html)

European Society of Cardiology. European Guidelines. CVD Prevention in clinical practice.

<http://www.escardio.org/guidelines-surveys/esc-guidelines/pages/cvd-prevention.aspx>

#### PAD

Peripheral arterial disease is associated with older age and with smoking. Cigarette smoking is a very important contributor to PAD and management of PAD includes smoking cessation.

### **Stroke or TIA**

There are few randomised clinical trials of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However, inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated.

SIGN clinical guideline 108 (2008). Recommendation.

<http://www.sign.ac.uk/guidelines/fulltext/108/index.html>

### **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. NICE clinical guideline 127<sup>154</sup> 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.

NICE clinical guideline 101 (2010). Management of chronic obstructive pulmonary disease in adults in primary and secondary care. <http://guidance.nice.org.uk/CG101>

See also the GOLD Guidelines. [www.goldcopd.com/](http://www.goldcopd.com/)

### **Asthma**

There are a surprisingly small number of studies on smoking related to asthma. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. Smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome<sup>155</sup>. There is also epidemiological evidence that smoking is associated with poor asthma control<sup>156</sup>.

### **Chronic kidney disease**

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 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<sup>157</sup>.

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<sup>154</sup> NICE Clinical Guideline 127 (2011). Hypertension: Clinical management of primary hypertension in adults. <http://www.nice.org.uk/guidance/CG127>

<sup>155</sup> 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

<sup>156</sup> Price D, Zhang Q, Kocevar V et al. Effect of a concomitant diagnosis of allergic rhinitis on asthma-related health care use by adults. *Clin Exp Allergy* 2005; 35: 282-7

<sup>157</sup> McDonald C. Cigarette smoking in patients with schizophrenia. *Br J Psychiatr* 2000; 176: 596-7

### **Non-smokers**

It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 15 months up to and including 25 years of age.

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

### **Smoking 5.2 Reporting and verification**

The practice reports the percentage of patients on any or any combination of the named registers in whom smoking status has been recorded.

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

## **Smoking indicator 6 (NICE 2011 menu NM39)**

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 smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months.

### **Smoking 6.1 Rationale**

This indicator covers patients who are on the existing QOF disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma and mental health whose notes record smoking status.

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<sup>158</sup>. At any one time, about 12 per cent of smokers intend to stop smoking in the next month<sup>159</sup>. 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<sup>160</sup>.

There 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

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<sup>158</sup> Office for National Statistics (2011) General Lifestyle Survey 2009: Smoking and drinking among adults, 2009. Available from <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2009-report/index.html>

<sup>159</sup> Office for National Statistics (2008/09) Smoking related behaviour and attitudes. Available from <http://www.ons.gov.uk/ons/rel/lifestyles/smoking-related-behaviour-and-attitudes/2008-09/index.html>

<sup>160</sup> West R (2008) Key performance indicators: findings from the Smoking Toolkit Study. Smoking in England. Available from [www.smokinginengland.info](http://www.smokinginengland.info)

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<sup>161</sup>.

NHS Stop Smoking Services, the first nationwide smoking cessation treatment service in the world, 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<sup>162</sup>.

'An offer of support and treatment' therefore means offering referral or self-referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. 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, should be offered.

NICE public health guidance on smoking cessation<sup>163</sup> states that healthcare professionals who advise on, or prescribe, NRT, varenicline or bupropion should:

- offer NRT, varenicline or bupropion, as appropriate, to patients who are planning to stop smoking
- offer advice, encouragement and support, including referral to the NHS Stop Smoking Service, to help patients in their attempt to quit
- 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 should:

- offer behavioural counselling, group therapy, pharmacotherapy, or a combination of treatments that have been proven to be effective
- 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'<sup>164</sup> or its updates
- provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups
- provide services in the language chosen by clients, wherever possible.

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<sup>161</sup> Stead LF, Perera R, Bullen C etc al. (2008) Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews: Reviews (John Wiley and Sons, Ltd) no.1

<sup>162</sup> NHS Information Centre (2009) Statistics on NHS Stop Smoking Services: England, April 2008 to March 2009. Available from <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2008-to-march-2009>

<sup>163</sup> NICE (2008) Smoking cessation services. NICE public health guidance 10. Available from [www.nice.org.uk/guidance/PH10](http://www.nice.org.uk/guidance/PH10)

<sup>164</sup> Health development agency (2003) Standard for training in smoking cessation treatments. Available from [http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard\\_for\\_training\\_in\\_smoking\\_cessation\\_treatments.jsp](http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/standard_for_training_in_smoking_cessation_treatments.jsp)

For further information see NICE public health guidance 1 and 10<sup>165,166</sup>, Health Scotland's guide to smoking cessation<sup>167</sup> and Primary Care Respiratory Society UK statement on managing smoking cessation in primary care<sup>168</sup>.

### **Smoking 6.2 Reporting and verification**

Practices should report the percentage of patients on any (or any combination) of the named registers who smoke and who have a record of having been offered support and treatment in the preceding 15 months.

## **Smoking indicator 7**

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

### **Smoking 7.1 Rationale**

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record.

Current smokers should be recorded as such in the preceding 27 months. Non-smokers should be recorded as such in the preceding 27 months up to and including 25 years of age. Patients over 25 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 last 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 practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter, smoking status may only need to be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

### **Smoking 7.2 Reporting and verification**

Practices should report the percentage of patients aged 15 years and over whose notes contain a record of smoking status in the preceding 27 months.

## **Smoking indicator 8 (NICE 2011 menu NM40)**

The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months.

### **Smoking 8.1 Rationale**

This indicator builds on QOF indicator Smoking 7.

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<sup>165</sup> NICE (2008) Smoking cessation services. NICE public health guidance 10. Available from [www.nice.org.uk/guidance/PH10](http://www.nice.org.uk/guidance/PH10)

<sup>166</sup> NICE (2006) brief interventions and referral for smoking cessation in primary care and other settings. NICE public health guidance 1. Available from <http://guidance.nice.org.uk/ph1>

<sup>167</sup> Health Scotland (2010) A guide to smoking cessation in Scotland 2010. Available from [www.healthscotland.com/documents/4661.aspx](http://www.healthscotland.com/documents/4661.aspx)

<sup>168</sup> Primary Care Respiratory Society UK (2010) Managing smoking cessation in primary care. Opinion No. 17. Available from [www.pcrs-uk.org/resources/os17\\_smoking\\_cess.pdf](http://www.pcrs-uk.org/resources/os17_smoking_cess.pdf)

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<sup>169</sup>. It is the primary reason for the gap in healthy life expectancy between rich and poor<sup>170</sup>.

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis (US Department of Health and Human Services 2004).

Women who smoke during pregnancy have a substantially higher risk of spontaneous abortion (miscarriage) than those who do not 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<sup>171</sup>.

Around 43 per cent of patients who smoke try to quit each year, often several times in 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 1-year continuous abstinence rate in untreated smokers who try to quit without help is about 3 per cent<sup>172</sup>.

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 practice staff, such as a practice nurse, providing regular weekly support, the 1-year continuous abstinence rate doubles to about 15 per cent.

See Smoking 6.1 for guidance on what 'support and treatment' and smoking cessation.

### **Smoking 8.2 Reporting and verification**

Practices should report the percentage of patients recorded as current smokers who have been offered support and treatment for smoking cessation within the preceding 27 months.

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<sup>169</sup> Twigg L, Moon G, Walker S (2004) The smoking epidemic in England. London: Health Development Agency.

<sup>170</sup> Jarvis M, Wardle J, (1999) Social patterning of individual health behaviours: the case of cigarette smoking. In: Marmot M, Wilkinson R, editors. Social determinants of health. Oxford: Oxford University Press.

<sup>171</sup> NICE (2008) Smoking cessation services. NICE public health guidance 10.

[www.nice.org.uk/guidance/PH10](http://www.nice.org.uk/guidance/PH10)

<sup>172</sup> Health Scotland (2010) A guide to smoking cessation in Scotland 2010. Available from <http://www.healthscotland.com/documents/4661.aspx>

## Peripheral Arterial Disease (PAD)

Indicator	Points	Payment stages
<b>Records</b>		
PAD1. The practice can produce a register of patients with peripheral arterial disease <i>NICE 2011 menu ID: NM32</i>	2	
<b>Ongoing management</b>		
PAD2. 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 <i>NICE 2011 menu ID: NM33</i>	2	40-90%
PAD3. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less <i>NICE 2011 menu ID: NM34</i>	2	40-90%
PAD4. The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less <i>NICE 2011 menu ID: NM35</i>	3	40-90%

### Peripheral Arterial Disease (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 myocardial infarction 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 for PAD focuses on cardiovascular risk factor management. Smoking is a very important risk factor for PAD, and management of PAD includes smoking cessation. Other established risk factors are high blood pressure and diabetes. This would mean that people with PAD and high blood pressure would currently be included in the hypertension indicator domain for QOF and people with diabetes and PAD would be included in the diabetes indicator domain for QOF.

This set of indicators for PAD aims 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.

NICE is developing a clinical guideline on PAD (publication expected October 2012).

## Peripheral Arterial Disease (PAD) indicator 1 (NICE 2011 menu NM32)

The practice can produce a register of patients with peripheral arterial disease.

### PAD 1.1 Rationale

Patients with PAD may have symptoms, but can also be asymptomatic.

About 20 per cent of patients older than 60 have PAD, although only a quarter of these have symptoms. Symptoms become severe and progressive in approximately 20 per cent of patients with symptomatic PAD<sup>173</sup>.

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<sup>173</sup>.

The SIGN guideline 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<sup>174</sup>. The SIGN 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<sup>174</sup>. 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.

See [SIGN clinical guideline 89](#) for further information<sup>174</sup>.

### PAD 1.2 Reporting and verification

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

## Peripheral Arterial Disease (PAD) indicator 2 (NICE 2011 menu 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.

### PAD 2.1 Rationale

Most cases of PAD are managed in primary care. The focus of management is on the secondary prevention of cardiovascular disease. 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 medical records of patients with PAD<sup>175,176</sup> suggest that these patients have poor hypertension control, use low levels of statin and antiplatelet therapy, and receive low levels of smoking cessation advice. This indicator addresses the issue of prescribing antiplatelet therapy.

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<sup>173</sup> Scottish Intercollegiate Guidelines Network (2006) Diagnosis and management of peripheral arterial disease: A national clinical guideline (89). Available from [www.sign.ac.uk/pdf/sign89.pdf](http://www.sign.ac.uk/pdf/sign89.pdf)

<sup>174</sup> NICE (2011) Lower limb peripheral arterial disease: SCOPE. Scope for a clinical guideline. Available from <http://www.nice.org.uk/guidance/index.jsp?action=download&o=50971>

<sup>175</sup> Bradley L, Kirker SGB (2006) Secondary prevention of arteriosclerosis in lower limb vascular amputees: a missed opportunity. *European Journal of Vascular and Endovascular Surgery* 32: 491-493

<sup>176</sup> Khan S, Flather M, Mister R et al. (2007) Characteristics and treatments of patients with peripheral arterial disease referred to UK vascular clinics: results of a prospective registry. *European Journal of Vascular and Endovascular Surgery* 33: 442-450

The SIGN clinical guideline on PAD states that antiplatelet therapy is recommended for patients with symptomatic PAD<sup>177</sup>.

The Antithrombotic Trialists' Collaboration meta-analysis showed a 23 per cent reduction in serious vascular events in a subgroup of 9214 people with PAD who were treated with antiplatelet drugs<sup>178</sup>. Similar results were found in a second systematic review of the effects of antiplatelet therapy in patients with PAD<sup>179</sup>. When comparing the effects of different antiplatelet drugs, the Antithrombotic Trialists' Collaboration found no evidence statistically significant differences between anti-platelets.

NICE has published technology appraisal guidance on the use of clopidogrel and modified-release dipyridamole to prevent occlusive vascular events (ischaemic stroke, TIA and MI). It recommends clopidogrel as an option to prevent occlusive vascular events in patients who have established PAD<sup>179</sup>. NICE is currently developing a clinical guideline on lower limb peripheral arterial disease (publication expected October 2012).

### **PAD 2.2 Reporting and verification**

The practice reports the percentage of patients on the PAD register who have been prescribed aspirin or clopidogrel within the preceding 15 months or have a record of taking over the counter aspirin updated in the preceding 15 months. Those patients already prescribed an anti-coagulant will be excluded from the indicator.

## **Peripheral Arterial Disease (PAD) indicator 3 (NICE 2011 menu 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 or less.

### **PAD 3.1 Rationale**

Most cases of PAD are managed in primary care. The focus of treatment is on the cardiovascular complications of atherosclerosis (that is, managing cardiovascular risk factors such as high blood pressure). Two small UK studies assessing clinical risk management based on the medical records of patients with PAD<sup>180,181</sup> suggest that these patients have poor hypertension control, use low levels of statin and antiplatelet therapy, and receive low levels of smoking cessation advice. This indicator addresses the issue of blood pressure control.

The SIGN guideline on the diagnosis and management of PAD<sup>182</sup> recommends that hypertensive patients with PAD should receive treatment to reduce their blood pressure. The guideline developers noted that treatment of PAD has often been considered difficult because of

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<sup>177</sup> Scottish Intercollegiate Guidelines Network (2006) Diagnosis and management of peripheral arterial disease: a national clinical guideline. Available from [www.sign.ac.uk/pdf/sign89.pdf](http://www.sign.ac.uk/pdf/sign89.pdf)

<sup>178</sup> Antithrombotics Trialists' Collaboration (2002) Collaborative meta-analysis of randomised trials of anti-platelet therapy for prevention of death, myocardial infarction and stroke in high risk patients. *British Medical Journal* 324: 71-86

<sup>179</sup> National Institute for Health and Clinical Excellence (2010) Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events. NICE technology appraisal guidance 210. London: National Institute for Health and Clinical Excellence. Available from [www.nice.org.uk/guidance/TA210](http://www.nice.org.uk/guidance/TA210)

<sup>180</sup> Bradley L, Kirker SG. Secondary prevention of arteriosclerosis in lower limb vascular amputees: a missed opportunity (2006) *European Journal of Vascular and Endovascular Surgery* 32: 491-493

<sup>181</sup> Khan S, Flather M, Mister R et al. (2007) Characteristics and treatments of patients with peripheral arterial disease referred to UK vascular clinics: results of a prospective registry. *European Journal of Vascular and Endovascular Surgery* 33: 442-450

<sup>182</sup> Scottish Intercollegiate Guidelines Network (2006) Diagnosis and management of peripheral arterial disease: a national clinical guideline (89). Available from <http://www.sign.ac.uk/guidelines/fulltext/89/index.html>

concerns that antihypertensive 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 events with certainty.

Recommendation 2.6 in the SIGN guideline<sup>182</sup> 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 (2011) sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the rationale for the hypertension domain. All patients aged under 80 years with CVD and 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 or higher) are recommended drug therapy for hypertension.

The NICE clinical guideline on Hypertension (2011) recommends a target clinic blood pressure below 140/90 mmHg in patients aged under 80 years with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 years and over, with a treated hypertension.

For the purpose of QOF, a measurement of 150/90 has been adopted.

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<sup>183</sup>.

### **PAD 3.2 Reporting and verification**

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

## **Peripheral Arterial Disease (PAD) indicator 4 (NICE 2011 menu NM35)**

The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less.

### **PAD 4.1 Rationale**

This indicator measures the immediate health outcome of total cholesterol of 5mmol/l or less in patients with PAD.

Most cases of PAD are managed in primary care. The focus of management is on preventing the cardiovascular complications of atherosclerosis (that is, managing cardiovascular risk factors such as high blood pressure). Two small UK studies assessing clinical risk management based on the medical records of patients with peripheral vascular disease<sup>184,185</sup> suggest that these patients

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<sup>183</sup> National Institute for Health and Clinical Excellence (2006) Hypertension in adults in primary care. NICE clinical guideline 34. Available from [www.nice.org.uk/CG34](http://www.nice.org.uk/CG34)

<sup>184</sup> Bradley L, Kirker SGB (2006) Secondary prevention of arteriosclerosis in lower limb vascular amputees: a missed opportunity. *European Journal of Vascular and Endovascular Surgery* 32: 491-493

have poor hypertension control, use low levels of statin and antiplatelet therapy, and receive low levels of smoking cessation advice. This indicator addresses the issue of cholesterol control.

NICE clinical guideline 67<sup>186</sup> states that statin therapy is recommended for adults with clinical evidence of cardiovascular disease, including patients with PAD. The SIGN guideline on PAD<sup>187</sup> states that lipid-lowering therapy with a statin is recommended for patients with PAD and total cholesterol level greater than 3.5 mmol/litre.

NICE clinical guideline 67<sup>185</sup> recommends that a total cholesterol level of 5 mmol/litre should be used as an 'audit' level to assess progress in patients with cardiovascular disease, in recognition that more than half of them will not achieve a total cholesterol level of less than 4 mmol/litre or a low density lipoprotein (LDL) cholesterol level of less than 2 mmol/litre<sup>185</sup>.

The appraisal committee for 'Statins for the prevention of cardiovascular events' concluded that statin therapy to achieve reductions in cholesterol is cost effective for patients with clinical evidence of cardiovascular disease<sup>188</sup>.

#### **PAD 4.2 Reporting and verification**

The practice reports the percentage of patients on the PAD register with a record of a total cholesterol level of 5 mmol/litre or less in the preceding 15 months.

The following approaches could be taken to verify that this information has been correctly recorded:

- inspection of the output from a computer search that has been used to provide information on this indicator
- inspection of a sample of medical records for patients with PAD to look at the proportion with a recorded serum cholesterol level of 5 mmol/litre or less
- inspection of a sample of medical records for patients with PAD for whom a record of serum cholesterol at 5 mmol/litre is claimed, to see if this can be confirmed.

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<sup>185</sup> Khan S, Flather M, Mister R et al. (2007) Characteristics and treatments of patients with peripheral arterial disease referred to UK vascular clinics: results of a prospective registry. *European Journal of Vascular and Endovascular Surgery* 33: 442-450

<sup>186</sup> National Institute for Health and Clinical Excellence (2010) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 67. London: National Institute for Health and Clinical Excellence. Available from [www.nice.org.uk/CG67](http://www.nice.org.uk/CG67)

<sup>187</sup> Scottish Intercollegiate Guidelines Network (2006) Diagnosis and management of peripheral arterial disease: a national clinical guideline (89). Available from <http://www.sign.ac.uk/guidelines/fulltext/89/index.html>

<sup>188</sup> National Institute for Health and Clinical Excellence (2006) Statins for the prevention of cardiovascular events. NICE technology appraisal guidance 94. London: National Institute for Health and Clinical Excellence. Available from [www.nice.org.uk/TA94](http://www.nice.org.uk/TA94)

## Osteoporosis : secondary prevention of fragility fractures (OST)

Indicator	Points	Payment stages
<b>Records</b>		
<p>OST1. The practice can produce a register of patients:</p> <ol style="list-style-type: none"> <li>1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and</li> <li>2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012</li> </ol> <p><i>NICE 2011 menu ID: NM29</i></p>	3	
<b>Ongoing management</b>		
<p>OST2. The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent</p> <p><i>NICE 2011 menu ID: NM30</i></p>	3	30-60%
<p>OST3. The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent</p> <p><i>NICE 2011 menu ID: NM31</i></p>	3	30-60%

### Osteoporosis : secondary prevention of fragility fractures (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.

### Osteoporosis (OST) indicator 1 (NICE 2011 menu: NM29)

The practice can produce a register of patients:

1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and
2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012.

### **OST 1.1 Rationale**

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<sup>189</sup>.

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.

NICE recommends that a diagnosis of osteoporosis may be assumed in women and men aged 75 years and over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible<sup>190</sup>. SIGN recommends that in frail elderly women (aged 80 years and over) a DXA scan would be a prerequisite to establish that BMD is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

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 the menopause, from approximately two per cent at 50 years, rising to more than 25 per cent at 80 years. The NICE cost impact report for technology appraisal 161<sup>191</sup> uses a prevalence of 11 per cent of post-menopausal women aged 50 years and over with osteoporosis and a clinically apparent osteoporotic fragility fracture, rising to 19 per cent for ages 65 years and over. There are an estimated 180,000 new fragility fractures in postmenopausal women in the UK each year; three quarters in women aged 65 years and 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 10 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<sup>192</sup>.

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<sup>189</sup> World Health Organisation (1998) Guidelines for preclinical evaluation and clinical trials in osteoporosis

<sup>190</sup> NICE (2008) Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. (amended January 2010 and January 2011). NICE technology appraisal guidance 161. Available from [www.nice.org.uk/guidance/TA161](http://www.nice.org.uk/guidance/TA161)

<sup>191</sup> NICE (2008) Costing report for technology appraisal guidance 161 on Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women

<sup>192</sup> World Health Organisation (1998) Guidelines for preclinical evaluation and clinical trials in osteoporosis

The SIGN clinical guideline on management of osteoporosis recommends that patients who have suffered one or more fragility fractures should be priority targets for investigation and treatment of osteoporosis<sup>193</sup>.

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.

### **OST 1.2 Reporting and verification**

The Business Rules for the two-part register will look for the following criteria:

In patients aged 50–74 years:

- 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 years and over:

- a fragility fracture at any point on or after the implementation date (1 April 2012).

The DXA scan codes will only be those that indicate a positive result of osteoporosis, and T-score codes will not be included. Patients aged 50-74 years in whom a diagnosis of osteoporosis has not been confirmed with DXA scanning will not be included in the register. Fragility fractures sustained in the last three months of the year will be excluded.

## **Osteoporosis (OST) indicator 2 (NICE 2011 menu NM30)**

The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.

### **OST 2.1 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<sup>194</sup>. Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

The SIGN guideline on 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 should be 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 of these groups bone-sparing agents are indicated to reduce subsequent fracture risk. NICE technology appraisal 161 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, the preparation prescribed should be chosen on the basis of the lowest acquisition

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<sup>193</sup> SIGN (2003) Management of osteoporosis. SIGN clinical guideline 71. Available from [www.sign.ac.uk/guidelines/fulltext/71/index.html](http://www.sign.ac.uk/guidelines/fulltext/71/index.html)

<sup>194</sup> SIGN (2003) Management of osteoporosis. SIGN clinical guideline 71. Available from [www.sign.ac.uk/guidelines/fulltext/71/index.html](http://www.sign.ac.uk/guidelines/fulltext/71/index.html)

cost available<sup>195</sup>. The bone-sparing agents risedronate and etidronate are recommended as alternative treatment options for the 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**

Age (years)	Number of independent clinical risk factors for fracture <sup>a</sup>		
	0	1	2
50 - 54	- <sup>b</sup>	-3.0	-2.5
55 - 59	-3.0	-3.0	-2.5
60 - 64	-3.0	-3.0	-2.5
65 - 69	-3.0	-2.5	-2.5
70 or older	-2.5	-2.5	-2.5

<sup>a</sup> Independent clinical risk factors for fracture are parental history of hip fracture, alcohol intake of four or more units per day, and rheumatoid arthritis.

<sup>b</sup> 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.

For more information see NICE technology appraisal 161, available from [www.nice.org.uk/guidance/TA161](http://www.nice.org.uk/guidance/TA161)

The SIGN clinical guideline<sup>196</sup> makes recommendations on men with a diagnosis of osteoporosis determined by DXA scan. It states that to reduce fracture risk at all sites, men with low BMD and/or a history of one or more vertebral fractures or one non-vertebral osteoporotic fracture should be treated with oral alendronate.

Calcium and vitamin D supplementation should be used in combination with bone-sparing agents. The SIGN clinical guideline 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 2.2 Reporting and verification

The practice reports the percentage of patients aged 50-74 on the 'Osteoporosis : secondary prevention of fragility fractures' register who are currently treated with a bone-sparing agent. Patients are considered to be 'currently treated' if they have had a prescription for a bone-sparing agent within the last six months of the QOF year.

<sup>195</sup> NICE (2008) Alendronate, etidronate, risedronate, raloxifene, strontium ranelate, and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (amended January 2010 and January 2011). NICE technology appraisal guidance 161. Available from [www.nice.org.uk/guidance/TA161](http://www.nice.org.uk/guidance/TA161)

<sup>196</sup> SIGN (2003) Management of osteoporosis. SIGN clinical guideline 71. Available from [www.sign.ac.uk/guidelines/fulltext/71/index.html](http://www.sign.ac.uk/guidelines/fulltext/71/index.html)

## **Osteoporosis (OST) indicator 3 (NICE 2011 menu NM31)**

The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent.

### **OST 3.1 Rationale**

See OST 2

This indicator does not require that in people aged over 75 with a fragility fracture a diagnosis of osteoporosis confirmed by DXA scan is made. But it is recommended clinical practice that this group should be considered for a DXA scan. NICE recommends that a diagnosis of osteoporosis may be assumed in women aged 75 years and over with a fragility fracture if the responsible clinical considers a DXA scan to be clinically inappropriate or unfeasible<sup>197</sup>. SIGN recommends that in frail elderly women (aged 80 years and over) a DXA scan would be a prerequisite to establish that BMD is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

### **OST 3.2 Reporting and verification**

The practice reports the percentage of patients aged 75 years and over on the osteoporosis register who are currently treated with a bone-sparing agent. Patients are considered to be 'currently treated' if they have had a prescription for a bone-sparing agent in the last six months of the QOF year.

A diagnosis of osteoporosis is not required in patients aged 75 years and over who have a fragility fracture. If, however, a patient aged over 75 has a DXA scan and this shows the patient not to have osteoporosis then the patient can be exception coded.

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<sup>197</sup> NICE (2008) Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (amended January 2010 and January 2011). NICE technology appraisal guidance 161. Available from [www.nice.org.uk/guidance/TA161](http://www.nice.org.uk/guidance/TA161)

# Section 4. Organisational domain

## Organisational domain introduction

The organisational (not including the Quality and Productivity indicators) domain indicators include indicator wording along with information in the following areas to support the indicator:

- practice guidance
- written evidence
- assessment visit
- assessors guidance.

The Quality and Productivity indicators follow the layout of clinical indicators referring to sections on the indicator rationale and reporting and verification.

Further detail on the above areas is included in the 'format' section below.

Please note exception reporting does not apply to the organisational indicators.

The organisational indicators are split into six areas:

1. Records and information about patients (A)
2. Information for patients (B)
3. Education and training (C)
4. Practice management (D)
5. Medicines management (E)
6. Quality and productivity (F)

## Format

Each of the indicators (X) in the first five organisational domains has four descriptions unless it is reported electronically.

### X.1 Practice guidance

This section contains a number of things, dependent on the indicator, including:

- justification for the indicator
- a more detailed description of the indicator
- references which practices may find useful
- some helpful guidance on how practices may go about meeting the requirements of the indicator.

## **X.2 Written evidence**

This specifies the written evidence which a practice would be expected to produce for an assessment visit. The evidence generally should be available in the practice and need not be submitted in advance. However, some written evidence will be required in advance and this is indicated in the document. In some instances no written evidence will be required but may be requested if there is an appeal.

In summary, written evidence is categorised as follows:

- Grade A – to be submitted in advance of a visit
- Grade B – to be available in the practice at the visit
- Grade C – optional or used in the event of an appeal

## **X.3 Assessment visit**

This section describes how a visiting assessment team will verify the written evidence.

## **X.4 Assessors' guidance**

This section contains more detailed guidance for assessors to use during practice assessment visits. This guidance has been produced to ensure that practices are being judged to the same standard across the UK.

Each of the indicators (X) in the quality and productivity (QP) organisational areas has two descriptions, namely practice guidance and reporting and verification:

### **X.1 Practice guidance**

As above.

### **X.2 Reporting and verification**

As per X.2 to X.4 above.

## **Equivalence – other schemes**

It is recognised that a number of schemes are currently in place across the UK to encourage practice development. Other practice-based accreditation schemes may apply to the National Reference Group to be recommended as equivalent to appropriate aspects of the organisational indicators of the QOF.

These schemes must involve the practice in meeting indicators considered by the Reference Group to be equivalent to a relevant indicator in the Framework. Any scheme which is to be considered must include as part of its process a visit to the practice.

The RCGP Quality Practice Award (QPA) has been approved for the first five sub domains of the organisational indicator areas in the Framework. Practices should be prepared to provide evidence that they have achieved the QPA in order to meet the requirements of this domain.

## **Quality and Productivity indicator set**

The Quality and Productivity indicators aim to support general practices in the review of current practice, both within the practice itself and with external peers. This review would be informed by the analysis of data specific to the practice in covering three areas, in order to understand the reasons for variation in performance and if appropriate to address any underlying reasons.

The three areas are:

- first outpatient referrals
- emergency admissions

- avoidable accident and emergency (A&E) attendances

Practices as a provider of primary care services and a gateway to secondary care services, should be prepared to make the most effective use of available NHS resources (including skills, premises and treatments) to deliver improvements to the population's health and social wellbeing. This is in line with the GMC's Good Medical Practice guidance<sup>198</sup>.

To ensure that this is delivered, practices are expected to:

- avoid duplicating work through ensuring clear communication, partnership working and appropriate information sharing with all parts of the health service and where relevant social care services
- minimise waste in prescribing and ineffective treatments; and
- engage effectively in the prevention of ill health to avoid the need for costly treatments by proactively managing patients to recovery through the whole care pathway in acting as conscientious gatekeepers to services.

For the purpose of the QP indicators, a care pathway is a defined process of diagnosis, treatment and care for a defined group of patients during a defined period.

The QP indicators on outpatient referrals and emergency admissions will be extended for a further year until 31 March 2013. The QP indicators on avoidable A&E attendances will remain in force until 31 March 2013.

In line with other indicators within the organisational domain, exception reporting will not apply.

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<sup>198</sup> GMC's Good Medical Practice guidance.  
[http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

## Records and information

	Indicator	Points
<b>Records 3</b>	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
<b>Records 8</b>	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
<b>Records 9</b>	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004) Minimum Standard 80%	4
<b>Records 11</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients	10
<b>Records 13</b>	There is a system to alert the out of hours service or duty doctor to patients dying at home	2
<b>Records 15</b>	The practice has up to date clinical summaries in at least 60% of patient records	25
<b>Records 17</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients	5
<b>Records 18</b>	The practice has up to date clinical summaries in at least 80% of patient records	8
<b>Records 19</b>	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
<b>Records 20</b>	The practice has up to date clinical summaries in at least 70% of patient records	12

### Records indicator 3

The practice has a system for transferring and acting on information about patients seen by other doctors out of hours.

#### Records 3.1 Practice guidance

Good Medical Practice for General Practitioners (GMP for GPs) 2008 states that the excellent GP “can demonstrate an effective system for transferring and acting on information from other doctors about patients”. Out of hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

If the practice undertakes its own out of hours cover, there needs to be a system to ensure that out of hours contacts are entered in the patient’s clinical record.

If out of hours cover is provided by another organisation, for example a cooperative, deputising service, PCO provided service or shared rota there needs to be a system for:

- transferring information to the practice
- transferring that information into the clinical record
- identifying and actioning any required follow-up.

### **Records 3.2 Written evidence**

There must be a written procedure for the transfer of information (Grade B).

### **Records 3.3 Assessment visit**

Inspection of the procedure for the transfer of information may be carried out on an assessment visit.

### **Records 3.4 Assessors' guidance**

Receptionists and doctors will be questioned on the system for the transfer of information.

## **Records indicator 8**

There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded.

### **Records 8.1 Practice guidance**

It is important that a clinician avoids prescribing a drug to which the patient is known to be allergic. Not all patients can recall this information and hence records of allergies are important.

All prescribing clinicians should know where such information is recorded. Ideally the place where this information is recorded should be limited to one place and not more than two places.

### **Records 8.2 Written evidence**

There should be a statement as to where drug allergies are recorded (Grade C).

### **Records 8.3 Assessment visit**

The practice should be able to demonstrate where drug allergies are recorded.

### **Records 8.4 Assessors' guidance**

The place where drug allergies are recorded can be on the computer or in the paper records. This information should be easily available to the prescribing clinician at the time of consultation.

## **Records indicator 9**

For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004).

Minimum standard 80%.

### **Records 9.1 Practice guidance**

When reviewing medication, it is important to know why a drug was started. This information in the past has often been difficult to identify in practice records, particularly if a patient has been on a medication for a long time or has transferred between practices. It is proposed that this information needs to be recorded clearly in the clinical records.

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

### **Records 9.2 Written evidence**

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80 per cent of repeat medications commenced after 1 April 2004 (Grade A).

### **Records 9.3 Assessment visit**

The records should be inspected.

### **Records 9.4 Assessors' guidance**

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of 20 patients for whom repeat medication has been started since that date should be surveyed. If the standard is not achieved then a further 20 clinical records should be surveyed and the cumulative total should be used.

The minimum standard is that 80 per cent of the indications for repeat medication drugs can be identified.

## **Records indicator 11**

The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients.

### **Records 11.1 Practice guidance**

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 years and over has been pragmatically chosen as the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is Records Indicator 17 but a higher standard must be achieved.

### **Records 11.2 Written evidence**

A survey of the records of patients 45 years of age and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in the preceding five years (Grade A).

### **Records 11.3 Assessment visit**

A random sample of 20 notes or computerised records of patients 45 years of age and over should be inspected, to confirm that blood pressure has been recorded in the preceding five years.

### **Records 11.4 Assessors' guidance**

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 years and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

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

The practice reports the percentage of patients aged 45 years and over in whom there is a record of blood pressure having been recorded in the preceding 5 years.

## Records indicator 13

There is a system to alert the out of hours service or duty doctor to patients dying at home.

### Records 13.1 Practice guidance

Good Medical Practice (2008) states that when off duty the doctor ensures there are arrangements which “include effective handover procedures and clear communication between doctors”. It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out of hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out of hours period. If a practice performs its own on call duties then a system should ensure that all doctors in the practice are aware of these patients. A single handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice e.g. on holiday.

### Records 13.2 Written evidence

The system for alerting the out of hours service or duty doctor to patients dying at home should be described (Grade C).

### Records 13.3 Assessment visit

The doctors in the practice should be questioned on the system that is in place.

### Records 13.4 Assessors' guidance

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill and/or dying at home and what information was passed to the out of hours service or duty doctor.

## Records indicator 15

The practice has up to date clinical summaries in at least 60% of patient records.

### Records 15.1 Practice guidance

GMP for GPs (2008) states “Important information in records should be easily accessible, for example, as part of a summary”.

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in the summary. All significant past and continuing problems should be included.

If a computer is used, the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data. Practices should adhere to the joint RCGP/GPC guidance on record keeping. This can be found at:  
[http://www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/gp2gp/docs/good\\_practice\\_guidelines.pdf/view](http://www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/gp2gp/docs/good_practice_guidelines.pdf/view)

Similar indicators are Records 18 and Records 20 but higher standards must be achieved.

### **Records 15.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date (Grade A).

### **Records 15.3 Assessment visit**

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

### **Records 15.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess this indicator based on their own experience and beliefs.

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

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

## **Records indicator 17**

The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients.

### **Records 17.1 Practice guidance**

See Records 11.1

### **Records 17.2 Written evidence**

See Records 11.2 (Grade A)

### **Records 17.3 Assessment visit**

See Records 11.3

### **Records 17.4 Assessors' guidance**

See Records 11.4

## **Records indicator 18**

The practice has up to date clinical summaries in at least 80% of patient records.

### **Records 18.1 Practice guidance**

See Records 15.1

### **Records 18.2 Written evidence**

See Records 15.2 (Grade A)

### **Records 18.3 Assessment visit**

See Records 15.3

### **Records 18.4 Assessors' guidance**

See Records 15.4

## Records indicator 19

80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice.

### Records 19.1 Practice guidance

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

### Records 19.2 Written evidence

A survey should be carried out of the records of newly registered patients whose notes have been received between eight and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively a computer print-out should be examined, showing the patients registered where the records have been received between eight and 26 weeks previously, to confirm whether the computer record contains a clinical summary (Grade A).

### Records 19.3 Assessment visit

A sample of 20 records of patients whose records were sent to the practice between nine and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

### Records 19.4 Assessors' guidance

A list of patients registered in the past 12 months and whose records have been forwarded between nine and 26 weeks ago to the practice will be obtained from the PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least 10 per cent) from the practice survey a further 20 records will be checked if appropriate.

## Records indicator 20

The practice has up to date clinical summaries in at least 70% of patient records.

### Records 20.1 Practice guidance

See Records 15.1

### Records 20.2 Written evidence

See Records 15.2 (Grade A)

### Records 20.3 Assessment visit

See Records 15.3

### Records 20.4 Assessors guidance

See Records 15.4

## Information for patients

	Indicator	Points
<b>Information 5</b>	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2

### Information indicator 5

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

#### Information 5.1 Practice guidance

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

#### Information 5.2 Written evidence

There should be a practice protocol concerning smoking cessation (Grade A).

#### Information 5.3 Assessment visit

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

#### Information 5.4 Assessors' guidance

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

## Education and training

	Indicator	Points
<b>Education 11</b>	There is a record of all practice-employed clinical staff and clinical partners having attended training/updating in basic life support skills in the preceding 18 months	4
<b>Education 5</b>	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
<b>Education 6</b>	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
<b>Education 7</b>	The practice has undertaken a minimum of 12 significant event reviews in the preceding 3 years which could include: <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• New cancer diagnoses</li> <li>• Deaths where terminal care has taken place at home</li> <li>• Any suicides</li> <li>• Admissions under the Mental Health Act</li> <li>• Child protection cases</li> <li>• Medication errors</li> <li>• A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)</li> </ul>	4
<b>Education 8</b>	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5
<b>Education 9</b>	All practice-employed non-clinical team members have an annual appraisal	3
<b>Education 10</b>	The practice has undertaken a minimum of 3 significant event reviews within the preceding year	6

### Education indicator 11

There is a record of all practice-employed clinical staff and clinical partners having attended training/updating in basic life support skills in the preceding 18 months.

#### Education 11.1 Practice guidance

The primary care team members, including GPs deal with cardio-pulmonary collapse relatively rarely, but require up to date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local A&E Department, BASICS, the PCO, out of hours cooperative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Further information

Cardiopulmonary Resuscitation Guidance for Clinical Practice and Training in Primary Care (2001). <http://www.resus.org.uk/pages/cpatpc.htm>

Resuscitation Council UK (2005). Resuscitation guidelines. <http://www.resus.org.uk/pages/guide.htm>

### **Education 11.2 Written evidence**

Attendance at basic life support (BLS) training should be listed (Grade B).

### **Education 11.3 Assessment visit**

Staff should be questioned on the date of their last BLS training.

### **Education 11.4 Assessors' guidance**

Assessors should confirm by checking the BLS attendance list that practice-employed clinical staff have attended.

## **Education indicator 5**

There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months.

### **Education 5.1 Practice guidance**

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outside the practice premises.

See Education 11.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

### **Education 5.2 Written evidence**

Attendance at BLS training should be listed. (Grade B)

### **Education 5.3 Assessment visit**

Staff should be questioned on the date of their last BLS training.

### **Education 5.4 Assessors' guidance**

Confirmation that practice non-clinical staff have attended training should be obtained by checking the BLS attendance list.

## **Education indicator 6**

The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team.

### **Education 6.1 Practice guidance**

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (indicators Education 7 and Education 10).

#### **Education 6.2 Written evidence**

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

#### **Education 6.3 Assessment visit**

The issue of learning from complaints should be discussed with staff and GPs.

#### **Education 6.4 Assessors' guidance**

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

### **Education indicator 7**

The practice has undertaken a minimum of 12 significant event reviews in the preceding 3 years which could include:

- Any death occurring in the practice premises
- New cancer diagnoses
- Deaths where terminal care has taken place at home
- Any suicides
- Admissions under the Mental Health Act
- Child protection cases
- Medication errors
- A significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss).

#### **Education 7.1 Practice guidance**

Detail of methodology on significant event analysis is given in indicator Education 10.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, e.g. patient suicide, then this should be stated in the evidence.

#### **Education 7.2 Written evidence**

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

#### **Education 7.3 Assessment visit**

The reviews should be discussed.

#### **Education 7.4 Assessors' guidance**

The practice should report on its analyses in a form consistent with either of the two methods described in indicator Education 10.

### **Education indicator 8**

All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal.

#### **Education 8.1 Practice guidance**

The production of a personal learning plan should be one of the outcomes of the appraisal system and the points allocated to this indicator have been allocated to reflect this. The plan should record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

An annual appraisal can reasonably be extended to employed members of the nursing team e.g. Health Care Assistants (HCAs) who have direct patient contact. This supports good practice arrangements.

#### **Education 8.2 Written evidence**

The staff appraisal system should be described. (Grade C)

#### **Education 8.3 Assessment visit**

A discussion should be held with practice-employed nursing staff (including employed members of the nursing team e.g. HCAs who have direct patient contact) about their personal learning plans and the appraisal system.

#### **Education 8.4 Assessors' guidance**

Personal learning plans and the appraisal system should be discussed with practice-employed nursing staff (including employed members of the nursing team e.g. HCAs who have direct patient contact) and the person responsible for managing the appraisal system.

### **Education indicator 9**

All practice-employed non-clinical team members have an annual appraisal.

#### **Education 9.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

#### **Education 9.2 Written evidence**

The staff appraisal system should be described. (Grade C)

#### **Education 9.3 Assessment visit**

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

### Education 9.4 Assessors' guidance

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

## Education indicator 10

The practice has undertaken a minimum of 3 significant event reviews within the preceding year.

### Education 10.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between healthcare professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1. A multidisciplinary meeting to explain the concept.
2. Consideration of events which should be important to the practice but need not imply criticism of the practice or of individuals. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper. Some of the examples from this are below.

Preventative care:	Measles Unplanned pregnancy Non-accidental injury Squint diagnosed by an ophthalmologist
Acute care:	Sudden unexpected death Death occurring on the practice premises Suicide or suicide attempt All new cancer diagnoses Myocardial Infarction Terminal care death at home Section under Mental Health Act
Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

3. Mechanism for identification of events. A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.
4. Significant events meetings. These are generally multidisciplinary but need not be so and need to be sensitively chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This could be:

- celebration of excellent care
- no change
- audit required
- immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

## **A.**

- Description of event. This should be brief and can be in note form.
- Learning outcome. This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- Action plan. The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

## **B.**

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

Further information

A description of significant event audit is also available in: Robinson et al. How to Do It: Use facilitated case discussions for significant event auditing<sup>199</sup>.

NPSA/RCGP (2008). SEA guidance for Primary Care Teams.

<http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/>

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<sup>199</sup> BMJ 1995; 311: 315-318

**Education 10.2 Written evidence**

Each case report should consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

**Education 10.3 Assessment visit**

The reviews should be discussed.

**Education 10.4 Assessors' guidance**

The practice should report their analyses in a form consistent with either of the two following methods:

A. statement of the problem or event, learning outcome and action plan;

OR

B. What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, if possible, all team members who were stakeholders in the event in the case discussion.

## Practice management

	Indicator	Points
<b>Management 1</b>	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
<b>Management 2</b>	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used	1
<b>Management 3</b>	The hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance	0.5
<b>Management 5</b>	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed with the PCO	3
<b>Management 7</b>	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> <li>• A defined responsible person</li> <li>• Clear recording</li> <li>• Systematic pre-planned schedules</li> <li>• Reporting of faults</li> </ul>	3
<b>Management 9</b>	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
<b>Management 10</b>	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access	2

### Management indicator 1

Individual healthcare professionals have access to information on local procedures relating to child protection.

#### Management 1.1 Practice guidance

Awareness of the existence of local child protection procedures is mandatory and all healthcare professionals should be able to access a copy.

#### Management 1.2 Written evidence

There should be a description of how local procedures are accessed. (Grade C).

#### Management 1.3 Assessment visit

Access to local procedures should be demonstrated.

### **Management 1.4 Assessors' guidance**

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

## **Management indicator 2**

There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used.

### **Management 2.1 Practice guidance**

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

### **Management 2.2 Written evidence**

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site
- authorisation to load programmes. (Grade A)

### **Management 2.3 Assessment visit**

The back-up and loading arrangements should be demonstrated.

### **Management 2.4 Assessors' guidance**

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

## **Management indicator 3**

The hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance.

### **Management 3.1 Practice guidance**

Useful guidance on hepatitis B risks and immunisation is contained in the UK Health Departments' publication *Guidance for Clinical Health Care Workers: Protection Against Infection with Blood-borne viruses* - recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis ([www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf](http://www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf)).

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 2002 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The Department of Health guidance Protecting Health Care Workers and Patients from Hepatitis B (1993)<sup>200</sup> and the 1996 and 2004 addenda (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90 per cent of patients vaccinated, but is not a substitute for good infection control procedures.

Advice on suitable immunisation policies can also be obtained from the employee's Occupational Health Service, which works with reference to guidelines published in Immunisation against Infectious Disease (see Annex 1 in the above website).

In relation to confidentiality it is extremely important that hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care.

Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information".

### **Management 3.2 Written evidence**

There should be evidence that the hepatitis B status of all staff is known. (Grade C)

### **Management 3.3 Assessment visit**

Questioning should take place on the system to check hepatitis B status.

### **Management 3.4 Assessors' guidance**

It should be confirmed that evidence is available that the hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

## **Management indicator 5**

The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed by the PCO.

### **Management 5.1 Practice guidance**

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and

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<sup>200</sup> [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceGuidelines/DH\\_4084234](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceGuidelines/DH_4084234)

this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

### **Management 5.2 Written evidence**

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

### **Management 5.3 Assessment visit**

The practice leaflet and appointment book should be checked.

### **Management 5.4 Assessors' guidance**

The assessor should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

## **Management indicator 7**

The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:

- A defined responsible person
- Clear recording
- Systematic pre-planned schedules
- Reporting of faults.

### **Management 7.1 Practice guidance**

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on <http://www.hse.gov.uk/>. The website provides a free booklet "Five Steps to Risk Assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website; others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

### **Management 7.2 Written evidence**

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

### **Management 7.3 Assessment visit**

Assessors should undertake a review of equipment requiring maintenance, and the log of inspection and maintenance.

### **Management 7.4 Assessors' guidance**

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule. The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (e.g. printer) up to larger items such as a steriliser or defibrillator.

## **Management indicator 9**

The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment.

### **Management 9.1 Practice guidance**

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

A carer is defined as, someone who, without payment, provides help and support to a partner, relative, friend or neighbour, who could not manage to stay at home without their help due to age, sickness, addiction or disability.

The practice should remember to include any young carers who are particularly vulnerable.

Further information

Supporting Carers: An action guide for general practitioners and their teams. Second edition.  
<http://static.carers.org/files/supporting-carers-an-action-guide-for-general-practitioners-and-their-teams-second-edition-5877.pdf>

Focus on Carers and the NHS - identifying and supporting hidden carers. Good practice guide.  
<http://www.carers.org/publications,185,GP.html>

Scottish Government and COSLA Caring Together: The Carers Strategy 2010-15.  
<http://www.scotland.gov.uk/Publications/2010/07/23153304/0>

### **Management 9.2 Written evidence**

The protocol is available. (Grade A)

### **Management 9.3 Assessment visit**

The policy is discussed.

### **Management 9.4 Assessors' guidance**

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

## Management indicator 10

There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access.

### Management 10.1 Practice guidance

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the Disciplinary and Grievance Procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers on [www.eoc.org.uk/](http://www.eoc.org.uk/). Guidance can also be found on the ACAS web site on [www.acas.org.uk](http://www.acas.org.uk). The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies
- Bullying and Harassment: ACAS as above
- IHM Healthcare Management Code at [www.ihm.org.uk](http://www.ihm.org.uk)
- IHM Diversity Group recommendations for recruitment and selection
- Sickness Absence: ACAS as above, including their booklet entitled Absence and Labour Turnover

### Management 10.2 Written evidence

Employment policies should be recorded (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

### Management 10.3 Assessment visit

The procedures manual should be inspected.

### Management 10.4 Assessors' guidance

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

# Medicines management

	Indicator	Points
<b>Medicines 2</b>	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
<b>Medicines 3</b>	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
<b>Medicines 4</b>	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)	3
<b>Medicines 6</b>	The practice meets the PCO prescribing adviser at least annually and agrees up to 3 actions related to prescribing	4
<b>Medicines 8</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)	6
<b>Medicines 10</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	4
<b>Medicines 11</b>	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%	7
<b>Medicines 12</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%	8

## Medicines indicator 2

The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis.

### Medicines 2.1 Practice guidance

GMP for GPs (2008) states that the excellent doctor “has up to date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

### Medicines 2.2 Written evidence

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

### Medicines 2.3 Assessment visit

The appropriate equipment and drugs are inspected.

### Medicines 2.4 Assessors' guidance

The dates of emergency drugs should be checked.

## Medicines indicator 3

There is a system for checking the expiry dates of emergency drugs on at least an annual basis.

### Medicines 3.1 Practice guidance

GMP for GPs (2008) states that the unacceptable GP “has drugs which are out of date” and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors’ bags.

### Medicines 3.2 Written evidence

The system is described. (Grade C)

### Medicines 3.3 Assessment visit

A random sample of doctors’ bags and other emergency drugs is checked.

### Medicines 3.4 Assessors’ guidance

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

## Medicines indicator 4

The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays).

### Medicines 4.1 Practice guidance

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice’s system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (indicator Medicines 8).

### Medicines 4.2 Written evidence

The practice leaflet or policy is available (Grade A). The receptionists are questioned on the policy.

### Medicines 4.4 Assessors’ guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

## Medicines indicator 6

The practice meets the PCO prescribing adviser at least annually and agrees up to 3 actions related to prescribing.

### Medicines 6.1 Practice guidance

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

### Medicines 6.3 Assessment visit

The actions should be discussed.

### **Medicines 6.4 Assessors' guidance**

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

## **Medicines indicator 8**

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays).

### **Medicines 8.1 Practice guidance**

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (indicator Medicines 4).

### **Medicines 8.2 Written evidence**

The practice leaflet or policy is available (Grade A). The receptionists are questioned on the policy.

### **Medicines 8.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

## **Medicines indicator 10**

The practice meets the PCO prescribing adviser at least annually, has agreed up to 3 actions related to prescribing and subsequently provided evidence of change.

### **Medicines 10.1 Practice guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

If the PCO prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 10.2 Written evidence**

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 10.3 Assessment visit**

Actions and improvements should be discussed.

### **Medicines 10.4 Assessors' guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support to the PCO prescribing adviser for its reasons for not achieving the areas in question.

## **Medicines indicator 11**

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines.  
Standard 80%.

### **Medicines 11.1 Practice guidance**

Medication is by far the most common form of medical intervention. Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four or more<sup>201</sup>. However, we also know that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5 - 17 per cent of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the briefing paper linked below:

[http://www.npc.nhs.uk/review\\_medicines/intro/resources/5mg\\_medreview.pdf](http://www.npc.nhs.uk/review_medicines/intro/resources/5mg_medreview.pdf)

The underlying principles of any medication review, whether using the patient's full notes or face to face are:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
4. Any changes resulting from the review are agreed with the patient.
5. The review is documented in the patient's notes.
6. The impact of any change is monitored.

Medicines DO NOT include dressings and emollients but would include topical preparations with an active ingredient such as steroid creams and ointments and hormone preparations.

### **Medicines 11.2 Written information**

A survey of medication review should be undertaken (Grade A). This could be a computerised search and print out or a survey of 50 records of patients on four or more medications.

### **Medicines 11.3 Assessment visit**

Inspection of records should be carried out.

### **Medicines 11.4 Assessors' guidance**

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

## **Medicines indicator 12**

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines.

Standard 80%

### **Medicines 12.1 Practice guidance**

See Medicines 11.1

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<sup>201</sup> Medicines and Older People – Supplement to the NSF for Older People, 2001

**Medicines 12.2 Written information**

A survey or medication review should be undertaken (Grade A) This could be a computerised search and print out or a survey of 50 records of patients on repeat medication.

**Medicines 12.3 Assessment visit**

See Medicines 11.3

**Medicines 12.4 Assessors' guidance**

See Medicines 11.4

## Quality and productivity

	Indicator	Points
QP6	The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5
QP7	The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	5
QP8	The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2013	11
QP9	The practice meets internally to review the data on emergency admissions provided by the PCO	5
QP10	The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	15
QP11	The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2013	27.5
QP12	The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practice is appropriate, in light of the patterns on accident and emergency attendance	7
QP13	The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements to the PCO	9

<b>QP14</b>	The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013	15
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## Quality and productivity (QP) indicator 6

The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO.

### Quality and productivity 6.1 Practice guidance

The PCO must provide practices with data on secondary care referrals which the practice reasonably requires to conduct the review. Practices should discuss with their PCO what data is required for the practice meeting and when.

Clinicians in the practice will meet at least once during the year to carry out the internal review. This meeting should involve the range of clinicians working within the practice.

At the meeting the practice identifies any apparent anomalies in referral patterns and discuss the reasons why this might be the case. Practices should compare the referral patterns with reference to existing care pathways in order to identify areas where improvement might be made to decision making on referrals. The output of this review must be made available to the group of practices taking part in the external peer review.

### Quality and productivity 6.2 Reporting and verification

The practice produces a report summarising the discussions that have taken place at the meeting.

This report should be submitted to the PCO no later than 31 March 2013.

## Quality and productivity (QP) indicator 7

The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.

### Quality and productivity 7.1 Practice guidance

The practice will identify a group of practices with which it will carry out an external review of their secondary care outpatient referrals. The group must contain a minimum of six practices that share similar referral routes (e.g. refer patients to a similar set of services).

The external review must consist of a comparison of the practice data with comparable data from the practices in the group or from all practices in the PCO area to determine why there are any variances and where it may be appropriate for the practice to amend current arrangements for the management of hospital referrals. The focus of review will be to reflect on referral behaviour and whether clinicians can learn from the data to improve how they refer and if they can reduce unnecessary hospital attendances either by following existing care pathways more closely or through the use of alternative care pathways.

Following the review, the practice should propose areas for commissioning or service design improvement to the PCO.

### **Quality and productivity 7.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and what areas have been proposed for commissioning or service design improvement.

The report must be submitted to the PCO no later than 31 March 2013.

## **Quality and productivity (QP) indicator 8**

The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate referrals and produces a report of the action taken to the PCO no later than 31 March 2013.

### **Quality and productivity 8.1 Practice guidance**

It is expected that PCOs will lead the development of care pathways as defined above, working with practice groups. The PCO may, if the contractor consents, seek the views of the LMC if any for its area on the development of the care pathway.

GPs in the practice must actively respond to the care pathway development process for the purpose of this indicator. This may, for example, involve attending meetings with other health professionals concerned with the care pathway or commenting to the pathway group electronically. The three care pathways cannot be the same as those identified for indicator QP11. Where possible, the focus of the care pathways should be on long term conditions.

Practices must then follow the agreed care pathways in the treatment of their patients, unless in individual cases they can justify clinical reasons for not doing this.

### **Quality and productivity 8.2 Reporting and verification**

The practice produces a report summarising the action taken, information about which care pathways were followed and changes in the patterns of referral that have resulted.

This report should be submitted to the PCO by 31 March 2013.

Achievement will be awarded on the basis that practices have both engaged in the development of care pathways and delivered care along the agreed care pathways.

It is expected that a practice will follow the agreed care pathways for all patients. However, it is recognised that it may not be clinically appropriate for every patient, for example not all patients may be able to tolerate certain drugs. In these circumstances the report should show that the practice has considered following the care pathway in treating these patients and has documented reasons why it is not clinically appropriate in those individual circumstances.

## **Quality and productivity (QP) indicator 9**

The practice meets internally to review the data on emergency admissions provided by the PCO.

### **Quality and productivity 9.1 Practice guidance**

The PCO must provide practices with data on emergency admissions which the practice reasonably requires to conduct the review. Practices should discuss with their PCO what data is required for the practice meeting and when.

Clinicians in the practice will meet at least once during the year to carry out the internal review. This meeting should involve the range of clinicians working within the practice. Emergency

admissions are defined as admissions that are unpredictable and at short notice because of clinical need<sup>202</sup>.

Practices should explore the reasons for emergency admissions with reference to available pathways in order to identify areas where improvement might be made.

The output of this review must be made available to the group of practices taking part in the external peer review.

### **Quality and productivity 9.2 Reporting and verification**

The practice produces a report summarising the discussions that have taken place at the meeting. This report should be submitted to the PCO no later than 31 March 2013.

## **Quality and productivity (QP) indicator 10**

The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.

### **Quality and productivity 10.1 Practice guidance**

The steps outlined in indicator QP7 apply to QP10, with references to “secondary outpatient referrals” replaced with references to “emergency admissions”.

### **Quality and productivity 10.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and what areas have been proposed for commissioning or service design improvement.

The report must be submitted to the PCO no later than 31 March 2013.

## **Quality and productivity (QP) indicator 11**

The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2013.

### **Quality and productivity 11.1 Practice guidance**

The steps outlined in indicator QP8 apply to indicators QP11, with references to “secondary outpatient referrals” replaced with references to “emergency admissions”.

### **Quality and productivity 11.2 Reporting and verification**

The practice produces a report summarising the action taken, information about which care pathways were followed and changes in the rates of emergency admissions that have resulted.

This report should be submitted to the PCO by 31 March 2013.

Achievement will be awarded on the basis that practices have both engaged in the development and delivered care along the agreed pathways.

It is expected that a practice will follow the agreed care pathways for all patients. However, it is recognised that it may not be clinically appropriate for every patient, for example not all

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<sup>202</sup> NHS Data Dictionary – Admission method codes 21, 22, 23, 24 and 28.

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1)

patients may be able to tolerate certain drugs. In these circumstances the report should show that the practice has considered following the care pathway in treating these patients and has documented reasons why it is not clinically appropriate in those individual circumstances.

## Quality and productivity (QP) indicator 12

The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practice is appropriate, in light of the patterns on accident and emergency attendance.

### Quality and productivity 12.1 Practice guidance

The PCO must provide practices with data from the final quarter of the 2011/12 financial year (1 January to 31 March 2012) on Accident and Emergency (A&E) attendances which the practice reasonably requires to conduct the review. The data should where possible include patient details, reasons for attendance/diagnosis and the time/date of attendance. Practices should discuss with their PCO what data is required for the practice meeting and by when. Thereafter, PCOs must provide monthly data.

Attendances at A&E are defined as those patients seen in a Type 1 A&E department for both first and follow-up attendances for the same condition (excluding planned follow-ups). The definition in the document *A&E Clinical Quality Indicators Data Definitions*, published by the Department of Health in England, defines a Type 1 A&E department as "a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients".

In circumstances where there is no Type 1 A&E department or where the majority of patients do not use a Type 1 A&E department, then practices and PCOs should agree the most frequently used local urgent care service and agree those that will be included (for example Type 2 and/or Type 3 A&E departments). The type of A&E attendance will be limited to both first and follow-up attendances for the same condition (excluding planned follow-ups).

Further information

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_122892.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122892.pdf)

Clinicians in the practice will meet at least once (before 31 July 2012) to carry out the internal review. This meeting should involve the range of clinicians working within the practice.

At the meeting the practice explores the reasons for registered patients' attendance(s) at A&E and any emerging patterns and discusses this with reference to available care pathways and the capability and access within primary care to see and treat patients. In the discussion, focus should be given to (1) older patients with co-morbidities at high risk of admission (patients aged 65 years and over), (2) children with minor illness/injury (patients aged 15 years and under) and (3) patients who frequently re-attend A&E that could be dealt with in primary care. The review should also specifically consider whether same day access to clinicians in the practice is appropriate and whether any comparisons can be drawn between this and the level of A&E attendances. The practice then uses this information to identify where improvements might be made to reduce avoidable A&E attendances.

The output of this review must be made available to the group of practices taking part in the external peer review (see QP13).

In developing the final report, practices may find it useful to refer to the Primary Care Foundation Report *Urgent Care - A Practical Guide to Reforming Same Day Care in General Practice* published in 2009. The report is available at:

[www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading\\_Reports/Reports\\_and\\_Articles/Urgent\\_Care\\_Centres/Urgent\\_Care\\_May\\_09.pdf](http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf)

### **Quality and productivity 12.2 Reporting and verification**

The practice produces a report summarising the discussions that have taken place at the meeting. The report should include information on the practices current access arrangements.

This report should be submitted to the PCO no later than 31 July 2012.

## **Quality and productivity (QP) indicator 13**

The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements to the PCO.

### **Quality and productivity 13.1 Practice guidance**

The practice will identify a group of practices with which it will carry out an external review of their A&E attendances. The group must contain a minimum of six practices unless the PCO otherwise agrees having due regard to local geography and the historical groupings of practices. Where possible, the practices should share similar care pathways and/or geographical locations. The groups may be the same as those used for other QP indicators.

The external review must consist of a comparison of the practice data with comparable data from the practices in the group or from all practices in the PCO area to determine why there are any variances and where it may be appropriate for the practice to amend current arrangements to help reduce avoidable A&E attendances. The focus of the review will be to reflect on the reasons and/or patterns of A&E attendances, and identify where improvements may be made to improve the quality of care for patients at the interface of primary care and A&E, in order to help reduce avoidable A&E attendances. Again, both in the discussion and final improvement plan, focus should be given to (1) older patients with co-morbidities at high risk of admission, (2) children with minor illness/injury and (3) patients who frequently re-attend A&E, that could be dealt with in primary care.

In circumstances where practices are already managing their patients in a way that means they have very low levels of 'avoidable A&E attendances', the plan may focus on how the practice intends to maintain or further reduce the current level of 'avoidable A&E attendances'.

Practices may also propose, via the peer group, areas for commissioning or service design improvements to the PCO that could help to reduce avoidable A&E attendances.

Following the review, the practice improvement plan is either amended or agreed by the group and a final improvement plan is then submitted to the PCO for agreement by no later than 30 September 2012.

### **Quality and productivity 13.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and details of the agreed improvement plan that aims to reduce avoidable A&E attendances.

The report must be submitted to the PCO no later than 30 September 2012.

## **Quality and productivity (QP) indicator 14**

The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013.

### **Quality and productivity 14.1 Practice guidance**

The practice will implement the arrangements and actions set out in their improvement plan and provide evidence to support their implementation to the PCO.

Practices will need to review their monthly data on the percentage of (1) older patients with co-morbidities at high risk of admission, (2) children with minor illness/injury and (3) patients who frequently re-attend A&E and where possible, provide information on how improvements in care and access to primary care have been made for these patients.

### **Quality and productivity 14.2 Reporting and verification**

The practice produces a report summarising the details of the improvement plan and the action taken to aim at reducing avoidable A&E attendances.

The report should include information about (1) older patients with co-morbidities at high risk of admission, (2) children with minor illness/injury and (3) patients who frequently re-attend A&E and how any improvements in care and access in primary care have helped to reduce avoidable A&E attendances. If the data quality provided to the practice does not allow this to be done for all patients this should be noted in the report.

This report should be submitted to the PCO no later than 31 March 2013.

# Section 5. Patient experience domain (PE)

The PE domain indicator follows the format of the organisational domains indicators. Further details are available on pages 143-144.

Please note exception reporting does not apply to the PE indicator.

Indicator	Points
<p><b>PE1. Length of consultations</b></p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (if the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria</p>	33

## PE1 Length of consultations

The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (if the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment).

For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes.

Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.

### PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things that are crucial parts of general practice, yet cannot easily be measured e.g. listening to patients, taking time, involving patients in decisions, explaining treatments, in addition to providing high quality care for the many conditions not specifically included in the QOF.

Practices can claim this payment if their normal booking interval is ten minutes or more. 'Normal' means that three quarters or more of their appointments should be ten minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

Practices with appointment systems

For practices where three quarters of patients are seen in booked appointments of ten minutes or more, and surgery sessions are not normally interrupted by 'extras', the contract requirement

is met. Extras seen at the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at ten minute intervals, but six extras are routinely added in, then the average time for patients will be  $120/18$  equals 6.7 minutes and these slots would not meet the ten minute requirement. Practices will generally find it easier to decide whether they meet the 'three quarters' requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are ten minutes or more in length should be three quarters of the total.

Practices without appointment systems or with mixed systems

Some practices do not run an appointment system. In this case, or where some surgeries are regularly 'open', practices should measure the actual time of consultations in two separate sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of ten minutes or more, as the 'three quarters' requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face to face time has been eight minutes in three quarters of consultations (equivalent to the face-to-face time in a ten minute booked slot) and five minutes in the remainder.

Unusual systems

Practices organise consulting in a wide variety of different ways. This guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

### **PE 1.2 Written evidence**

For practices where three quarters of patients are seen in booked appointments of ten minutes or more and surgery sessions are not normally interrupted by 'extras' the contract requirement is met. Practices should submit a statement to this effect. (Grade A).

For other practices, claiming against this indicator, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

### **PE 1.3 Assessment visit**

If the practice operates an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year. If the practice has submitted a survey of consultation length, this should be reviewed.

### **PE 1.4 Assessors' guidance**

The assessors may need to look at a number of sample days to confirm that 75 per cent of consultations have been booked at least at ten minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the clinical and administrative staff on how and when this was carried out.

# Section 6. Additional services domain

For practices providing additional services the following indicators apply. The additional services domain indicators follow the format of the either the clinical or organisational domain indicators. Further details can be found on page 28 and page 143-144.

Please note exception reporting does not apply to those additional services indicators that are Boolean.

## Cervical screening (CS)

	Indicator	Points
CS 1	The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical screening test has been performed in the preceding 5 years  (Payment stages 45–80%)	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
CS 7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates	7

## Child health surveillance (CHS)

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

## Maternity services (MAT)

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

## Contraception (SH)

	Indicator	Points
SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months (Payment stages 50–90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within 1 month of, the prescription (Payment stages 50–90%)	3

## Cervical screening (CS)

### CS indicator 1

The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical screening test has been performed in the preceding 5 years.

#### CS 1.1 Practice guidance

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged, from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales, who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 40 per cent and 80 per cent, in a similar fashion to the clinical indicators.

Exception reporting (as detailed in the clinical section) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

#### Exception reporting

From April 2011, the exception reporting rules regarding 'did not attend' (DNA) letters for the additional services cervical screening indicators in the QOF have changed. The first two letters from the central cancer screening services inviting a patient to attend for a screening will now count towards the three letters required to code a patient as DNA.

Practices will be responsible for sending out the third letter before a DNA code may be used. In Scotland, all three letters will be sent out centrally.

This revised exception reporting criteria is not applicable to practices that have opted to run their own call/recall system. These practices will still be required to issue all three reminder letters directly in order to meet the DNA criteria. Copies of the letters sent by the practice may be required for assessment purposes.

England. NHS Cancer Screening Programme.  
<http://www.cancerscreening.nhs.uk/cervical/index.html>

Scotland. Scottish Cervical Call/Recall system (SCCRS). (available (through NHS net only).  
[www.sccrs.scot.nhs.uk](http://www.sccrs.scot.nhs.uk)

Wales. Cervical Screening Wales. <http://www.screeningservices.org.uk/csw/pub/index.asp>

Northern Ireland. The Public Health Agency (PHA) has the lead role in screening in NI. Screening services are jointly commissioned with the Health and Social Care Board (HSCB). The general practice role in screening is through the HSCB.

### **CS 1.2 Written evidence**

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had a cervical smear performed in the last five years (Grade A). In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

### **CS 1.3 Assessment visit**

The print-out should be inspected.

### **CS 1.4 Assessors' guidance**

The assessors should enquire on how patients who are exception reported are identified and recorded.

## **CS indicator 5**

The practice has a system for informing all women of the results of cervical smears.

### **CS 5.1 Practice guidance**

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outside the practice.

### **CS 5.2 Written evidence**

There should be a description of the system and examples of letters sent to patients. (Grade C)

### **CS 5.3 Assessment visit**

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

### **CS 5.4 Assessors' guidance**

A letter sent to the patient containing and explaining the result is ideal.

## **CS indicator 6**

The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years.

### **CS 6.1 Practice guidance**

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear-takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

### **CS 6.2 Written evidence**

An audit of inadequate smears should be recorded. (Grade A)

### **CS 6.3 Assessment visit**

A discussion with smear-takers should take place, dealing with the audit and any educational needs which arose and how these were met.

### **CS 6.4 Assessors' guidance**

All the elements for an audit stated in the practice guidance need to be present.

## **CS indicator 7**

The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates.

### **CS 7.1 Practice guidance**

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outside the practice and should be in line with national guidance.

See guidance on DNA letters in section CS1.1 practice guidance.

### **CS 7.2 Written evidence**

There should be a written policy covering the issues outlined above. (Grade A)

### **CS 7.3 Assessment visit**

The policy should be discussed with relevant staff and the practice should demonstrate how the systems operate.

### **CS 7.4 Assessors guidance**

It may be necessary to ask the practice to demonstrate how its policy operates.

## **Child health surveillance (CHS)**

### **CHS indicator 1**

Child development checks are offered at intervals that are consistent with national guidelines and policy.

### **CHS 1.1 Practice guidance**

The child health surveillance programme should be based on national guidelines<sup>203</sup>. It is important that the practice has a system to ensure follow-up of any identified concern and that referrals are made as appropriate<sup>204</sup>.

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<sup>203</sup> Healthy Child Programme (2009). Pregnancy and the first five years of life.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_107563](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107563)

<sup>204</sup> Hall, D. and Elliman D. (2003) eds Health for all children (fourth ed) Oxford University Press

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

<http://www.scotland.gov.uk/Publications/2005/04/15161325/13269>

### **CHS 1.2 Written evidence**

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

### **CHS 1.3 Assessment visit**

The practice team is asked for details of child health surveillance in the practice and how concerns are followed up.

### **CHS 1.4 Assessors' guidance**

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure concerns are followed up.

## **Maternity services (MAT)**

### **MAT indicator 1**

Ante-natal care and screening are offered according to current local guidelines.

#### **MAT 1.1 Practice guidance**

Most local areas have produced guidelines, which should be adopted within the practice.

#### **MAT 1.2 Written evidence**

There should be written guidelines on ante-natal care and screening. (Grade A)

#### **MAT 1.3 Assessment visit**

The assessment should involve a description of ante-natal care, using the illustration of one case.

#### **MAT 1.4 Assessors' guidance**

The case should show that the guidance is known and is being used.

## **Contraception (SH)**

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

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

Sexual Health Strategy for Scotland. Respect & Responsibility.

<http://www.scotland.gov.uk/Resource/Doc/35596/0012575.pdf>

NHS Quality Improvement Scotland Sexual Health Services (2008). Standards.

<http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=ebc412bc-4cce-46ed-8441-2da10f731f19&version=-1>

This indicator set seeks to increase the awareness of women seeking contraceptive advice in general practices of LARC methods and thus to increase the percentage of women using these methods<sup>205</sup>.

## Contraception (SH) indicator 1

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

### SH 1.1 Rationale

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

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

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

This indicator is prospective from 1 April 2009.

### SH 1.2 Reporting and verification

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

## Contraception (SH) indicator 2

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

### SH 2.1 Rationale

A woman's contraceptive needs can change over her reproductive lifespan. Women requiring contraception should be given detailed information about and offered a choice of all methods, including long-acting reversible contraception (LARC). This indicator seeks to encourage practices to review these needs on a regular basis and ensure that women are informed of advances in contraceptive choices.

All currently available LARC methods are more cost-effective than the combined oral contraceptive even at one year of use. LARC methods include IUDs, the intrauterine system (IUS), injectable contraceptives and implants. This is largely because their effectiveness is independent of patient compliance. Of the LARC methods, injectable contraceptives are the

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<sup>205</sup> See also J Fam Plann Reprod Health Care 2008; 34(4): 000–000 "Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods" Anna Glasier, Jane Scorer, Alison Bigrigg.

least cost-effective. Increasing the uptake of LARC methods will reduce the number of unintended pregnancies. However, currently in the UK, about eight per cent of contraceptive users use LARC. Whilst international comparison is difficult, this percentage is very low.

NICE clinical guideline 30 (2005). Guidance on LARCs <http://www.nice.org.uk/Guidance/CG30>

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

See <http://www.fpa.org.uk/Information/Readourinformationbooklets/guide>

Faculty of Sexual & Reproductive Healthcare guidelines on contraceptive methods are available at [www.ffprhc.org.uk](http://www.ffprhc.org.uk).

### SH 2.2 Reporting and verification

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

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

## Contraception (SH) indicator 3

The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice, who have received information from the practice about long acting reversible methods of contraception at the time of, or within 1 month of, the prescription.

### SH 3.1 Rationale

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

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

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

### SH 3.2 Reporting and verification

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

# Section 7. QOF queries process

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, Quality Management and Analysis System (QMAS), clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

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 is submitted to the incorrect party, the query will be passed to the correct organisation. Alternatively, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

NHS Employers and GPC have published a set of UK QOF FAQs which cover a number of historical issues and commonly asked questions. This document should be consulted before queries are raised with any of the parties outlined below. The document will be reviewed annually and is available on the NHS Employers website in the 'related publications' section at: <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx>.

Queries should be directed as follows:

- All queries relating to QOF, in particular clinical and Business Rules/coding queries should be sent to the NHS IC via [enquiries@ic.nhs.uk](mailto:enquiries@ic.nhs.uk). Where appropriate, the NHS IC will work with other key stakeholders (e.g. NICE) to respond.
- Miscellaneous, non-clinical organisational and patient experience domains queries should be sent to:
  - NHS Primary Care Commissioning for PCTs only via the helpdesk <http://helpdesk.pcc.nhs.uk>
  - NHS Employers for PCO's via [QOF@nhsemployers.org](mailto:QOF@nhsemployers.org)
  - GPC for general practice via [info.gpc@bma.org.uk](mailto:info.gpc@bma.org.uk)

There is no formal helpdesk facility in Northern Ireland therefore queries should be directed as follows:

- queries relating to the content of the QOF tables should be sent to [gofdataenquiries@dhsspsni.gov.uk](mailto:gofdataenquiries@dhsspsni.gov.uk)
- queries relating to GMS policy should be sent to [gmsenquiries@dhsspsni.gov.uk](mailto:gmsenquiries@dhsspsni.gov.uk)

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.

# Section 8. Glossary of terms

Abbreviation	Definition
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACE	Angiotensin Converting Enzyme
ACE-Inhibitor	Angiotensin Converting Enzyme Inhibitor
ACR	Albumin:Creatinine Ratio
ACS	Acute Coronary Syndrome
ACTIVE-W	Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events
ADA	After Death Analysis
AED	Antiepileptic Drugs
AF	Atrial Fibrillation
APHO	Association of Public Health Observatories
ARB	Angiotensin Receptor Blocker
BAFTA	Birmingham Atrial Fibrillation Treatment of the Aged
BDI-II	Beck Depression Inventory, second edition
BHSOC	British Hypertension Society
BLS	Basic Life Support
BMI	Body Mass Index
BMA	British Medical Association
BNF	British National Formulary
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
CBT	Cognitive Behavioural Therapy

CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control of Substances Hazardous to Health
CPA	Care Programme Approach
CT	Computerised Tomography
CVD	Cardiovascular Disease
DAs	Devolved Administrations
DBP	Diastolic Blood Pressure
DH	Department of Health
DM	Diabetes Mellitus
DNA	Did Not Attend
DRS	Diabetic Retinopathy Screening
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
EC	Emergency Contraception
eGFR	Estimated Glomerular Filtration Rate
EOLC	End of Life Care
EPIC	European Prospective Investigation into Cancer
EPP	Exposure Prone Procedures
FBC	Full Blood Count
FEV <sub>1</sub>	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMP	Good Medical Practice
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner
GPC	General Practitioners Committee

GPRD	General Practice Research Database
GPwSI	GP with a Special Interest
GSF	Gold Standards Framework
HAD-D	Hospital Anxiety and Depression Scale Depression Sub-Scale
HADS	Hospital Anxiety and Depression Scale
HbA1c	Glycated Haemoglobin (please note that from 1 June 2011 all HbA1c measurements should be recorded in IFCC values (mmol/mol) only – see explanation and table on page 60-61)
HCA	Healthcare Assistant
HF	Heart Failure
HIS	Healthcare Improvement Scotland
HSWA	Health and Safety at Work Act
IC	NHS Health and Social Care Information Centre
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
INR	International Normalised Ratio
IUD	Intrauterine Device
IUS	Intrauterine System
JBS	Joint British Societies
JCVI	Joint Committee on Vaccination and Immunisation
LARC	Long Acting Reversible Contraception
LD	Learning Disability
LMC	Local Medical Committee
LVD	Left Ventricular Dysfunction
MCM	Major Congenital Malformation
MH	Mental Health
MI	Myocardial Infarction
MR	Modified Release
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging

NAO	National Audit Office
NHANES	National Health and Nutrition Examination Survey
NHS	National Health Service
NHSE	NHS Employers
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NPV	Negative Predictive Value
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
NSF	National Service Framework
ONS	Office for National Statistics
OTC	Over The Counter
PAD	Peripheral Arterial Disease
PCO	Primary Care Organisation
PCR	Protein:Creatinine Ratio
PCT	Primary Care Trust
PE	Patient Experience
PEF	Peak Expiratory Flow
PHQ-9	Nine Item Patient Health Questionnaire
PP	Primary Prevention
QMAS	Quality Management and Analysis System
QOF	Quality and Outcomes Framework
QPA	Quality Practice Award
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCTs	Randomised Controlled Trials
SCR	Supportive Care Register
SEA	Significant Event Auditing
SIGN	Scottish Intercollegiate Guidelines Network

SIMD	Scottish Index of Multiple Deprivation
SMI	Serious Mental Illness
SSRI	Selective Serotonin Reuptake Inhibitors
TIA	Transient Ischemic Attack
TPCR	Total Protein: Creatinine Ratio
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
WHO	World Health Organisation

## NHS Employers

[www.nhsemployers.org](http://www.nhsemployers.org)  
[enquiries@nhsemployers.org](mailto:enquiries@nhsemployers.org)

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London  
SW1E 5DD

2 Brewery Wharf  
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LS10 1JR

## General Practitioners Committee

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