Contents

Section 1 Introduction

   General information on indicators 4
   Disease registers 6
   Business rules 8
   Exception reporting 8

Section 2 Summary of all indicators

Section 3 Clinical domain

   Atrial fibrillation (AF) 31
   Coronary heart disease (CHD) 35
   Heart failure (HF) 40
   Hypertension (HYP) 45
   Stroke and transient ischaemic attack (STIA) 48
   Diabetes mellitus (DM) 53
   Asthma (AST) 66
   Chronic obstructive pulmonary disease (COPD) 73
   Dementia (DEM) 81
   Depression (DEP) 84
   Mental health (MH) 87
   Cancer (CAN) 96
   Epilepsy (EP) 99
   Learning disabilities (LD) 102
   Osteoporosis: secondary prevention of fragility fracture (OST) 105
   Rheumatoid arthritis (RA) 111
Quality and Outcomes Framework guidance for GMS contract Wales 2014/15

Palliative care (PC) 118

Section 4 Public health domain 122
Cardiovascular disease – primary prevention (CVD-PP) 123
Blood pressure (BP) 128
Obesity (OB) 129
Smoking (SMOK) 132
Public health – additional services 138
Cervical screening (CS) 138

Section 5 Medicines Management Domain 141

Section 6 GP Cluster Network Development (CND) Domain 146

Section 7 QOF queries process 155

Section 8 Exception reporting guidance 156

Section 9 Glossary of terms 162

GP Cluster Network Development (CND) Domain

Annex 1 LHB Support and Engagement 168
Annex 2 GP Practice and Development Proforma 173
Annex 5 The Clinical Governance Practice Self Assessment Toolkit 199
Annex 7 Guidance Note on the National Priorities for Quality and Productivity Indicators – End of Life Care 209
Annex 8 Guidance Note on the National Priorities for General Practice 2014/15 – Minimising the Harms of Polypharmacy 215
Section 1: Introduction

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

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

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

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

Changes to QOF are agreed as part of wider changes to the General Medical Services (GMS) Contract. Since 2013 changes to the GMS Contract for Wales are negotiated annually by Welsh Government and the General Practitioners Committee Wales (GPCW) of the British Medical Association.

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

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

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

These comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be considered during negotiations between Welsh Government and the GPCW on potential changes to QOF. The online facility is available on the NICE website. QOF indicators. Interested individuals/organisations are encouraged to register with NICE as a stakeholder in the development of individual quality standards. Once registered, stakeholders are

¹ NICE website. QOF. www.nice.org.uk/aboutnice/qof/qof.jsp
able to comment on the content of quality standards during their development. The comments facility and full details of quality standards in development are available on the NICE website.²

**Principles**

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

1. Indicators should, where possible, be based on the best available evidence.

2. The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.

3. Data should never be collected purely for audit purposes.

4. Only data which is useful in patient care should be collected. The basis of the consultation should not be distorted by an over emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.

5. Data should never be collected twice e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

**2024/15 GMS Contract Agreement**

WG and GPCW agreed on changes to the GMS Contract for 2014/15 with the intention to help remove the treadmill of bureaucracy and place greater reliance and trust on the professionalism of GPs to use their clinical judgement. The changes included the removal of 300 QOF points and the transfer of the associated funding, £21.6m, into global sum equivalent. In placing greater reliance on the professionalism of GPs and the use of clinical judgement, it is expected that a more holistic patient centred approach will be taken to the management of some conditions and embedded good practice will continue without the need for a tick box target approach. WG and GPCW will work together to explore how activity on retired indicators is monitored unobtrusively, to ensure there are no unintended consequences.

**General information on indicators**

Indicators across all domains were renumbered from April 2013. Since April 2013 indicators have been prefixed by an abbreviation of the category to which they belong, for example coronary heart disease (CHD) indicator number one, became

² NICE website. Quality standards. www.nice.org.uk/ourguidance/niceguidancebytype/clinicalguidelines/shregistration/shregistration.jsp
CHD001. The addition of zeros indicated the change from previous years numbering. In addition some indicators were introduced in Wales only and appeared in the 2013/14 QOF with the number and letter 100W e.g. HF100W. For 2014/15 a consistent approach to numbering has been adopted by Welsh Government, Scottish Government and the Northern Ireland Executive, the new approach means that a couple of indicators that were numbered 100W in 2013/14 have been renumbered for 2014/15. The indicators renumbered are:

<table>
<thead>
<tr>
<th>QOF ID 2013/14</th>
<th>QOF ID 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF100W</td>
<td>HF005W</td>
</tr>
<tr>
<td>COPD100W</td>
<td>COPD008W</td>
</tr>
</tbody>
</table>

Indicators that have been developed through the NICE process\(^3\) are identified by the reference 'NICE [YEAR] menu ID: NMXX' for information. No new indicators from the NICE indicator development process have been added into QOF this year. A change has been made to indicator LD001 which has removed the age restriction on the register, this followed a recommendation from the NICE indicator development group.

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

- on the last day of the relevant financial year (31 March); or
- in the case where the contract terminates mid-year, on the last day on which the contract subsists. For example, for payments relating to the financial year 1 April 2014 to 31 March 2015, unless the contract terminates mid-year, achievement is measured on 31 March 2015. If the GMS contract ends on 30 June 2014, achievement is measured on 30 June 2014.

Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the achievement relates. For example: Indicator CAN003W - "The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months", the phrase "within the preceding 15 months" means the period of 15 months which ends on 31 March in the financial year to which the achievement payments relate; This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.

- Indicator HYP006 – “The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less”, the phrase “in the preceding 12 months” means the period of 12

---

\(^3\) NICE menu of indicators. [www.nice.org.uk/aboutnice/qof/indicators.jsp](http://www.nice.org.uk/aboutnice/qof/indicators.jsp)
months which ends on 31 March in the financial year to which the achievement payments relate.

- Indicator CS002 – “The percentage of women (aged 25 or over and under the age of 65) whose notes record that a cervical screening test has been performed in the preceding 5 years” the phrase “in the preceding 5 years” means the period of five years which ends on 31 March in the financial year to which the achievement payments relate.

Indicator CHD007 – “The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March” the phrase “in the preceding 1 August to 31 March” means the period of 8 months which ends on 31 March in the financial year to which the achievement payments relate.

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

- Where an indicator refers to the financial year, this means the period of 12 months from 1 April to 31 March.

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

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

In the case of a contract that has come to an end before 31 March in any relevant financial year, the reference to periods of time are still calculated on the basis that the period ends on 31 March in the financial year to which the achievement payment relates. Annex D of the SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the financial year.

**Disease registers**

An important feature of the QOF is the establishment of disease registers. These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification may involve asking how the register is constructed and maintained. The
LHB may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who are aged 25 years or over and under the age of 65. Indicators in the clinical and public health (PH) domain are arranged in terms of clinical areas. Most of these areas either relate to a register or to a target population group.

Some areas in the clinical and PH domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Practice Disease Factor (APDF) for different indicators within the area. For all relevant disease areas, the registered population used to calculate the APDF are set out in the summary of indicators section.

Indicators in the GP Cluster Network Development Domain have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and where the points available are awarded in full if it is carried out or not at all if it is not carried out.

**Verification**

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

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

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

(d) contractors not utilising computer systems approved by the LHB must make available to the LHB similar monthly returns, in such form as the LHB may reasonably request that a contractor fill in manually a printout of the standard spreadsheet in the form specified by the LHB); and

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

The SFE states (section 6.4) that in order for a contractor to claim payment for achievement “a contractor must make a return in respect of the information required of it by the LHB in order for the LHB to calculate its achievement payment”.

Data from GP clinical systems will be sent to CM Web for QOF achievement purposes.
The SFE states (paragraph D16): “The contractor must ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to the LHB on request. In verifying that an indicator has been achieved and information correctly recorded.”

Where ‘reporting and verification’ is included it provides additional information to support practices in meeting the criteria for the indicator.

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

**Business rules**

In April 2010, the NHS Health and Social Care Information Centre (HSCIC) took over the development of the Business Rules from NHS Employers and NHS Connecting for Health (CfH). Different contractual arrangements for QOF will apply in each country for 2014/15, this will require different Business Rules to support QOF in Wales. The development of Business Rules to support QOF will be overseen by NHS Wales Informatics Service (NWIS) on behalf of Welsh Government. The clinical system suppliers to practices in Wales will work to the Business Rules developed to support QOF in Wales.

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

The Dataset and Business Rules and will be made available from the GMS Contract Wales website during 2014/15.

**Exception reporting**

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

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

“Exceptions” relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of

---

4 GMS Contract Wales website. [www.wales.nhs.uk/GMS](http://www.wales.nhs.uk/GMS)
the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted and they have not received the care specified in the indicator wording. If the patient has been excepted but subsequently the care has been carried out within the relevant time period the patient will be included in both the denominator and the numerator (e.g. achievement will always override an exception).

**Exception reporting criteria**

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

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate (except in the case of indicator CS002, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (e.g. the preceding five years ending on 31 March in the financial year to which achievement payments relate).

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

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

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

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.

F. Where a patient has not tolerated medication.

G. Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

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

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

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

In addition, contractors may exception report patients from single indicators if they meet criteria in C to I, for example a patient who has heart failure (HF) due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin converting enzyme inhibitors (ACE-inhibitors/ACE-I) and angiotensin receptor blocker (ARB) could be exception reported from HF003. This would result in the patient being removed from the denominator for that indicator only.

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

Additional guidance on exception reporting can be found in section nine.

A small number of indicators were introduced in 2013/14 that required referral to a service that may not be available in all areas of Wales, an example is HF005W (previously HF100W). Unfortunately no service unavailable exception codes are currently established for these indicators and advice agreed by WG and GPCW was circulated to LHBs and GPs on how to deal with these indicators in such circumstances. The intention is for exception codes to be established during 2014/15.
Section 2: Summary of all indicators

Section 2.1: Clinical domain

Section 2.1: applies to all contractors participating in QOF.

Atrial fibrillation (AF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF001. The contractor establishes and maintains a register of patients with atrial fibrillation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF002. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS₂ risk stratification scoring system in the preceding 3 years (excluding those whose previous CHADS₂ score is greater than 1)</td>
<td>5</td>
<td>50–90%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM24</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF004. In those patients with atrial fibrillation whose latest record of a CHADS₂ score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy</td>
<td>6</td>
<td>40–70%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM46</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF005W. In those patients with atrial fibrillation in whom there is a record of a CHADS₂ score of 1, in the preceding 3 years, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy</td>
<td>3</td>
<td>54-94%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM45</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Secondary prevention of coronary heart disease (CHD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD001. The contractor establishes and maintains a register of patients with coronary heart disease</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>17</td>
<td>51-91%</td>
</tr>
<tr>
<td>CHD005. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken</td>
<td>7</td>
<td>53-93%</td>
</tr>
</tbody>
</table>
| CHD006. The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin  
* NICE 2010 menu ID: NM07 | 10 | 60–100% |
| CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March | 7 | 53-93% |

# Heart failure (HF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF001. The contractor establishes and maintains a register of patients with heart failure</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Initial diagnosis

HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 12 months after entering on to the register

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF002</td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

Ongoing management

HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF003</td>
<td>10</td>
<td>50-90%</td>
</tr>
</tbody>
</table>

HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF004</td>
<td>9</td>
<td>50–65%</td>
</tr>
</tbody>
</table>

HF005W. The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months

*NICE 2012 menu ID: NM48*

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF:

1. a register of patients with HF is used to calculate APDF for HF001, HF002 and HF005
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF004.

Register 1. is defined in indicator HF001. Register 2. is a sub-set of register 1. and is composed of patients with a diagnostic code for LVSD as well as for HF.

Hypertension (HYP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYP001</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
### Ongoing management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYP006. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>25</td>
<td>45-80%</td>
</tr>
</tbody>
</table>

### Stroke and transient ischaemic attack (STIA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA001. The contractor establishes and maintains a register of patients with stroke or TIA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>5</td>
<td>50–80%</td>
</tr>
<tr>
<td>STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken</td>
<td>4</td>
<td>54-94%</td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA008W. The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the first TIA only and after each latest recorded stoke.</td>
<td>2</td>
<td>45–80%</td>
</tr>
<tr>
<td>STIA009. The percentage of patients with a history of a stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>2</td>
<td>50-90%</td>
</tr>
</tbody>
</table>
### Diabetes mellitus (DM)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM41</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>8</td>
<td>51–91%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM01</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less</td>
<td>10</td>
<td>40-72%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM02</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months</td>
<td>17</td>
<td>40-72%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM14</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months</td>
<td>8</td>
<td>45-81%</td>
</tr>
<tr>
<td>DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>3</td>
<td>52-92%</td>
</tr>
<tr>
<td>DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months</td>
<td>4</td>
<td>55–90%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM13</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register  
*NICE 2011 menu ID: NM27*  

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM014</td>
<td>11</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

DM015W. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 3 years  
*NICE 2012 menu ID: NM51*  

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM015W</td>
<td>4</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

DM016W. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 3 years  
*NICE 2012 menu ID: NM52*  

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM016W</td>
<td>3</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

**Asthma (AST)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST001.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Initial diagnosis**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST002.</td>
<td>15</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

**Ongoing management**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST003.</td>
<td>20</td>
<td>45–70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST004.</td>
<td>6</td>
<td>50–80%</td>
</tr>
</tbody>
</table>
## Chronic obstructive pulmonary disease (COPD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD001. The contractor establishes and maintains a register of patients with COPD</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months</td>
<td>9</td>
<td>50–90%</td>
</tr>
<tr>
<td>COPD004W. The percentage of patients with COPD and a MRC dyspnoea score greater than or equal to 3 in the preceding 15 months who also have a record of FEV1 in the preceding 15 months. Patients with MRC dyspnoea scoring less than 3 will be monitored according to an agreed management plan</td>
<td>4</td>
<td>50–75%</td>
</tr>
<tr>
<td>COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months</td>
<td>5</td>
<td>40–90%</td>
</tr>
<tr>
<td>COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>6</td>
<td>54–94%</td>
</tr>
<tr>
<td>COPD008W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

*NICE 2012 menu ID: NM63, NM47*
### Dementia (DEM)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months</td>
<td>15</td>
<td>35–70%</td>
</tr>
</tbody>
</table>

### Depression (DEP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP003W. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 2 weeks after and not later than 8 weeks after the date of diagnosis</td>
<td>10</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

**Disease register for depression**

There is no register indicator for the depression indicators. The disease register for the depression indicators for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

### Mental health (MH)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
other psychoses and other patients on lithium therapy

<table>
<thead>
<tr>
<th>Ongoing management</th>
<th></th>
<th>6</th>
<th>40–90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate</td>
<td></td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months</td>
<td></td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>MH008. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td></td>
<td>1</td>
<td>50–90%</td>
</tr>
<tr>
<td>MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td></td>
<td>2</td>
<td>50–90%</td>
</tr>
<tr>
<td>MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months</td>
<td></td>
<td>12</td>
<td>45-85%</td>
</tr>
<tr>
<td>MH011W. The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure and BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Disease register for mental health**

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

**Remission from serious mental illness**

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

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

Where a patient is recorded as being ‘in remission’ they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002, MH007, MH008 and MH011W.

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

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

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

**Cancer (CAN)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN001. The contractor establishes and maintains a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003’</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN003W. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.</td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

*NICE 2012 menu ID: NM62*
### Epilepsy (EP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP003W. The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of being given information and advice about pregnancy or conception, or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

### Learning disability (LD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD001. The contractor establishes and maintains a register of patients with learning disabilities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD002W. The percentage of patients on the learning disability register with Down’s Syndrome aged 18 or over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)</td>
<td>3</td>
<td>45–70%</td>
</tr>
</tbody>
</table>

*NICE 2010 menu ID: NM04*
### Osteoporosis: secondary prevention of fragility fractures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012  
* NICE 2011 menu ID: NM29 | 2 |                         |
| **Ongoing management** |        |                         |
| OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent  
* NICE 2011 menu ID: NM30 | 3 | 30–60% |
| OST005. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent  
* NICE 2011 menu ID: NM31 | 3 | 30–60% |

### Disease register for osteoporosis

Although the register indicator OST001 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

### Rheumatoid arthritis (RA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis  
* NICE 2012 menu ID: NM55 | 1 |                         |
| **Ongoing management** |        |                         |
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months

*NICE 2012 menu ID: NM58*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA002.</td>
<td>5</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

RA003. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years

*NICE 2012 menu ID: NM56*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA003.</td>
<td>4</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years

*NICE 2012 menu ID: NM57*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA004.</td>
<td>5</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

**Palliative care (PC)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC001.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC002W.</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

There is no APDF calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register during the financial year then they will be eligible for payment for PC001.
Section 2.2: Public health domain

Section 2.2.1: Public health domain

Section 2.2.1. applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the LHB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins</td>
<td>10</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

NICE 2011 menu ID: NM26

Disease register for CVD-PP

The disease register for the purpose of calculating the APDF for the CVD-PP indicators is defined as follows: patients diagnosed with a first episode of hypertension on or after 1 April 2009, excluding patients with the following conditions:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes
### Blood pressure (BP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP001W. The percentage of patients aged 50 or over who have a record of blood pressure in the preceding 5 years</td>
<td>10</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

*NIce 2012 menu ID: NM61*

### Obesity (OB)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

### Smoking (SMOK)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMOK002. 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</td>
<td>25</td>
<td>60–90%</td>
</tr>
</tbody>
</table>

*NIce 2011 menu ID: NM38*

<table>
<thead>
<tr>
<th>Ongoing management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months</td>
<td>12</td>
</tr>
</tbody>
</table>

*NIce 2011 menu ID: NM40*

| | |
| SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months | 25 | 53–93% |
Disease register for smoking

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

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

Smokers
For patients who smoke this recording should be made in the preceding 15 months for SMOK002.

Non-smokers
It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 15 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

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

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

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

Section 2.2.2: Public health (PH) domain – additional services sub domain

Section 2.2.2. applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.
Cervical screening (CS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>11</td>
<td>45–80%</td>
</tr>
</tbody>
</table>
### Section 2.3 Medicines Management Domain

Section 2.3. applies to all contractors participating in QOF.

**Medicines management**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED005W. The contractor meets the LHB prescribing advisor at least annually and agrees up to three actions related to prescribing</td>
<td>4</td>
</tr>
<tr>
<td>MED006W. The contractor meets the LHB prescribing advisor at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change</td>
<td>4</td>
</tr>
<tr>
<td>MED007W. 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%</td>
<td>10</td>
</tr>
</tbody>
</table>
Section 3: Clinical domain

Clinical domain introduction

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

- where the responsibility for 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.

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

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

Establishing and maintaining disease registers is good professional practice and ensures a defined population is identified for undertaking further evidence-based interventions. Disease registers also make it possible to call and recall patients effectively to provide systematic care and to undertake care audits.

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

The drugs which count towards achievement for the clinical and health improvement indicators are included in the Business Rules for the relevant year. The code clusters within the Business Rules are updated each April and October. For this reason, references to acceptable drugs are not included in the guidance. The Business Rules can be found on the GMS Contract website5.

'xxx.1 Rationale'

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

---

5 GMS Contract Wales website. www.wales.nhs.uk/GMS
In some areas, more extensive information is provided. The aim is to achieve a balance of providing helpful information without attempting to provide a textbook of medicine or replicating guidelines.

The indicators included in the QOF are not intended to cover all the process issues or outcomes for each disease category. In some areas, the indicators cover only a very small part of the care for those conditions.

'xxx.2 Reporting and verification'

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

See section one for full details on reporting and verification.
### Atrial Fibrillation (AF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF001. The contractor establishes and maintains a register of patients with atrial fibrillation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF002. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 3 years (excluding those whose previous CHADS2 score is greater than 1)</td>
<td>5</td>
<td>50–90%</td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF004. In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy</td>
<td>6</td>
<td>40–70%</td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF005W. In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1, in the preceding 3 years, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy</td>
<td>3</td>
<td>54-94%</td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

AF is common and significant cause or morbidity and mortality. The age-specific prevalence of AF is rising, presumably due to improved survival of patients with CHD (the commonest underlying cause of AF). One per cent of a typical practice population will be in AF; five per cent of patients aged 65 or over and nine percent of patients aged 75 or over. AF is associated with a five-fold increase in risk of stroke⁷.

SIGN clinical guideline 94. Cardiac arrhythmias in CHD 2007.  
www.sign.ac.uk/guidelines/fulltext/94/index.html

**AF indicator 001**

The contractor establishes and maintains a register of patients with atrial fibrillation

AF001.1 Rationale

The register includes all patients with an initial event; paroxysmal; persistent and permanent AF.

AF 001.2 Reporting and verification

See indicator wording for requirement criteria.

AF indicator 002 (NICE 2011 menu ID: 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 3 years (excluding those whose previous CHADS<sub>2</sub> score is greater than 1)

AF 002.1 Rationale

A cornerstone of managing AF is deciding whether or not to use an anti-coagulant. Despite strong evidence supporting the efficacy of anti-coagulants in preventing thromboembolism related to AF<sup>8</sup>, many patients with AF who would benefit from their use are not prescribed them<sup>9</sup>.

In order to decide whether or not a patient with AF needs anti-coagulation therapy, 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 AF.

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>10,11,12,13</sup>. The scoring system recommended for QOF is CHADS<sub>2</sub>, which is validated and particularly suitable for identifying high-risk AF patients, while also being relatively simple to use<sup>14</sup>. The CHADS<sub>2</sub> system is based on the AF Investigators I Study (AFI1) and Stroke Prevention in AF I Study (SPAF1) risk criteria<sup>15, 16</sup>.

---


<sup>10</sup> RCP. National Collaborating Centre for Chronic Conditions. AF: national clinical guideline for management in primary and secondary care 2006.


The revised CHADS$_2$ system scores one point, up to a maximum of six, for each of the following risk factors (except previous stroke or TIA, which scores double, hence the ‘2’):

C - congestive HF (one point)  
H - hypertension (one point)  
A - age 75 or over (one point)  
D - diabetes mellitus (one point)  
S$_2$ - previous stroke or TIA (two points)

A score of zero is classified as low risk, one is moderate risk and two or more is high risk.

The intention of this indicator is that all patients on the contractor's AF disease register will be assessed. The risk score can be calculated through a review of the patient's patient record.

**AF 002.2 Reporting and verification**  
See indicator wording for requirement criteria. This indicator excludes patients whose previous CHADS$_2$ score is greater than one.

The LHB may wish to discuss with contractors the processes they have in place for performing this calculation and how any results indicating that anti-coagulation may be required are acted upon.

**AF indicator 004 (NICE 2011 menu ID: NM46)**  
In those patients with atrial fibrillation whose latest record of a CHADS$_2$ score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy

**AF 004.1 Rationale**  
See AF 005W.1

Where the CHADS$_2$ 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.

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

**AF indicator 005W (NICE 2011 menu ID: NM45)**  
In those patients with atrial fibrillation in whom there is a record of a CHADS$_2$ score
of 1, (in the preceding 3 years), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy

**AF 005W.1 Rationale**

AF 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) and less so by aspirin (approximately 22 per cent risk reduction)\(^1\).\(^7\)

Evidence from the Birmingham AF Treatment of the Aged Study (BAFTA)\(^1\)\(^8\) and AF Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE-W)\(^1\)\(^9\) 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 per cent 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 per cent CI 0.46 to 1.63), which suggested 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 AF was an isolated event that was not expected to re-occur (for example, one-off AF with a self-limiting cause).

This indicator uses the CHADS\(^2\) risk stratification scoring system to inform treatment options. The use of a risk stratification scoring system is in line with European Society of Cardiology (ESC) guidance that states that 'recommendations for therapy should be based on the presence (or absence) of risk factors for stroke and thromboembolism'.

Where the CHADS\(^2\) score is 0 (low risk), then the patient can be offered treatment with aspirin\(^2\)\(^0\). Where the CHADS\(^2\) score is 1 (moderate risk) then either aspirin or anti-coagulants can be offered.

**AF 005W.2 Reporting and verification**

See indicator wording for requirement criteria.

Secondary prevention of coronary heart disease (CHD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD001. The contractor establishes and maintains a register of patients with coronary heart disease</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Ongoing management**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>17</td>
<td>51-91%</td>
</tr>
<tr>
<td>CHD005. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken</td>
<td>7</td>
<td>53-93%</td>
</tr>
<tr>
<td>CHD006. The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin</td>
<td>10</td>
<td>60–100%</td>
</tr>
<tr>
<td>CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>7</td>
<td>53-93%</td>
</tr>
</tbody>
</table>

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

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

**CHD indicator 001**

The contractor establishes and maintains a register of patients with coronary heart disease

**CHD 001.1 Rationale**

The register includes all patients who have had coronary artery revascularisation procedures, such as coronary artery bypass grafting (CABG). Patients with Cardiac Syndrome X are not included on the CHD register.
Contactors should record those with a past history of myocardial infarction (MI) as well as those with a history of CHD.

**CHD 001.2 Reporting and verification**
See indicator wording for requirement criteria.

**CHD indicator 002**

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

**CHD 002.1 Rationale**
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of cardiovascular disease (CVD) through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

The NICE clinical guideline on hypertension\(^\text{21}\) sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the hypertension indicator set. To summarise, patients with CHD and stage one hypertension are recommended drug therapy for hypertension.

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

A major overview of randomised trials showed that a reduction of 5–6 mmHg in blood pressure sustained over five years reduces coronary events by 20–25 per cent in patients with CHD\(^\text{22}\).

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

**CHD indicator 005**

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

**CHD 005.1 Rationale**
Both NICE\(^\text{23, 24}\) and SIGN\(^\text{25, 26}\) clinical guidelines recommend that aspirin (75 – 150 mg per day) is given routinely and continued for life in all patients with CHD unless


\(^{22}\) Collins et al. Lancet 1990; 335: 827-38
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.

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

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

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

**CHD 006.1 Rationale**
There is evidence from meta-analyses and RCTs (level one evidence) for a range of relevant health outcomes, including mortality, to support all patients who have had an acute MI being offered treatment with a combination of the following drugs:

- an ACE-I OR ARB if ACE-I intolerant
- aspirin
- a beta-blocker
- statin.

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

**ACE-I**

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

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

**Aspirin and anti-platelet therapy**

---

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

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

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

**Statins**
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 technology appraisal TA94. Statins for the prevention of cardiovascular events in patients at increased risk of developing CVD or those with established CVD 2006. [http://www.nice.org.uk/guidance/TA94](http://www.nice.org.uk/guidance/TA94)


**CHD 006.2 Reporting and verification**
This indicator requires a patient to be on four drugs, one from each of the following categories:

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

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

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

b. contraindicated for an ACE-I BUT receiving an ARB AND receiving either aspirin or an alternative anti-platelet or anti-coagulant therapy AND receiving a beta-blocker AND receiving a statin.
A patient will not be included in the denominator if they are:

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

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

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

a. not appropriately exception coded

b. not receiving the medicines described above.

**CHD indicator 007**

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

**CHD 007.1 Rationale**

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

Further information

**CHD 007.2 Reporting and verification**

See indicator wording for requirement criteria.

From April 2012, the FLU_COD cluster in the Business Rules was replaced. Contractors should note the change and use the new codes for recording purposes.
# Heart failure (HF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF001. The contractor establishes and maintains a register of patients with heart failure</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 12 months after entering on to the register</td>
<td>6</td>
<td>50–90%</td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB</td>
<td>10</td>
<td>50-90%</td>
</tr>
<tr>
<td>HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure</td>
<td>9</td>
<td>50–65%</td>
</tr>
<tr>
<td>HF005W. The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
</tbody>
</table>

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

HF represents the only major cardiovascular disease with increasing prevalence and is responsible for dramatic impairment of quality of life, carries a poor prognosis for patients and is very costly for the NHS to treat (second only to stroke). This indicator set refers to all patients with HF unless specified otherwise.

**HF indicator 001**

The contractor establishes and maintains a register of patients with heart failure

**HF 001.1 Rationale**

All patients with a diagnosis of HF, are included on the register.
HF 001.2 Reporting and verification
See indicator wording for requirement criteria.

There are two disease registers used for the purpose of calculating APDF for the HF indicators:

1. a register of patients with HF is used to calculate APDF for HF001, HF002 and HF005
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF004.

Register 1. is defined in indicator HF001. Register 2. is a sub-set of register 1. and is composed of patients with a diagnostic code for LVSD as well as HF.

HF indicator 002
The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 12 months after entering on to the register

HF 002.1 Rationale
This indicator requires that all patients with suspected HF are investigated and this is expected to involve, as a minimum, further specialist investigation (such as echocardiography) and often specialist opinion. Serum natriuretic peptides can be used to determine whether patients with clinically suspected HF need a referral for echocardiography and their use is recommended as below. Specialists may include GPs identified by the LHB as having a special interest in HF. Many HF patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintography or angiography rather than echocardiography.

Current NICE guidance recommends that patients with suspected HF receive both echocardiography and specialist assessment. The guidance also recommends that serum natriuretic peptides are measured in patients with suspected HF without previous MI. Patients with suspected HF who have had a previous MI or who have very high levels of serum natriuretic peptide are considered to require urgent referral due to their poor prognosis. The SIGN clinical guideline on the management of chronic HF recommends that echocardiography is performed in patients with suspected HF who have either a raised serum natriuretic peptide or abnormal electrocardiograph result to confirm the diagnosis and establish the underlying cause.

HF 002.2 Reporting and verification

See indicator wording for requirement criteria.

**HF indicator 003**

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

**HF 003.1 Rationale**

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

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

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

**HF 003.2 Reporting and verification**

See indicator wording for requirement criteria.

**HF indicator 004**

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

**HF 004.1 Rationale**

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

---


32 CIBIS-II Investigators and Committees. Cardiac Insufficiency Bisoprolol Study II. Lancet 1999; 353:9-13
randomised patients aged over 70 with significant benefits and no safety signal) and there are no contraindications for use in patients with COPD.

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

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

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

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

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

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

**HF indicator 005W (NICE 2012 menu ID: NM48)**
The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months

**HF 005W.1 Rationale**
NICE clinical guideline CG108, recommends that patients with HF are offered a supervised, group-based exercise rehabilitation programme. Attendance can reduce HF and hospitalisations, and significantly improve quality of life and six minute walking test results.

---

33 BNF. [http://bnf.org/bnf/bnf/current/319651.htm](http://bnf.org/bnf/bnf/current/319651.htm) (password protected site)
GPs are advised to ensure that patients are stable and do not have conditions or devices that would preclude an exercise-based rehabilitation programme. These conditions and devices include uncontrolled ventricular response to AF and uncontrolled hypertension high-energy pacing devices set to be activated at rates likely to be achieved during exercise.

The NICE clinical guideline notes that these programmes may target patients with HF or they may be incorporated into an existing cardiac rehabilitation programme.

For this indicator, if a patient has already attended a cardiac rehabilitation programme, for example following an MI, they do not need to be referred again. A further offer of referral could be made if the GP feels that the patient would benefit from repeating the programme. If a previous offer of referral was declined, it is advised that the potential benefit of attending these programmes be discussed with the patient and an offer of referral made if clinically appropriate.

**HF005W.2 Reporting and verification**
See indicator wording for requirement criteria.

Patients who have previously completed a cardiac rehabilitation programme need to have a 'cardiac rehabilitation programme completed' code in their patient record. These patients will then be excepted from this indicator.

The LHB may wish to compare referral rates across contractors to identify good practice in encouraging patients to accept the offer of a referral.
Hypertension (HYP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP001. The contractor establishes and maintains a register of patients with established hypertension</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP006. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>25</td>
<td>45-80%</td>
</tr>
</tbody>
</table>

HYP – rationale for inclusion of indicator set

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

HYP indicator 001

The contractor establishes and maintains a register of patients with established hypertension

HYP 001.1 Rationale

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\(^{34}\) uses the following definitions:

**Stage 1 hypertension**

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

**Stage 2 hypertension**

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

**Severe hypertension**

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

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

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

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

Further information

**HYP 001.2 Reporting and verification**
See indicator wording for requirement criteria.

The contractor may be required by the LHB to discuss their plans for ensuring that new diagnoses are confirmed using ABPM or HBPM as appropriate.

**HYP indicator 006**

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

**HYP 006.1 Rationale**
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension. Its intent is to promote the primary and secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

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

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

The NICE guideline recommends anti-hypertensive drug treatment for patients of any age with stage 2 hypertension.

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

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

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

Further information

**HYP 006.2 Reporting and verification**
See indicator wording for requirement criteria.
Stroke and TIA (STIA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA001. The contractor establishes and maintains a register of patients with stroke or TIA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>5</td>
<td>50–80%</td>
</tr>
<tr>
<td>STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken</td>
<td>4</td>
<td>54-94%</td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA008W. The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the first TIA only and after each latest recorded stoke</td>
<td>2</td>
<td>45–80%</td>
</tr>
<tr>
<td>STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>2</td>
<td>50-90%</td>
</tr>
</tbody>
</table>

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

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

**STIA indicator 001**

The contractor establishes and maintains a register of patients with stroke or TIA

**STIA 001.1 Rationale**

For patients diagnosed prior to 1 April 2003 it is accepted that various diagnostic criteria may have been used. For this reason the presence of the diagnosis of stroke or TIA in the records will be acceptable. Generally patients with a diagnosis of transient global amnesia or vertebra-basilar insufficiency are not be included in the retrospective register. However, contractors may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.
It is up to the contractor to decide, on clinical grounds, when to include a patient on the register e.g. when a ‘dizzy spell’ becomes a TIA. Patient records coded with ‘Amaurosisfugax’, but without a code for TIA are excluded from the register.

**STIA 001.2 Reporting and verification**
See indicator wording for requirement criteria.

**STIA indicator 003**
The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less

**STIA 003.1 Rationale**
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

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

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

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

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

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

Further information

36 PROGRESS collaborative group, Lancet 2001: 358: 1033-41

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

**STIA indicator 007**

The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken

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

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

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

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

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

Further information

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

---

\(^{39}\) BNF 62. [http://bnf.org/bnf/index.htm](http://bnf.org/bnf/index.htm)
**STIA indicator 008W**

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

**STIA 008W.1 Rationale**

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

The National Audit Office (NAO) report\(^\text{40}\) highlights that UK national guidelines recommend that all patients with suspected TIA are assessed and investigated within seven days, but notes that only a third of patients with TIA are seen in a clinic. The UK guideline and the NAO concern reflect the evidence that there is a high early risk of stroke following TIA and that there is insufficient recognition of the serious nature of this diagnosis.

Contractors are advised that a referral should be considered for each new stroke or TIA unless specific agreement has been reached with a local specialist not to refer the patients..

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

**STIA 008W.2 Reporting and verification**

See indicator wording for requirement criteria.

**STIA indicator 009**

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

**STIA 009.1 Rationale**

While there have been no RCTs looking at the impact of flu vaccination specifically in patients with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke\(^\text{41}\).

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

Further information


\(^{41}\) Lavallee et al. Stroke 2002; 33: 513-518; Nichol et al. *NEJM* 2003; 1322-32
STIA 009.2 Reporting and verification
See indicator wording for requirement criteria.

In 1 April 2012, the FLU_COD cluster in the Business Rules was replaced. Contractors should note the change and use the new codes for recording purposes.
## Diabetes mellitus (DM)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>NICE 2011 menu ID: NM41</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td>8</td>
<td>51–91%</td>
</tr>
<tr>
<td>DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>8</td>
<td>51–91%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less</td>
<td>10</td>
<td>40-72%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months</td>
<td>17</td>
<td>40-72%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months</td>
<td>8</td>
<td>45-81%</td>
</tr>
<tr>
<td>DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>3</td>
<td>52-92%</td>
</tr>
<tr>
<td>DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months</td>
<td>4</td>
<td>55–90%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register  
*NICE 2011 menu ID: NM27*  
11 40–90%

DM015W. The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 3 years  
*NICE 2012 menu ID: NM51*  
4 40–90%

DM016W. The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 3 years  
*NICE 2012 menu ID: NM52*  
3 40–90%

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

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

The indicators for diabetes are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by NICE and SIGN.

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

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

Further information

[http://guidance.nice.org.uk/CG10/NICEGuidance/pdf/English](http://guidance.nice.org.uk/CG10/NICEGuidance/pdf/English)

[http://guidance.nice.org.uk/CG87](http://guidance.nice.org.uk/CG87)

NICE clinical guideline CG15. Type 1 diabetes 2004.  
[http://guidance.nice.org.uk/CG15](http://guidance.nice.org.uk/CG15)
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 for the contractor to carry out all of these items (e.g. retinal screening) but it is the contractor’s responsibility to ensure that they have been done.

**DM indicator 001 (NICE 2011 menu ID: NM41)**

The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus which specifies the type of diabetes where a diagnosis has been confirmed.

**DM 001.1 Rationale**

A greater understanding and knowledge of the complexities of diabetes has lead 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. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes. In line with this report, the diabetes register indicator includes 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, contractors are asked to use the parent term ‘diabetes mellitus’. Contractors are expected to update these patients’ records when their specific type of diabetes is confirmed. This is advised to be within six to 12 months of the initial diagnosis of diabetes mellitus.

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

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

---

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycosylated haemoglobin (HbA1c) in diagnosing DM\textsuperscript{46}. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values, and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5 per cent)\textsuperscript{47} is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/mol (6.5 per cent).

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

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

DM 001.2 Reporting and verification
See indicator wording for requirement criteria.

Verification – The LHB may require randomly selecting a number of patient records of patients coded with the parent term ‘diabetes mellitus’ and requesting information about how long the specific diagnosis has been unknown.

The LHB may require contractors to demonstrate that they have processes in place to ensure that patient records are updated once a specific diagnosis has been made. Good practice is that this occurs within six to 12 months of the initial diagnosis.

DM indicator 002 (NICE 2010 menu ID: NM01)

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

DM 002.1 Rationale
Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.


\textsuperscript{47} 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.
DM003 sets a target of 140/80 mmHg as per the target recommended by NICE while the target of 150/90 mmHg has been set for those patients who cannot manage this, such as those with retinopathy, micro-albuminuria or cerebrovascular disease.

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

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

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

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

**DM 003.1 Rationale**
Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

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

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

**DM indicator 007 (NICE 2010 menu ID: NM14)**

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

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

There is a near linear relationship between glycaemic control and death rate in patients with type 2 diabetes. In the EPIC Norfolk population cohort, a one per cent higher HbA1c was independently associated with 28 per cent higher risk of death, an

---


49 NICE clinical guideline CG87. Type 2 Diabetes: the management of Type 2 diabetes 2010.

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\textsuperscript{51}.

However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial highlighted the risks of adopting an aggressive treatment strategy for patients at risk of CVD. In the trial’s intervention group, HbA1c fell from 8.1 per cent to 6.4 per cent, but this was associated with increased mortality\textsuperscript{52}. However, a recent meta-analysis did not confirm such an increase in risk\textsuperscript{53} and reassuringly, the ADVANCE study\textsuperscript{54} and the Veteran Affairs Diabetes Trial\textsuperscript{55} found no increase in all-cause mortality in their intensive treatment groups. Also, long-term follow up of the UK Prospective Diabetes Study demonstrated a ‘legacy effect’ with fewer deaths after ten years in those initially managed intensively\textsuperscript{56}.

A retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim\textsuperscript{57}. The study found that, among people whose treatment had been intensified by the addition of insulin or a sulphonylurea, there was no benefit in reducing HbA1c below 59 mmol/mol, although these differences were not statistically significant. The mortality rate was higher among those with the tightest control (this lowest decile of cohort had HbA1c below 6.7 per cent; median = 6.4 per cent). The reasons for these findings are unclear, but they raise further questions about the possibility of some groups of patients for whom a tight glycaemic target is inappropriate.

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

- **Offer structured education to every patient and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform patients and their carers that structured education is an integral part of diabetes care.**
- **Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.**
- **When setting a target HbA1c:**

\textsuperscript{52} ACCORD Study Group. Effects of intensive glucose lowering in type 2 diabetes 2008. NEJM; 358: 2545-59
\textsuperscript{54} ADVANCE collaborative group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. NEJM 2008; 358: 2560-72
\textsuperscript{56} Holman RR, Paul SK, Bethel MA et al. 10-year follow-up of intensive glucose control in type 2 diabetes 2008. NEJM; 359: 1577-89
1. involve the patient in decisions about their individual HbA1c target level, which may be above that of 48 mmol/mol set for people with type 2 diabetes in general

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

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

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

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

The NICE and SIGN clinical guidelines are consistent\textsuperscript{58}.

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

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

Table 1. IFCC values expressed as mmol/mol

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

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

DM indicator 008

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

DM 008.1 Rationale
See DM 007.1

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

DM 008.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 010

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

DM 010.1 Rationale
This is a current recommendation from the CMO and the JCVI.

Further information

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

In April 2012, the FLU_COD cluster in the Business Rules was replaced. Contractors should note the change and use the new codes for recording purposes.

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

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

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

The foot inspection and assessment includes:

- identifying the presence of sensory neuropathy (loss of ability to feel a monofilament, vibration or sharp touch) and/or the abnormal build-up of callus
- identifying when the arterial supply to the foot is reduced (absent foot pulses, signs of tissue ischaemia or symptoms of intermittent claudication)
- identifying deformities or problems of the foot (including bony deformities, dry skin or fungal infection), which may put it at risk
- identifying other factors that may put the foot at risk (which may include reduced capacity for self-care, impaired renal function, poor glycaemic control, cardiovascular and cerebrovascular disease, or previous amputation).

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

- at low current risk: normal sensation, palpable pulses
- at increased risk: neuropathy or absent pulses or other risk factor

---

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

ulcerated foot.

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

- discuss with the patient their individual level of risk and agree plans for future surveillance
- initiate appropriate referrals for expert review of those with increased risk
- give advice on action to be taken in the event of a new ulcer/lesion arising
- give advice on the use of footwear which will reduce the risk of a new ulcer/lesion
- give advice on other aspects of foot care which will reduce the risk of a new ulcer/lesion.

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

DM 012.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 014 (NICE 2011 menu ID: NM27)

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

DM 014.1 Rationale
Diabetes is a progressive long-term medical condition that is predominantly managed by the person with the diabetes and/or their carer as part of their daily life. Accordingly, understanding of diabetes, informed choice of management options and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. These needs are not always fulfilled by conventional clinical consultations. Structured educational (SE) programmes have been designed not only to improve people’s knowledge and skills, but also to help motivate and sustain people with both type 1 and type 2 diabetes in taking control of their condition and in delivering effective self-management. The indicator requires that SE is offered (preferably through a group education programme) to every person with diabetes and/or their carer from the time of diagnosis, with annual reinforcement and review. An alternative education programme of equal standard may be offered to people unable or unwilling to participate in group education sessions.
The NICE technology appraisal on patient education models\textsuperscript{60} and the NICE clinical guideline on type 2 diabetes\textsuperscript{61} considered SE models for diabetes to be both clinically and cost-effective. There are a number of SE programmes available for diabetes. Some programmes will be more suitable for type 1 diabetes and others for type 2 diabetes.

The NICE quality standard for diabetes in adults\textsuperscript{62} is based on NICE clinical guidelines for diabetes\textsuperscript{63}. The NICE quality statement on SE states that 'People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education'. The NICE quality standard states that a patient educational programme meets five key criteria laid down by the DH and the Diabetes UK Patient Education Working Group\textsuperscript{64}:

- Any programme should be evidence-based and suit the needs of the individual. The programme should have specific aims and learning objectives. It should support the learner plus his or her family and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes.

- The programme should have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials and is written down.

- The programme should be delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the learners and who are trained and competent to deliver the principles and content of the programme.

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

- The outcomes from the programme should be regularly audited.

Some practices may be able to deliver SE programmes in-house. These programmes would need to meet the requirements outlined above.

\textsuperscript{60} NICE technology appraisal TA60. Guidance on the use of patient education models for diabetes 2003. www.nice.org.uk/guidance/TA60

\textsuperscript{61} NICE clinical guideline CG87. Type 2 Diabetes: the management of type 2 diabetes 2010. www.nice.org.uk/guidance/CG87


\textsuperscript{63} NICE clinical guideline CG15. Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults 2004. www.nice.org.uk/guidance/CG15

A NICE commissioning guide on patient education programmes for people with type 2 diabetes\(^{65}\) gives further information on providing services.

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

**DM 014.2 Reporting and verification**

See indicator wording for requirement criteria.

**DM indicator 015W (NICE 2012 menu ID: NM51)**

The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 3 years

**DM 015W.1 Rationale**

Erectile dysfunction (ED) is a manifestation of autonomic neuropathy as a complication of long-term hyperglycaemia and as such is a common complication of diabetes. Reported prevalence in men with diabetes ranges from 35-90 per cent, depending upon the study methodology and population characteristics. In the Massachusetts Male Aging Study\(^{66}\), the age-adjusted probability of complete ED was three times greater in men with type 2 diabetes than in those without.

ED is a traumatic complication for some men with diabetes. Although a benign disorder that is not perceived as life-threatening, it can have a significant impact on the quality of life for men with diabetes, their partners and families.

The NICE clinical guideline on type 2 diabetes\(^{67}\), recommends that all men with diabetes are asked about ED on an annual basis, irrespective of age.

The issue of ED can be a difficult topic for both patients and healthcare professionals. It is important that it is discussed in a sensitive manner which allows patients to voice their concerns in a safe and supportive environment. Contractors may wish to consider who in the practice team is best placed to address this issue with patients, how to discuss the issue and whether or not to integrate it into the diabetes annual review.

Nurses who feel uncomfortable addressing sexual health issues with patients may wish to follow the Royal College of Nursing’s (RCN) guidance on sexuality and sexual health in nursing practice\(^{68}\).

---


DM indicator 016W (NICE 2012 menu ID: NM52)

The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 3 years

DM 016W.1 Rationale

NICE recommends that men with ED are offered an assessment of contributory factors and a discussion of treatment options if applicable. Risk factors for ED include sedentary lifestyle, obesity, smoking, hypercholesterolemia and metabolic syndrome.

The guideline also recommends that men who need treatment could be offered phosphodiesterase type 5 (PDE-5) inhibitors, which can be prescribed on the NHS for men aged 18 or over with diabetes. If treatment is unsuccessful, men could be referred for other medical, surgical or psychological services.

This indicator specifies that treatment options and their effectiveness be reviewed every 3 years.

DM 016W.2 Reporting and verification

See indicator wording for requirement criteria.
Asthma (AST)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis</td>
<td>15</td>
<td>45–80%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions NICE 2011 menu ID: NM23</td>
<td>20</td>
<td>45–70%</td>
</tr>
<tr>
<td>AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months</td>
<td>6</td>
<td>50–80%</td>
</tr>
</tbody>
</table>

AST – rationale for inclusion of indicator set

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

AST indicator 001

The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months

AST 001.1 Rationale

Proactive structured review as opposed to opportunistic or unscheduled review is associated with reduced exacerbation rates and days lost from normal activity. The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most patients, the diagnosis can be corroborated by suggestive changes in lung function tests.
One of the main difficulties in asthma is the variable and intermittent nature of asthma. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV₁) but which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma is in doubt.

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

**Children**

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

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

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

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

Further information

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

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

It is for this reason that the asthma register is 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 clinical computer systems will be able to identify the defined patient list.
AST 001.2 Reporting and verification
See indicator wording for requirement criteria.

AST indicator 002

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

AST 002.1 Rationale
There is no single infallible test to confirm a diagnosis of asthma. On the basis of the clinical history and examination it will be possible to decide if the probability of asthma is high, intermediate or low and the aim of investigations is to demonstrate objectively the presence of variability in order to support or reject the diagnosis. There are Read codes for ‘suspected asthma’ and ‘suspected respiratory condition’ which may be used whilst investigations are undertaken and the diagnosis confirmed.

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

Asthma history
The diagnosis of asthma is suspected when a patient presents a history of variable wheeze, chest tightness, shortness of breath or cough, commonly triggered by viral infections and/or allergy and/or exercise. A personal or family history of atopy (including positive skin prick testing) increases the probability of asthma.

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

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

- Spirometry may be used to demonstrate reversibility in symptomatic patients with demonstrated airflow obstruction. A bronchodilator reversibility test can be performed with inhaled or nebulised short acting beta agonist and if the obstruction reverses then asthma is confirmed. Significant reversibility is a change in FEV₁ >12 per cent and 200 ml (the absolute change is scaled down according to predicted FEV₁ in children). Increases of >400 mls are strongly

---

suggestive of asthma. Lower levels of bronchodilator reversibility may be demonstrated in some patients with COPD. Normal spirometry, however, does not exclude asthma; indeed the variable nature of asthma means that many of the milder patients seen in primary care will be asymptomatic at the time of the lung function test and will have completely normal lung function with no reversibility at the time of testing.

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

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

A trial of treatment, with repeated lung function measurements and/or symptoms scores over time will demonstrate objective improvement of symptoms and lung function in people with asthma, thereby confirming the diagnosis. In children it is particularly important to reduce and stop treatment to exclude spontaneous improvement.

**If the probability of asthma is intermediate**

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations. More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any

---

73 Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. Euro Respiratory Journal 1999;14:902-7
76 Brand P. New guidelines on recurrent wheeze in preschool children: implications for primary care. PCRJ 2008; 17:243-245
patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

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

Co-morbidity: asthma and COPD
A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility.  

AST 002.2 reporting and verification
See indicator wording for requirement criteria.

AST indicator 003 (NICE 2011 menu ID: NM23)
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions

AST 003.1 Rationale
Structured care has been shown to produce benefits for patients with asthma. The reckoning of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. The BTS/SIGN clinical guideline proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

The clinical guideline recommends the use of standard questions for the monitoring of asthma. Proactive structured review, rather than opportunistic or unscheduled review, is associated with reduced exacerbation rate and fewer days lost from normal activity.

The QOF now explicitly requires that the following RCP questions are used as an effective way of assessing symptoms:

In the last month:

- Have you had difficulty sleeping because of your asthma symptoms (including cough)?
- Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?

---

80 RCP. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: patient focused approach.
• Has your asthma interfered with your usual activities (for example, housework, work/school, etc.)?

The questions are to be asked at the same time and as part of the review. A response of ‘No’ to all questions is consistent with well-controlled asthma. If the asthma appears to be uncontrolled, the following are to be managed appropriately before increasing asthma therapy:

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

There is increasing evidence to support personalised asthma action plans in adults with persistent asthma. Contractors may wish to follow the advice of the BTS/SIGN guideline and offer a personalised asthma action plan to patients.

Peak flow is a valuable guide to the status of a patient’s asthma, especially during exacerbations. However, it is much more useful if there is a record of their best peak flow (that is, peak flow when they are well). Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients aged 19 or over no particular time limit is needed for measuring best peak flow. However in view of the reduction in peak flow with age, it is recommended that the measurement be updated every few years. For patients aged 18 or under the peak flow will be changing; therefore it is recommended that the best peak flow be re-assessed annually. Inhaler technique is to be reviewed regularly. The BTS/SIGN clinical guideline emphasises the importance of assessing ability to use inhalers before prescribing and regularly reviewing technique, especially if control is inadequate. Inhalers are to be prescribed only after patients have received training in the use of the device and have demonstrated satisfactory technique. Reassess inhaler technique as part of their structured asthma review.

During an asthma review the following takes place:

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

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

AST 003.2 Reporting and verification
See indicator wording for requirement criteria.

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

**AST indicator 004**

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

**AST 004.1 Rationale**
Many young people start to smoke at an early age. It is therefore justifiable to ask about smoking on an annual basis in this age group.

Studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control\(^8\)\(^2\).

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity\(^8\)\(^3\).

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

\(^8\)\(^3\) Thomson et al. Euro Respiratory Journal 2004; 24: 822-833
### Chronic obstructive pulmonary disease (COPD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD001. The contractor establishes and maintains a register of patients with COPD</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months</td>
<td>9</td>
<td>50–90%</td>
</tr>
<tr>
<td>COPD004W. The percentage of patients with COPD and a Medical Research Council dyspnoea score greater than or equal to 3 in the preceding 15 months, who also have a record of FEV1 in the preceding 15 months. Patients with MRC dyspnoea scoring less than 3 will be monitored according to an agreed management plan</td>
<td>4</td>
<td>50–75%</td>
</tr>
<tr>
<td>COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
<tr>
<td>COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>6</td>
<td>54-94%</td>
</tr>
<tr>
<td>COPD008W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
</tbody>
</table>
COPD – rationale for inclusion of indicator set

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

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

COPD indicator 001

The contractor establishes and maintains a register of patients with COPD

COPD 001.1 Rationale
A diagnosis of COPD is considered in any patient who has symptoms of a persistent cough, sputum production, or dyspnoea and/or a history of exposure to risk factors for the disease. The diagnosis is confirmed by post bronchodilator spirometry.

See COPD 002.1

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

NICE clinical guideline CG101 recommended a change to the diagnostic threshold for COPD in 2010.
Table 2. Gradation of severity of airflow obstruction

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

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

COPD 001.2 Reporting and verification
See indicator wording for requirement criteria.

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

COPD indicator 002

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

COPD 002.1 Rationale
A diagnosis of COPD relies on clinical judgement based on a combination of history, physical examination and confirmation of the presence of airflow obstruction using spirometry.

The NICE clinical guideline on COPD⁸⁶ provides the following definition of COPD:

• airflow obstruction is defined as a reduced FEV₁/FVC ratio (where FEV₁ is forced expired volume in one second and FVC is forced vital capacity), such that FEV₁/FVC is < 0.7

• if FEV₁ is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

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

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

Routine reversibility testing is not recommended. However, where doubt exists as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. Where asthma is present, these patients would be managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FEV₁ of less than 80 per cent of predicted normal as well as an appropriate medical history.

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

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

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

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

---

87 Johannessen et al. Thorax 2005; 60(10): 842-847
88 NICE quality standard on COPD 2011.
http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp
**COPD indicator 003**

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

**COPD 003.1 Rationale**

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management is based on NICE clinical guideline CG101 and international GOLD guidelines in terms of both drug and non-drug therapy.

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

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

A tool such as the Clinical COPD Questionnaire[^89] could be used to assess current health status.

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

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

**COPD 003.2 Reporting and verification**

See indicator wording for requirement criteria.

**COPD indicator 004W**

The percentage of patients with COPD and a Medical Research Council dyspnoea score greater than or equal to 3 in the preceding 15 months who have a record of FEV1 in the preceding 15 months. Patients with MRC dyspnoea scoring less than 3 will be monitored according to an agreed management plan.

**COPD 004W.1 Rationale**

[^89]: Clinical COPD Questionnaire. [http://www.ccq.nl/](http://www.ccq.nl/)
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.

The NICE clinical guideline on COPD recommends that FEV$_1$ and inhaler technique are assessed at least annually for patients with mild/moderate/severe COPD (and 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 CG101 – see table six.

Contractors 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 is to 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 CG101.

**COPD 004W.2 Reporting and verification**
See indicator wording for requirement criteria.

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

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

**COPD 005.1 Rationale**
As COPD progresses, patients often become hypoxaemic. Many patients tolerate mild hypoxaemia well, but once the resting partial pressure of oxygen in arterial blood (PaO2) falls below 8 KPa patients begin to develop signs of right-sided HF (cor pulmonale), principally peripheral oedema. The prognosis is poor and if untreated the five year survival is less than 50 per cent.

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

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

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

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

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

**COPD indicator 007**

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

**COPD 007.1 Rationale**
This is a current recommendation from the CMO and the JCVI.

Further information


**COPD 007.2 Reporting and verification**
See indicator wording for requirement criteria.

From April 2012, the FLU_COD cluster in the Business Rules was replaced. Contractors should note the change and use the new codes for recording purposes.
COPD indicator 008W (NICE 2012 menu ID: NM47)

The percentage of patients with COPD and Medical Research Council Dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months

COPD 008W.1 Rationale
Pulmonary rehabilitation is defined as a multidisciplinary programme of care for patients with chronic respiratory impairment. It is individually tailored and designed to optimise each patient’s physical and social performance and independence. Its aim is to reduce disability and to improve quality of life.

NICE clinical guideline CG101 recommends that the programme is offered to all patients who consider themselves to be functionally disabled by their COPD (MRC grade greater than or equal to three). While most patients are likely to benefit, a pulmonary rehabilitation programme is not suitable for patients who are unable to walk, have unstable angina or who have recently had an MI.

It is advised that prior to referral, patients receive optimal medical management. As there is limited evidence on the benefits of repeated attendance at pulmonary rehabilitation programmes, patients who have previously completed a pulmonary rehabilitation programme do not need to be offered a further referral unless the GP feels that there would be some clinical benefit to re-attendance.

COPD 008W.2 Reporting and verification
See indicator wording for requirement criteria.

Patients who have previously completed a pulmonary rehabilitation programme will need to have a 'pulmonary rehabilitation programme completed' code in their patient record. These patients will then be excepted from this indicator.

The LHB may wish to compare referral rates across contractors to identify good practice in encouraging patients to accept the offer of referral.
### Dementia (DEM)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months</td>
<td>15</td>
<td>35–70%</td>
</tr>
</tbody>
</table>

### DEM – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at the age of 80. The annual incidence of vascular dementia is 1.2/100 overall person years at risk and is the same in all age groups. Alzheimers disease accounts for 50–75 per cent of cases of dementia.

The annual incidence of dementia of the Alzheimers type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is an indicator of dementia especially where there is altered functioning in terms of activities of daily living.

### DEM indicator 001

The contractor establishes and maintains a register of patients diagnosed with dementia

**DEM 001.1 Rationale**

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.
**DEM 001.2 Reporting and verification**
See indicator wording for requirement criteria.

**DEM indicator 002**

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

**DEM 002.1 Rationale**
The face-to-face review focuses on support needs of the patient and their carer. In particular the review addresses four key issues:

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

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

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

Depression could also be considered as it is more common in patients with dementia than those without\(^90\).

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia\(^{91}\). 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

---

\(^{90}\) Burt et al. Psychol Bull 1995; 117: 285-305

\(^{91}\) Eccles et al. BMJ 1998; 317: 802-808
person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions they can contact the carer’s own GP for further support and treatment.

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

Further information


**DEM 002.2 Reporting and verification**

See indicator wording for requirement criteria.

Verification – the LHB may require randomly selecting a number of patient records of patients in which the review has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.
Depression (DEP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP003W. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 2 weeks after and not later than 8 weeks after the date of diagnosis</td>
<td>10</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

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

Depression is common and disabling.

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

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

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier that 2 weeks after and not later than 8 weeks after the date of diagnosis

**DEP 003W.1 Rationale**

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

---


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

This indicator promotes a single depression review between ten and 35 days after the date of diagnosis. For some patients this may not be their first review as they will have been reviewed initially within a week of the diagnosis. Unless a patient’s symptoms have resolved, further reviews may be required.

Practitioners are reminded of the importance of regular follow-up in this group of patients to monitor response to treatment, identify any adherence issues and provide on-going support. This review could address the following:

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

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

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

---

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

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

**DEP 003W.2 Reporting and verification**

See indicator wording for requirement criteria.

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

It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should try to find out the diagnosis date in order to record this and invite the patient for a review within the timeframe for DEP003W. If the date of diagnosis is unknown or the letter arrives too late then the contractor records the date of diagnosis as the date the letter arrives and invites the patient for review within the timeframe for DEP0023W from that date.

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

The disease register for the depression indicators for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

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

---

## Mental health (MH)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate</td>
<td>6</td>
<td>40–90%</td>
</tr>
<tr>
<td>MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months</td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM15</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH008. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM20</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td>1</td>
<td>50–90%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM21</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months</td>
<td>2</td>
<td>50–90%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM22</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH011W. The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure and</td>
<td>12</td>
<td>45-85%</td>
</tr>
</tbody>
</table>
BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose of HbA1c in the preceding 15 months

MH – rationale for inclusion of indicator set

This indicator set reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs.

Indicators MH002, MH007, MH008 and MH011W relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders. Indicators MH009 and MH010 relate to the care of patients who are currently prescribed lithium. Indicator MH001 requires contractors to establish and maintain a register of individuals with a diagnosis of serious mental illness e.g. schizophrenia, bipolar or other affective disorders and other patients on lithium therapy.

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

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

Mental health indicators MH007, MH008 and MH11W

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

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

The NICE clinical guideline on bipolar disorder\(^98\) recommends that patients with bipolar affective disorder have an annual physical health review, normally in primary care, to ensure that the following are assessed each year:

- lipid levels, including cholesterol in all patients aged 40 or over even if there is no other indication of risk
- plasma glucose 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 or dyslipidaemia) which is a predictor of type 2 diabetes and CHD\(^99\).

**MH indicator 001**

The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.

**MH 001.1 Rationale**

The register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.

**Remission from serious mental illness**

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

Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the ‘remission code’ is largely based on clinical judgement. A longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery\(^{100}\) is used.

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

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

---


Where a patient is recorded as being ‘in remission’ they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002, MH007, MH008 and MH011W.

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

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

**MH 001.2 Reporting and verification**
See indicator wording for requirement criteria.

The register includes patients with a current condition and also those recorded as being in remission, however patients recorded as ‘in remission’ will be excluded from mental health indicators MH002, MH007, MH008 and MH011W.

Verification – the LHB may require randomly selecting a number of patient 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’.

Contractors may be expected to demonstrate they 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.

The LHB may require contractors 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.

**MH indicator 002**

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

**MH 002.1 Rationale**

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

Patients on the mental health disease register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for

---

care. This consultation may include the views of their relatives or carers where appropriate.

Up to half of patients who have a serious mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes responsibility for discussing and documenting a care and treatment 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\(^\text{102}\).

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

4. Occupational status. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (office of national statistics (ONS) Labour Force Survey, Autumn 2003). People with mental health problems also earn only two thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work\(^\text{103}\).

5. "Early warning signs" from the patient's perspective that may indicate a possible relapse\(^\text{104}\). Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.

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

It is recommended that a care and treatment plan is accurate, easily understood, reviewed annually and discussed with the patient, their family and/or carers. If a


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

patient is treated under the Mental Health Wales Measure by secondary care services, then they have a documented care and treatment plan discussed with their care co-ordinator available. This is acceptable for the purposes of QOF.

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

MH 002.2 Reporting and verification
See indicator wording for requirement criteria.

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

MH indicator 007 (NICE 2010 menu ID: NM15)

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

MH 007.1 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. 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. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

MH 007.2 Reporting and verification
See indicator wording for requirement criteria.

MH indicator 008 (NICE 2010 menu ID: NM20)

The percentage of women aged 25 or over and under the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose records note that a cervical screening test has been performed in the preceding 5 years

MH 008.1 Rationale
A report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less

likely to have had a cervical sample taken in the preceding five years (63 per cent) compared with the general population (73 per cent). This did not apply to patients with bipolar affective disorder. This finding may reflect an underlying attitude that such screening is less appropriate for women with schizophrenia. This indicator therefore encourages contractors to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to national guidelines.

MH 008.2 Reporting and verification
See indicator wording for requirement criteria.

MH indicator 009 (NICE 2010 menu ID: NM21)

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

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

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

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

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

MH indicator 010 (NICE 2010 menu ID: NM22)

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

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

---

The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium for bipolar disorder, which demonstrated that wrong or unclear dose or strength and monitoring were key issues for lithium therapy\(^\text{110}\). 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\(^\text{111}\).

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

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

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

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

**MH 010.2 Reporting and verification**

See indicator wording for requirement criteria.

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

**MH indicator 011**

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

**MH 011W.1 Rationale**

Patients with schizophrenia have mortality between two and three times that of the general population and most excess deaths are from diseases that are the major

\(^{110}\) NPSA alert 0921. Safer lithium therapy 2009. [www.nrls.npsa.uk/alerts](http://www.nrls.npsa.uk/alerts)

\(^{111}\) Prescribing Observatory for Mental Health. Topic 7 baseline report. Monitoring of patients prescribed lithium: baseline. 2009.
causes of death in the general population. There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. Patients with psychosis may lead more sedentary lives, eat less fruit and vegetables, be much more likely to be obese and are more likely to smoke cigarettes. There is insufficient evidence to support the use of blood glucose testing in patients of all ages and therefore an age limit of 40 or over has been adopted for this part of the indicator.

MH 011W.2 Reporting and verification
See indicator wording for requirement criteria.
**Cancer (CAN)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN001. The contractor establishes and maintains a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003’</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN003W. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment. <em>NICE 2012 menu ID: NM62</em></td>
<td>6</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

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

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

**CAN indicator 001**

The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'

**CAN 001.1 Rationale**

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 are included except non-melanomatous skin lesions.

**CAN 001.2 Reporting and verification**

See indicator wording for requirement criteria.
**CAN indicator 003W (NICE 2012 menu ID: NM62)**

The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.

**CAN 003W.1 Rationale**
A GP will have an average of eight or nine new cancer diagnoses per year and will be looking after 20 to 30 patients with cancer. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management. Given the importance of primary care practitioners making early contact with patients who have been diagnosed with cancer, the timeframe for this indicator has been set at three months.

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

A cancer review in primary care includes:

- The patient’s individual health and support needs, which will vary with, for example, the diagnosis, staging, age and pre-morbid health of the patient and their social support networks. In collaboration with the National Cancer Survivorship Initiative (NCSI)\(^\text{112}\), Macmillan primary care community has produced a template\(^\text{113}\) which recommends that this could cover a discussion of the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer’s details.

- The coordination of care between sectors.

Further information on survivorship and the potential role for primary care can be found on the NCSI website\(^\text{114}\).

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


\(^\text{114}\) NCSI website. [http://www.ncsi.org.uk/](http://www.ncsi.org.uk/)
CAN 003W.2 Reporting and verification
See indicator wording for requirement criteria.

Verification – the LHB may wish to review records where a review is claimed to confirm that both elements have been completed.
Epilepsy (EP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP003W. The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of being given information and advice about pregnancy or conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years</td>
<td>2</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**EP – 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'.

**EP indicator 001**

The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy

**EP 001.1 Rationale**

The disease register includes patients aged 18 or over, as care for younger patients is generally undertaken outside of primary care.

The phrase 'receiving treatment' has been included in order to exclude the large number of patients who may have had epilepsy in the past, may have not received treatment and been 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 are excluded from the register. Drugs on repeat prescription will be picked up on a search.

**EP 001.2 Reporting and verification**
See indicator wording for requirement criteria.

Verification – the LHB 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.

**EP indicator 003W**

*The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of being given information and advice about pregnancy or conception, or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years.*

**EP 003W.1 Rationale**

It is estimated that in the UK 131,000 women with epilepsy are of child bearing age (12 or over and under the age of 50). Approximately 25 per cent of all patients with epilepsy are women of reproductive age and one in 200 women attending antenatal clinics are receiving antiepileptic drugs (AEDs). Around 2500 women with epilepsy will have a baby each year in the UK.

AEDs taken during pregnancy are associated with an increased risk of major congenital malformation (MCMs). Women in the general population have a one or 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. 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 or over and under the age of 34 have received information about oral contraception and epilepsy medication. 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 CG137 on epilepsy made the following recommendation as a key priority for implementation:

"Women and girls with epilepsy and their partners, as appropriate, must be given accurate information and counselling 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 are advised to use their judgement 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 3 years period.

Contractors are advised that it is best practice to give the advice in the context of a face-to-face consultation.

**EP 003W.2 Reporting and verification**

See indicator wording for requirement criteria.

The Business Rules require that contractors deliver all three pieces of advice as described in this indicator in order to meet the requirements for this indicator. However, the advice does not need to be given on the same day. 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.

Verification - the LHB may require contractors to 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 may be demonstrated by a print out of summary of appointment bookings.
Learning disabilities (LD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD001. The contractor establishes and maintains a register of patients with learning disabilities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD002W. The percentage of patients on the learning disability register with Down’s Syndrome aged 18 or over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)</td>
<td>3</td>
<td>45–70%</td>
</tr>
</tbody>
</table>

NICE 2010 menu ID: NM04

LD – 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 3-4/1,000 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 general practice for their primary care needs.

Further information

RCN learning disabilities guidance.
http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities/guidance

DH. ‘Valuing People Now’ 2009.

Valuing People Now delivery plan 2010/2011 (published in 2010, this paper includes a section on further work needed following the 2009 paper.


LD indicator 001

The contractor establishes and maintains a register of patients with learning disabilities

LD 001.1 Rationale
The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike\(^\text{118}\). The creation of a full register of patients 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 is defined in Valuing People 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 (under the age of 18), 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, is not, in isolation, to be used in deciding whether someone has a learning disability.

The definition does not include all those people who have a “learning difficulty”, e.g. 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 multi-disciplinary specialist learning disability team (where available) may be necessary to assess the degree of disability and diagnose any underlying condition. In some areas, Locality Community Learning Disability Teams, working along with LHBs, provide expertise and data about and for people with learning disabilities. Contractors may wish to liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where available to assist in the construction of a primary care database\(^\text{119}\).

Further information

\(^{118}\) See Treat Me Right, Mencap 2004. [www.mencap.org.uk](http://www.mencap.org.uk)

LD 001.2 Reporting and verification
See indicator wording for requirement criteria.

LD indicator 002W (NICE 2010 menu ID: NM04)

The percentage of patients on the learning disability register with Down’s Syndrome aged 18 or over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)

LD 002W.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. Poor thyroid function can impair an individual’s quality of life. Earlier intervention and management can help to improve health outcomes.

LD 002W.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with a diagnosis of hypothyroidism will be excluded from this indicator as these patients are managed according to the hypothyroid indicator set.

---

Osteoporosis: secondary prevention of fragility fractures (OST)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| OST001. The contractor establishes and maintains a register of patients:  
1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and  
2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012  
*NICE 2011 menu ID: NM29* | 2 |                        |
| Ongoing management |        |                        |
| OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent  
*NICE 2011 menu ID: NM30* | 3 | 30–60% |
| OST005. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent  
*NICE 2011 menu ID: NM31* | 3 | 30–60% |

**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.

**OST indicator 001 (NICE 2011 menu ID: NM29)**
The contractor establishes and maintains a register of patients:

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

2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012.

**OST 001.1 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.\(^{121}\)

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

The NICE clinical guideline on osteoporosis fragility fractures\(^{122}\) recommends that a diagnosis of osteoporosis may be assumed in women and men aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible.\(^{123}\) The SIGN clinical guideline on the management of osteoporosis\(^{124}\) recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish that bone mass density (BMD) is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

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

In women, the prevalence of osteoporosis increases markedly with age after menopause, from approximately two per cent at 50 years, rising to more than 25 per cent at 80 years. The NICE cost impact report for technology appraisal TA161 uses a prevalence of 11 per cent of post-menopausal women aged 50 or over with osteoporosis and a clinically apparent osteoporotic fragility fracture, rising to 19 per cent for ages 65 or over. There are an estimated 180,000 new fragility fractures in

---

\(^{121}\) WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.

\(^{122}\) NICE clinical guideline CG146. Osteoporosis fragility fracture 2012. [http://www.nice.org.uk/CG146](http://www.nice.org.uk/CG146)


postmenopausal women in the UK each year; three quarters in women aged 65 or over.

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

Hip fractures are associated with increased mortality; estimates of the relative mortality risk vary from two to greater than ten in the 12 months following hip fracture. However, it is unclear to what extent this can be attributed to fracture alone, as opposed to pre-existing co-morbidity\textsuperscript{125}.

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

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

\textbf{OST 001.2 Reporting and verification}

The Business Rules for the two part register will look for the following criteria:

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

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

In patients aged 75 or over:

- a fragility fracture at any point on or after the implementation date (1 April 2012).

Patients aged 50 or over and under the age of 75 in whom a diagnosis of osteoporosis has not been confirmed with DXA scanning will not be included in the register. Patients with fragility fractures sustained in the last three months of the year will be excepted from this indicator.

Although this indicator defines two separate registers, The disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

\textsuperscript{125} WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.
OST indicator 002 (NICE 2011 menu ID: NM30)

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

OST 002.1 Rationale

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

The SIGN clinical guideline on the management of osteoporosis\(^{126}\) addresses the pharmacological management in three groups of postmenopausal women: postmenopausal women with multiple vertebral fractures (DXA scan not essential but other destructive diseases are excluded); postmenopausal women with osteoporosis determined by DXA scan and a history of at least one vertebral fracture; and postmenopausal women with osteoporosis determined by DXA scan with or without a previous non-vertebral fracture.

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

- who are unable to comply with the special instructions for the administration of alendronate, or have a contraindication to or are intolerant of alendronate and
- who also have a combination of T-score, age and number of independent clinical risk factors for fracture as indicated in the following table.

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

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Number of independent clinical risk factors for fracture*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>50-54</td>
<td>-**</td>
</tr>
<tr>
<td>55-59</td>
<td>-3.0</td>
</tr>
<tr>
<td>60-64</td>
<td>-3.0</td>
</tr>
<tr>
<td>65-69</td>
<td>-3.0</td>
</tr>
<tr>
<td>70 or over</td>
<td>-2.5</td>
</tr>
</tbody>
</table>

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

**Treatment with risedronate or etidronate is not recommended.

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

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

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

**OST 002.2 Reporting and verification**

See indicator wording for requirement criteria.

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

The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent

**OST 005.1 Rationale**

See OST 002W.1.

This indicator does not require that a diagnosis of osteoporosis is confirmed by DXA scan in patients aged 75 or over with a fragility fracture. But it is recommended clinical practice that this group are considered for a DXA scan. NICE recommends that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible. SIGN recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish BMD is sufficiently low.

---

**127 NICE technology appraisal TA161.**
before starting treatment with bone-sparing agents (biophosphonates), unless the patient has suffered multiple vertebral fractures.

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

A diagnosis of osteoporosis is not required in patients aged 75 or over who have a fragility fracture. If, however, a patient aged 80 or over has a DXA scan and this shows the patient not to have osteoporosis then the patient can be exception reported.
# Rheumatoid arthritis (RA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><em>NICE 2012 menu ID: NM55</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months</td>
<td>5</td>
<td>40–90%</td>
</tr>
<tr>
<td><em>NICE 2012 menu ID: NM58</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA003. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years</td>
<td>4</td>
<td>40–90%</td>
</tr>
<tr>
<td><em>NICE 2012 menu ID: NM56</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years</td>
<td>5</td>
<td>40–90%</td>
</tr>
<tr>
<td><em>NICE 2012 menu ID: NM57</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## RA – rationale for inclusion of indicator set

Rheumatoid arthritis (RA) is a chronic, disabling auto-immune disease characterised by inflammation in the peripheral joints, which causes swelling, stiffness, pain and progressive joint destruction. For a small proportion of people with RA, inflammatory disease outside the joints (for example, eye and lung disease, vasculitis) can pose a significant problem. RA affects around one per cent of the population; of these people, approximately 15 per cent have severe RA.

Although the confirmation of diagnosis and initiation of treatment may take place in secondary care, primary care has an important role to play in the management of RA. This may include checking cardiovascular risk and blood pressure, checking the person's risk for osteoporosis and assessing for signs of low mood or depression. An annual face-to-face review in primary care is an opportunity to assess the effect of the disease upon the person’s life, for example side effects to medication and whether they would benefit from any referrals to the multi-disciplinary team.
RA indicator 001 (NICE 2012 menu ID: NM55)

The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis

RA 001.1 Rationale

The RA register includes patients aged 16 or over with established and recent-onset disease and in whom there is a definite diagnosis of RA, irrespective of evidence of positive serology and current disease activity status.

When creating the register from historical diagnoses, the diagnosis may have been made by either a GP or a specialist. In future, it is anticipated that new diagnoses will be made by a specialist.

The register is restricted to patients aged 16 or over, to conform to international standards for differentiating RA from juvenile idiopathic arthritis.

The register also includes patients with inactive RA. There are three potential groups of patients whose disease may be referred to as inactive:

- patients who are being treated and whose disease is in remission
- patients who are not receiving treatment for RA but have evidence of past disease, for example, joint deformities. This type of RA is sometimes known as ‘burnt out’ RA. These patients are on the register as they remain at risk of the systemic effects of RA
- patients who are not receiving treatment for RA who have no evidence of past disease but there is doubt about their diagnosis. The contractor may wish to request erythrocyte sedimentation rate (ESR) or plasma viscosity, C-reactive protein (CRP), rheumatoid factor and hand X-ray to determine the accuracy of the diagnosis. Inaccurate diagnoses can be removed from the patient’s patient record which would also remove them from the register.

Recognition of synovitis in primary care and prompt referral for specialist advice is key to the early identification and treatment of RA. Synovitis is inflammation of the membrane that lines the inside of synovial joints (most of the joints in the body). Symptoms of inflammation include pain, swelling, heat and loss of function of an affected joint.

Identifying recent-onset RA can be challenging in primary care because of the variety of ways in which synovitis can present itself and the small number of patients who have RA compared with the number of patients with musculoskeletal symptoms. The NICE clinical guideline on RA\textsuperscript{128} recommends that patients with persistent synovitis are referred for specialist opinion. Urgent referral is needed when any of the following are present:

\textsuperscript{128} NICE clinical guideline CG79. RA 2009. \url{http://publications.nice.org.uk/rheumatoid-arthritis-cg79}
- the small joints of the hands or feet are affected
- more than one joint is affected
- there has been a delay of three months or longer between the onset of symptoms and seeking medical advice.

Early identification of recent-onset RA is important because long-term outcomes are improved if disease modifying anti-rheumatic drugs (DMARDs) treatment is started within three months of the onset of symptoms.

RA 001.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the LHB may wish to discuss with contractors the process they use to identify patients with RA, and the number of patients with inactive disease whose diagnoses have been reviewed and the outcomes of this review.

RA indicator 002 (NICE 2012 menu ID: NM58)

The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months

RA 002.1 Rationale
RA is a chronic disease with a variable course over a long period of time. Therefore, there is a need for regular monitoring to determine disease status, assess severity, efficacy and toxicity of drug therapy and identify co-morbidities or complications.

Patients with satisfactorily controlled established disease require review appointments for ongoing drug monitoring, additional visits for disease flares and rapid access to specialist care. RA and its treatment can also have a negative effect upon a patient's quality of life. It is recommended that contractors review the following aspects of care with a patient:

- disease activity and damage, which may include requesting C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) or plasma viscosity test
- a discussion of DMARDS, if relevant
- the need for referral for surgery
- the effect the disease is having on their life, for example employment or education
- the need to organise appropriate cross-referral within the multi-disciplinary team.

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease upon the patient's life and whether they would benefit from any referrals to the multi-disciplinary team.
RA 002.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the LHB may wish to review patient records to ensure that all essential elements of the review have been performed.

RA indicator 003 (NICE 2012 menu ID: NM56)

The percentage of patients with rheumatoid arthritis aged 30 or over and under the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years

RA 003.1 Rationale

RA is a significant, independent risk factor for CVD and causes increased mortality compared with the general population. The increased risk appears to be due to both an increased prevalence of traditional risk factors, such as smoking, in addition to inflammation.

Most existing CVD risk assessment models do not treat RA as an independent risk factor for CVD and therefore the scores underestimate the person’s risk.

Currently, the only tool which adjusts for RA as an independent risk factor within the risk algorithm itself is QRISK2. This tool was developed and validated using primary care data from 26,907 patients with RA.

This indicator may be updated with new tools which adjust for RA.

It is recommended that the CVD risk assessment is repeated annually, unless patients have established CVD (for example, CHD, stroke and transient ischemic attack), or familial hypercholesterolemia. The assessment is repeated annually because lipid levels have an impact on the risk of developing CVD and lipids may not be constant in patients with RA and therefore can change over a course of a year. RA treatment for the control of inflammations may alter lipid levels.

Further information


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

Patients with CHD, stroke, transient ischemic attack, or familial hypercholesterolemia, are excluded from this indicator.

**RA indicator 004 (NICE 2012 menu ID: NM57)**

The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years

**RA 004.1 Rationale**
Osteoporosis is more common in patients with RA because of reduced mobility, inflammation and the effects of pharmacological treatments, especially steroids. NICE\textsuperscript{130} and SIGN\textsuperscript{131} clinical guidelines highlight the importance of checking for the development of osteoporosis. Therefore, assessing for risk of fracture is an important part of holistic primary care for patients with RA.

Draft recommendations from NICE\textsuperscript{132} propose that fracture risk assessment is considered in women aged 65 or over, in men aged 75 or over and in younger patients if they have the following risk factors:

- previous fragility fracture
- current use or frequent past use of oral glucocorticoids
- history of falls
- family history of hip fracture
- other secondary causes of osteoporosis including RA
- low BMI (less than 18.5 kg/m2)
- smoking more than ten cigarettes per day

---

\textsuperscript{130} NICE clinical guideline CG79. RA 2009. \url{http://publications.nice.org.uk/rheumatoid-arthritis-cg79}
\textsuperscript{131} SIGN clinical guideline 123. Management of early RA 2011. \url{http://www.sign.ac.uk/guidelines/fulltext/123/index.html}
\textsuperscript{132} (Draft) NICE clinical guideline. Osteoporosis: assessing the risk of fragility fracture. \url{http://guidance.nice.org.uk/CG/Wave25/2}
alcohol intake of more than 14 units per week for women and more than 21 units per week for men.

However, it is recommended that fracture risk assessment is not routinely performed in patients aged 50 or under unless they have major risk factors such as current or frequent use of oral or systemic glucocorticoids, untreated, premature menopause or previous fragility fracture. Therefore, the age range for this indicator has been set at 50 or over and under the age of 91.

A ten year predicted absolute fracture risk can be calculated using either FRAX\(^{133}\) (without a bone mineral density value) or QFracture\(^{134}\).

FRAX is the WHO’s fracture risk assessment tool which is available to use free of charge. It gives a ten year probability of hip fracture and a ten year probability of a major osteoporotic fracture (for example, clinical spine, forearm, shoulder or hip fracture).

QFracture is also available to use free of charge and it estimates an individual’s risk of developing a hip fracture or an osteoporotic fracture (for example, hip, vertebral or distal radius fracture) over the next ten years. The original research was carried out using the QResearch anonymised primary care research database and has since been validated in a different primary care database.

The draft NICE guidance recommends that, following risk assessment, measurement of bone mineral density be considered:

- in patients whose fracture risk is in the region of the intervention threshold for proposed treatment; or
- before starting treatments that may adversely affect bone density, for example high dose glucocorticoids.

Absolute fracture risk is then recalculated using FRAX.

The draft guidance also recommends that fracture risk be recalculated when there is a change in the patient’s risk factors or after a minimum of two years if the original calculated risk was close to the intervention threshold for treatment. This indicator requires that fracture risk assessment is recalculated every 27 months.

Further information


\(^{133}\)FRAX. \text{http://www.shef.ac.uk/FRAX/}

\(^{134}\)QFracture. \text{http://www.qfracture.org/}
RA 004W.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with a pre-existing diagnosis of osteoporosis or who are currently treated with bone-sparing agents will be excluded from this indicator.
Palliative care (PC)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

PC – rationale for inclusion of indicator set

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

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

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

The National EoLC Strategy suggests that all contractors adopt a systematic approach to EoLC and work to develop measures and markers of good care. They recommend the Gold Standards Framework (GSF) and the associated After Death

---

135 DH. National End of Life Care (EoLC) Strategy 2008.
Analysis (ADA) as examples of good practice. Evidence suggests that over 60 per cent of practices across the UK now use GSF to some degree to improve provision of palliative care by their primary care team.

The introduction of the GSF\textsuperscript{136} to primary care and its associated audit tool, the ADA, are associated with a considerable degree of research and evaluation. The GSF provides ideas and tools that help contractors to focus on implementing high quality patient-centred care.

**PC indicator 001**

The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age

**PC 001.1 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 may therefore be possible to predict the majority of deaths, however, this is difficult and errors occur 30 per cent of the time. Two thirds of errors are based on over optimism and one third on pessimism. However, the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them and anticipating need.

Identifying patients in need of palliative care, assessing their needs and preferences and proactively planning their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator set is focused on the maintenance of a register (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient’s care have been assessed and future care can be co-ordinated and planned proactively\textsuperscript{137}.

A patient is 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 'the 'surprise question' - 'Would I be surprised if this patient were still alive in 12 months?')

2. They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of the GSF website)

3. They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered

\textsuperscript{136} GSF. [http://www.goldstandardsframework.org.uk/](http://www.goldstandardsframework.org.uk/)

\textsuperscript{137} NAO EoLc Report. 'In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly quarter of these had been in hospital for over a month'. November 2008.
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.

PC 001.2 Reporting and verification
See indicator wording for requirement criteria.

In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register in the financial year then they will be eligible for payment.

PC indicator 002W
The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed

PC 002W.1 Rationale
The aims of multidisciplinary case review meetings are to:

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

Many staff directly employed by the contractor find use of a checklist during the meeting helpful, as it helps to ensure all aspects of care are covered e.g. supportive care register (SCR) templates SCR1 and SCR2 the assessment tools on the GSF website.

PC 002W.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the LHB may request that the contractor provides evidence that the meetings took place which could be in the form of minutes of the meetings.
Contractors may also be required to provide written evidence describing the system for initiating and recording meetings.
Section 4: Public health (PH) domain

Public health domain introduction

The clinical and health improvement indicators within this domain follow the layout of the clinical domain indicators, referring to sections on the indicator rationale and reporting and verification.

The additional services indicators, within this domain either:

1. follow the format of the four areas below along with information to support the indicator:
   - contractor guidance
   - reporting and verification

2. follow the format of the clinical domain indicators.

Further detail on the above two formats is included in the ‘format’ section below.

Format

For each of the indicators (X.X) using the first format above, there are four descriptions unless it is reported electronically.

X.1 Rationale
This section contains a range of information, dependent on the indicator, including:

- justification for the indicator
- a more detailed description of the indicator
- references which contractors may find useful

X.2 Reporting and verification
This section outlines the evidence which the LHB may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested. In some instances no evidence will be required but may be requested by the LHB at any time.
Cardiovascular disease – primary prevention (CVD-PP)

### Initial diagnosis

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD-PP001</td>
<td>10</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the LHB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins

*NICE 2011 menu ID: NM26*

### CVD-PP – rationale for inclusion of indicator set

Cardiovascular disease (CVD) is the most common cause of death in the UK and importantly for patients, the major cause of premature death (before the age of 65). Moreover, of greater significance for the NHS, CVD is not the commonest cause of disability (through stroke and HF particularly) and hospital admission. This results in CVD being the major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

Primary prevention works and evidence-based interventions can dramatically reduce risk. This was evidenced in North Karelia when CVD mortality was reduced by 50 per cent through rigid implementation of public health and individual patient interventions. Analysis of CHD trends in Ireland found that over a 15 year period, primary prevention achieved a two-fold larger reduction in CHD deaths than secondary prevention, where 68 per cent of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in patients without recognised CHD compared to 32 per cent in CHD patients.
CVD-PP indicator 001 (NICE menu 2011: NM26)

In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the LHB) of ≥20% in the preceding 15 months: the percentage who are currently treated with statins

CVD-PP 001.1 Rationale
For primary prevention of CVD, people at risk need to be identified before CVD has become established. To assess risk in those likely to be at high-risk (for example, people with hypertension) a validated assessment tool is needed that evaluates a range of modifiable and non-modifiable risk factors.

The NICE clinical guideline on lipid modification recommends statin therapy for the primary prevention of CVD for adults who have an estimated 20 per cent or greater 10-year risk of developing CVD.

A number of risk assessment tools can be used to estimate cardiovascular risk for this QOF indicator. These include:

- Framingham
- Joint British Society 2 (JBS2)
- QRISK.

The three assessment tools listed above allow a structured risk assessment to be undertaken. However, each has a different age threshold; so to include the use of all three tools, the age range for this indicator has been set at aged 30 or over and under the age of 75. Contractors will be expected to use one of the three tools to assess their patients. If the tool normally available on the contractor's clinical system is not age appropriate, one of the other tools may be used.

Framingham and JBS2 are based on the American Framingham equations. These equations are of limited use in the UK because they were developed in a historic US population. The equations overestimate risk by up to 50 per cent in most contemporary northern European populations, particularly for people living in more affluent areas and underestimate risk in higher risk populations, such as people who are the most socially deprived. Framingham makes no allowance for a family history of premature CHD and does not take account of ethnicity, but does have a full data set.

---

The newer risk score QRISK has the advantage of including other variables, such as measures of social deprivation, ethnicity and family history. QRISK uses data from UK general practice databases.

**Framingham and JBS2**

The variables needed to estimate risk using the Framingham tool are age, sex, systolic blood pressure (mean of two previous systolic readings), total cholesterol, high density lipoprotein cholesterol, smoking status and presence of left ventricular hypertrophy. JBS2 uses the Framingham variables with the exception of the presence of left ventricular hypertrophy.

Framingham is an assessment of actual, not estimated, risk. The values used should have been recorded no longer than six months before the date of the risk assessment and before any treatment for hypertension. Framingham is not suitable for patients with pre-existing CVD (CHD, angina, stroke, TIA or PAD), diabetes, CKD (if the patient has an eGFR below 60) or familial hypercholesterolemia, or in patients already taking lipid-lowering medication before a new diagnosis of hypertension.

The Framingham risk score may be used in patients aged 35 or over and under the age of 75. JBS2 may be used in people aged 40 or over.

**QRISK**

The QRISK CVD risk calculator was developed by doctors and academics working in the NHS and is based on routinely collected data from GPs across the country. The current version of QRISK is QRISK2. QRISK2 uses the following variables to calculate CVD risk: self-assigned ethnicity, age, sex, smoking status, systolic blood pressure, total cholesterol, HDL cholesterol, BMI, family history of CHD in a first degree relative younger than 60, Townsend deprivation score, treated hypertension, type 2 diabetes, renal disease, AF and RA.

QRISK2 may be used in patients aged 30 or over and under the age of 85.

**Clinical effectiveness of primary prevention**

For people without clinical evidence of CVD, statin therapy is associated with a reduction of fatal and nonfatal MI and the composite outcome CHD death or nonfatal MI, fatal and nonfatal stroke and revascularisation. In trials predominantly comprising primary prevention but including a minority of people with established CVD, meta-analysis found that statin therapy was associated with a reduction in the risk of all-cause mortality, fatal and nonfatal MI and the composite outcomes of CHD death, nonfatal MI, fatal or nonfatal stroke and coronary revascularisation. For primary prevention lower intensity statins are safe and cost-effective. It is recommended that treatment for the primary prevention of CVD in patients with hypertension be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

---

142 QRISK. [www.qrisk.org](http://www.qrisk.org)
The NICE clinical guideline on lipid modification makes recommendations on how a 10-year CVD risk score of 20 per cent or greater should be managed. It also makes recommendations on communication between practitioners and patients about CVD risk assessment and treatment. These include the following.

- Setting aside adequate time during the consultation to provide information on risk assessment and to allow any questions to be answered.
- Documenting the discussion relating to the consultation on risk assessment and the patient’s decision.
- Offering information about the person’s absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. This information:
  1. presents individualised risk and benefit scenarios
  2. presents the absolute risk of events numerically
  3. uses appropriate diagrams and text.

See www.npci.org.uk for more information about explaining risk.

The guideline also recommends that if the patient's CVD risk is considered to be at a level that merits intervention but they decline the offer of treatment, they are advised that their CVD risk should be considered again in the future. The guideline also notes that CVD risk may be underestimated in people who are already taking anti-hypertensive or lipid modification therapy, or who have recently stopped smoking. It recommends that clinical judgement be used in such cases to decide on further treatment of risk factors in people who are below the 20 per cent CVD risk threshold.

For patients with hypertension, the guideline recommends that before they are offered lipid modification therapy for primary prevention, all other modifiable CVD risk factors are considered and their management optimised if possible. Baseline blood tests and clinical assessment are to be performed and co-morbidities and secondary causes of dyslipidaemia treated. Assessment includes:

- smoking status
- alcohol consumption
- BMI or other measures of obesity (see the NICE clinical guideline on Obesity\textsuperscript{143})
- fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)
- fasting blood glucose

\textsuperscript{143} NICE clinical guideline CG43. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children 2006. www.nice.org.uk/guidance/CG43
renal function

liver function (transaminases)

TSH if dyslipidaemia is present.

The NICE guideline on lipid modification also recommends that the decision whether to initiate statin therapy is made after an informed discussion between the responsible clinician and the person about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

The guideline also states that a target for total or LDL cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD and that once a person has been started on a statin for primary prevention, repeat lipid measurement is unnecessary. It is recommended that clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.

CVD-PP 001.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with the following conditions are excluded from this indicator:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes

Verification - the LHB may request that the contractor randomly selects a number of case records of patients recorded as having had a risk assessment, to confirm that the key risk factors have been addressed and that biochemical and other clinical data used to inform the risk assessment are up-to-date. The LHB may also require contractors to demonstrate that age-appropriate risk assessment tools have been used.
Blood pressure (BP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP001W. The percentage of patients aged 50 or over who have a record of blood pressure in the preceding 5 years</td>
<td>10</td>
<td>50–90%</td>
</tr>
</tbody>
</table>

**BP indicator 001W (NICE 2012 menu ID: NM61)**

The percentage of patients aged 50 or over who have a record of blood pressure in the preceding 5 years

**BP 001W.1 Rationale**

This indicator replaces two 2012/13 indicators from the organisational domain on the measurement of blood pressure (Records 11 and 17). The previous two indicators have been merged to reflect changes in the construction of the indicator. The merged indicator is measured as a fractional indicator in common with other clinical and PH indicators. This change allows for the measurement of continuous quality improvement.

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. Guideline recommendations for the diagnosis and treatment of hypertension\(^{144}\) are to be followed by practitioners when deciding on whether to treat raised blood pressure.

The age limit of aged 50 or over, has been chosen as the vast majority of patients develop hypertension after this age. The age range 50 or over, coupled with a five year reference period, is designed to ensure that a blood pressure measurement takes place by the time someone reaches the age of 50.

It is anticipated that contractors will opportunistically check blood pressures in all adult patients.

**BP 001W.2 Reporting and verification**

See indicator wording for requirement criteria.

---

Obesity (OB)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

OB – rationale for inclusion of indicator set

The prevalence of obesity is a major PH challenge for the UK. In Wales, for example, 22 per cent of adults are obese\(^{145}\). In Scotland in 2010, 27.4 per cent of the adult population aged 16 or over and under the age of 65 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 most common causes of death and disability in developed economies, most notably greater rates of diabetes\(^{146}\) and accelerated onset of CVD\(^{147}\). Obesity has therefore become a major health issue for the UK. 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.

Recognising the need for an effective response to the health threat posed by obesity, the Welsh Government along with the Department of Health in England jointly commissioned NICE to conduct a systematic review of the evidence and to produce both clinical and public health guidance informed by the evidence.

Local Health Boards in Wales are required to plan and develop in partnership with local authorities and voluntary sector Health, Social Care and Well-being (HSCWB) Strategies. These set out how the identified health, social care and well-being needs of local residents will be addressed through joint working across organisations, and through effective targeting of resources. They are aimed at improving the health of the people in their locality, and making sure that they can get treatment and help when they need it.

Health Challenge Wales signposts members of the public to information or activity to help them improve their own health including tips on Food and Fitness.

http://www.healthchallengewales.org/food-and-fitness

\(^{146}\) Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603
\(^{147}\) Gregg et al. JAMA 2005; 20; 293 (15): 1868-74
Further information

NICE public health guidance 2. 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 2006. http://guidance.nice.org.uk/PH2


**OB indicator 001**

The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15months

**OB 001.1 Rationale**

The register includes all patients whose BMI has been recorded in the practice as part of routine care. It is expected that this data will inform PH measures.

**OB 001.2 Reporting and verification**

See indicator wording for requirement criteria.
Smoking (SMOK)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SMOK002.</strong> 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</td>
<td>25</td>
<td>60–90%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM38</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SMOK004.</strong> The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months</td>
<td>12</td>
<td>40–90%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM40</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SMOK005.</strong> The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months</td>
<td>25</td>
<td>53-93%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM39</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Requirements for recording smoking status**

**Smokers**
For patients who smoke, smoking status should be recorded in the preceding 15 months for SMOK002.

**Non-smokers**
It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 15 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:
Quality and Outcomes Framework guidance for GMS contract Wales 2014/15

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

**Ex-smokers**

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

**SMOK indicator 002 (NICE 2011 menu ID: NM38)**

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

**SMOK 002.1 Rationale**

**CHD**

Smoking is known to be associated with an increased risk of CHD.


**PAD**

PAD is associated with older age and with smoking. Cigarette smoking is a very important contributor to PAD and as such the management of PAD includes smoking cessation.

**Stroke or TIA**

There are few RCTs of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However, inferences can be drawn from the finds of primary prevention trials that cessation of cigarette smoking be advocated.


**Hypertension**

There is no strong direct link between smoking and blood pressure. However, there is overwhelming evidence of the relationship between smoking and cardiovascular
and pulmonary diseases. The NICE clinical guideline on hypertension\textsuperscript{148} recommends that patients who smoke are offered advice and help to stop smoking.

**Diabetes**
The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.

**COPD**
Smoking cessation is the single most effective and cost-effective intervention to reduce the risk of developing COPD and stop its progression.


**Asthma**
There are a surprisingly small number of studies on smoking related asthma. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. Smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome\textsuperscript{149}. There is also epidemiological evidence that smoking is associated with poor asthma control\textsuperscript{150}.

**CKD**
There is good evidence from observational studies that patients with CKD are at increased cardiovascular risk and hence the rationale for including CKD here.

**Schizophrenia, bipolar affective disorder or other psychoses**
Patients with a serious mental illness are far more likely to smoke than the general population (61 per cent of patients with schizophrenia and 46 per cent of patients with bipolar disorder smoke compared to 33 per cent of the general population). Premature death and smoking related diseases, such as respiratory disorders and heart disease, are however, more common among patients with serious mental illness who smoke than in the general population of smokers\textsuperscript{151}.

See requirements for recording smoking status for further information.

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


\textsuperscript{149} Tomlinson JE, McMahon AD, Chaudhuri R et al. Efficacy of low and high dose inhaled corticosteroids in smokers versus non-smokers with mild asthma. Thorax 2005; 60:282-7


\textsuperscript{151} McDonald C. Cigarette smoking in patients with schizophrenia. BJP 2000; 176: 596-7
For patients who smoke this recording is to be made in the preceding 15 months. Ex-smokers are to be recorded as described above. Those who have never smoked are to be recorded as such in the preceding 15 months up to and including the age of 25.

The disease register for the purpose of calculating APDF for SMOK002 and SMOK005W is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities e.g. diabetes and CHD are only counted once.

**SMOK indicator 004 (NICE 2011 menu ID: NM40)**

The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months

**SMOK 004.1 Rationale**

Smoking remains the main cause of preventable morbidity and premature death, leading to an estimated annual average of 86,500 deaths between 1998 and 2002 in England\(^{152}\). It is the primary reason for the gap in healthy life expectancy between the rich and the poor\(^{153}\).

Smoking is the greatest single cause of avoidable mortality in Wales. One of the key themes identified in Our Healthy Future is the need to further reduce smoking and exposure to second-hand smoke, which has lead to the development of a Tobacco Control Action Plan for Wales, which aims to address these issues. A report on Tobacco and Health in Wales\(^{154}\) was published jointly by the Welsh Government and the Public Health Wales Observatory in June 2012. This detailed report provides a wide range of data on smoking in Wales to support the implementation of the Welsh Government’s Tobacco Control Action Plan for Wales\(^{155}\).

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, CHD and other circulatory diseases, stomach and duodenal ulcers, ED and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis (US DH and Human Services 2004).

Women who smoke during pregnancy have a substantially higher risk of spontaneous abortion (miscarriage) than those who do no smoke. Smoking can also cause complications in pregnancy and labour, including ectopic pregnancy, bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes\(^{156}\).

---


\(^{154}\) Tobacco and Health in Wales http://www.wales.nhs.uk/sitesplus/922/page/59800

\(^{155}\) Tobacco Control Action Plan http://wales.gov.uk/topics/health/improvement/index/tobaccoplan/?lang=en

Around 43 per cent of patients who smoke try to quit each year, often several times a year. Many of these attempts fail because they are made without treatment and the aim of this domain is to increase the proportion of quit attempts that succeed by providing best available support and treatment. The one year continuous abstinence rate in untreated smokers who try to quit without help is about three per cent\footnote{Health Scotland. A guide to smoking cessation in Scotland 2010. \url{http://www.healthscotland.com/documents/4661.aspx}}. There is evidence that when doctors and other health professionals advise on smoking cessation and particularly when they offer support and treatment, that people are more likely to quit.

Around four per cent of patients who quit without using either pharmacotherapy or behavioural support will remain abstinent at 12 months. With pharmacotherapy and brief supervision from a GP or other clinician, this would be about eight per cent. If a patient takes up the offer of referral to an NHS Stop Smoking Service or a specially trained member of staff directly employed by the contractor, such as a practice nurse, providing regular weekly support, the one year continuous abstinence rate doubles to about 15 per cent.

See SMOK005W.1 for guidance on ‘support and treatment’ and smoking cessation.

\textbf{SMOK 004.2 Reporting and verification}

See indicator wording for requirement criteria.

There is no APDF calculation for SMOK004.

\textbf{SMOK indicator 005 (NICE 2011 menu ID: NM39)}

The percentage of patients with any of any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months

\textbf{SMOK 005.1 Rationale}

This indicator relates to patients who are on the disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma and mental health who are recorded as current smokers.

See requirements for recording smoking status for further information.

In 2009, 21 per cent of the adult population of Great Britain were cigarette smokers. The Welsh Health Survey 2011 reported 23 per cent of the Welsh population were cigarette smokers. The overall prevalence of smoking has been at this level since 2007\footnote{ONS 2011. General Lifestyle Survey 2009: Smoking and drinking among adults 2009. \url{http://www.ons.gov.uk/ons/rel/qlhs/general-lifestyle-survey/2009-report/index.html}}. At any one time, about 12 per cent of smokers intend to stop smoking in the last month\footnote{ONS. Smoking related behaviour and attitudes 2008/09. \url{http://www.ons.gov.uk/ons/rel/lifestyles/smoking-related-behaviour-and-attitudes/2008-09/index.html}}.


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\(^\text{160}\).

There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone.

For example, a Cochrane review that included 132 trials of nicotine replacement therapy (NRT), with over 40,000 people in the main analysis, found evidence that all forms of NRT made it more likely that a person’s attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70 per cent\(^\text{161}\).

NHS Stop Smoking Services, combine psychological support and medication. Results for April 2008 to March 2009 showed that 671,259 people who had contact with the service had set a quit date. Four weeks later, 337,054 people had successfully quit (based on self-report) representing half of those who set a quit date\(^\text{162}\).

'An offer of support and treatment' therefore means offering a referral or self-referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. Where such support is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

The NICE public health guidance on smoking cessation\(^\text{163}\) states that healthcare professionals who advise on, or prescribe, NRT, varenicline or bupropion:

1. offer NRT, varenicline or bupropion, as appropriate, to patients who are planning to stop smoking
2. offer advice, encouragement and support, including referral to the NHS Stop Smoking Service (http://www.stopsmokingwales.com/home), to help patients in their attempt to quit
3. when deciding which therapies to use and in which order, discuss the options with the client and take into account:
   - whether a first offer of referral to the NHS Stop Smoking Service has been made
   - contra-indications and the potential for adverse effects


\(^{161}\) Stead LF, Perera R, Bullen C etc al. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews. 2008. John Wiley and Sons, Ltd no.1


\(^{163}\) NICE public health guidance 10. Smoking cessation services. http://www.nice.org.uk/guidance/PH10
Quality and Outcomes Framework guidance for GMS contract Wales 2014/15

- the client's personal preferences
- the availability of appropriate counselling or support
- the likelihood that the client will follow the course of treatment
- their previous experience of smoking cessation aids.

The guidance also states that managers and providers of NHS Stop Smoking Services:

1. offer behavioural counselling, group therapy, pharmacotherapy, or a combination of treatments that have been proven to be effective

2. ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments'\(^{164}\) or its updates

3. provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups

4. provides services in the language chosen by clients, wherever possible.

For further information see NICE public health guidance 1 and 10\(^{165}\) and the Primary Care Respiratory Society UK statement on managing smoking cessation in primary care\(^{166}\).

Smoking cessation services in Wales are provided by Stop Smoking Wales, information on their services can be found at [http://www.stopsmokingwales.com](http://www.stopsmokingwales.com)

**SMOK 005.2 Reporting and verification**

See indicator wording for requirement criteria.

The disease register for the purpose of calculating APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities e.g. diabetes and CHD are only counted once.

---

\(^{164}\) HDA. Standard for training in smoking cessation treatments 2003. [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)


Public health domain – additional services

For contractors providing additional services the following indicators apply.

Please note exception reporting does not apply to those additional services indicators that do not have achievement thresholds.

Cervical screening (CS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>11</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

CS indicator 001

The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates

CS 001.1 Rationale

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outside the practice and is recommended to be in line with national guidance.

See guidance on exception reporting in section CS 002.1 contractor guidance.

The contractors protocol could be in the form of a written policy covering the issues outlined in the indicator wording.

CS 001.2 Reporting and verification

See indicator wording for requirement criteria.

The relevant practice staff are to be aware of the policy and the LHB may require that the contractor can demonstrate how the systems operate.
CS indicator 002

The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years

CS 002.1 Rationale
This indicator is designed to encourage and incentivise contractors to continue to achieve high levels of uptake in cervical screening.

The contractor may be required to provide evidence of the number of eligible women, aged 25 or over and under the age of 65, who have had a cervical screening test performed in the last five years/60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 45 and 80 per cent, in a similar way to the clinical indicators.

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as ‘did not attend’. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before ‘informed dissent’ can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

CS 002.2 Reporting and verification
See indicator wording for requirement criteria.

The LHB may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number exception reported and the number who have had a cervical screening test performed in the preceding five years. Contractors can exception report patients in the same way as the clinical indicators and the LHB may enquire how patients who are exception reported are identified and recorded.
Section 5: Medicines Management Domain

For each indicator detailed guidance supporting the indicator is provided under 'rationale' and where appropriate additional detail around 'reporting and verification' requirements are also included.

'xxx.1 Rationale'
This sub section explains why the indicator has been selected. Wherever possible, the evidence source is described and if available, a web address (hyperlink in an electronic version of this guidance) is provided. When available, national guidelines have been used as the main evidence source, but individual papers are also quoted.

In some areas, more extensive information is provided. The aim is to achieve a balance of providing helpful information without attempting to provide a textbook of medicine or replicating guidelines.

'xxx.2 Reporting and verification'
Annex D to the SFE sets out the requirements in relation to verification. The contractor is required to ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled and the contractor is required to make that information available to the LHB on request. In verifying that an indicator has been achieved and information correctly recorded, the LHB may chose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator, or view appropriate procedure manuals or protocol documents.

See section one for full details on reporting and verification.
Medicines Management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED005W</td>
<td>4</td>
</tr>
<tr>
<td>MED006W</td>
<td>4</td>
</tr>
<tr>
<td>MED007W</td>
<td>10</td>
</tr>
</tbody>
</table>

MED005W: The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing.

MED006W: 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.

MED007W: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%.
MED indicator 005W

The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing.

MED 005W.1 Rationale

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.

MED 005W.2 Reporting and Verification

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

MED indicator 006W

The practice meets the LHB prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.

MED 006W.1 Rationale

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 LHB prescribing adviser for its reasons for not achieving the areas in question.

If the LHB 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.

MED 006W.2 Reporting and Verification

Actions and improvements may be discussed during an assessment visit or with the LHB prescribing advisor.
MED indicator 007W

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines.

Standard 80%

MED 007W.1 Rationale

Medication is by far the most common form of medical intervention. Four out of five people over 75 years take a prescription medicine and 36% are taking four or more\textsuperscript{167}. However, we also know that up to 50% of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5-17% of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the Briefing Paper.

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

The underlying principles of any medication review, whether using the patient's full notes or face to face are:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
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.

MED 007W.2 Reporting and Verification

A survey of medication review should be undertaken. This could be a computerised search and print out or a survey of fifty records of patients on four or more medications. An inspection of records should be carried out during an assessment visit.

\textsuperscript{167} Medicines and Older People – Supplement to the National Service Framework for Older People, 2001
The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.
Section 6: GP Cluster Network Development Domain

Strategic context

Together for Health, the five year vision for the NHS in Wales, places the development of community services as a key priority for the delivery of new models of care.

Setting the Direction and Delivering Local Health Care, which builds on Together for Health, outlines the framework for Local Health Boards (LHB) to deliver improved primary care and community based services and the mechanisms to strengthen local collaborative working between GP practices, linking with community nursing teams and social care partners to provide more care in the community and at home.

Rising health and social care demands continue to place increasing pressure on all public and voluntary sector services. It is therefore vital that practices plan to ensure sustainability and that GP cluster networks are strengthened to play a central role in coordinating the response to these demands.

Key aims

As the first step in a three year development programme, the GP Cluster Network Development Domain will strengthen GP cluster networks as active agents for change in local services in the delivery of Setting the Direction and Delivering Local Health Care.

GP cluster network development will:

- recognise the value of peer review and horizontal integration to support sustainable general practice and new models of care led by local teams (for example, developments may include cross referral for clinical care, federations of GP practices, shared administrative support and full practice mergers)
- develop the maturity of GP clusters to lead the development of local services including the direction of resources and management of delegated budgets and community staff where appropriate.
- increase the use of data to support local needs assessment and service prioritisation.
- utilise the results of the previous Quality and Productivity (QOF) analyses in relation to the management of referrals, accident and emergency and unscheduled care admissions to hospitals and risk profiling / stratification.
- deliver improvements in care in the 3 national priority areas outlined at indicators CND 006W, CND 007W and CND 008W.

The GP Cluster Network Development Domain will enable GP cluster networks to collaborate to:

---

168 A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board’s area of operation as previously designated for QOF QP purposes
- understand local health needs and priorities.
- develop an agreed GP Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- work with partners to improve the coordination of care and the integration of health and social care.
- work with local communities and networks to reduce health inequalities.

The delivery of local health services and more care in the community is a key element of LHB’s 3 year service delivery plans.

Annex 1 sets out the role of LHBs in supporting and engaging with GP practices and GP clusters in the delivery of local health care.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agreeing a Practice Development Plan</strong></td>
<td></td>
</tr>
<tr>
<td>CND 001W. The contractor undertakes a review of local need and the provision of services within the practice, developing priorities for action to inform the production of a Practice Development Plan.</td>
<td>30</td>
</tr>
<tr>
<td>The contractor completes the Practice Development Plan (utilising the proforma at Annex 2) to assist practice analysis and planning and to inform discussions at GP cluster network meetings.</td>
<td></td>
</tr>
<tr>
<td>The contractor ensures patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal / informal feedback obtained from patients.</td>
<td></td>
</tr>
<tr>
<td>The Practice Development Plan objectives and priorities (page 14/15 Annex 2) to be completed and shared with the LHB by 30 June 2014.</td>
<td></td>
</tr>
<tr>
<td><strong>Agreeing a GP Cluster Network Action Plan</strong></td>
<td></td>
</tr>
<tr>
<td>CND 002W. The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the GP Cluster Network, including relevant issues identified within Practice Development Plan that can be most effectively addressed as a GP cluster network action. The contractor agrees the contents of a GP Cluster Network Action Plan to deliver against shared local objectives.</td>
<td>25</td>
</tr>
<tr>
<td>A GP Cluster Network Action Plan (based on the proforma at Annex 3) will address the following key areas:</td>
<td></td>
</tr>
<tr>
<td>a. Access arrangements - comparison of core access arrangements (including capacity, profiling the normal working week and usage analysis); exploration of adjuvants to access (including telephone arrangements); user experience; the impact of My Health On Line where it is available to practices. The analysis should also consider how practices respond to urgent requests and same day requests from care homes, Welsh Ambulance Services and hospital emergency departments.</td>
<td></td>
</tr>
<tr>
<td>b. Actions to foster greater integration of health and social care.</td>
<td></td>
</tr>
<tr>
<td>c. Consideration of how community resources can be maximised to meet local needs through the more effective use of local resources.</td>
<td></td>
</tr>
</tbody>
</table>
d. Consideration of how Third Sector support may be maximised.

e. Mapping of local GP services to highlight where services are delivered across practices (for example, contraceptive services, minor surgery).

f. Consideration of how new approaches to the delivery of primary care might aid service delivery and ensure sustainability of local services. Developments might include new technologies, development of clinical roles, further development of cross referral and increased skill mix.

g. Consideration of the impact of local care pathway work relating to previous QOF work.

The contractor participates in the completion of a GP Cluster Network Action Plan (at Annex 3).

The LHB Network Lead or nominated person will be responsible for collating and ensuring the GP Cluster Network Action Plan is completed by 30 September 2014.

The GP cluster network members are responsible for the agreement and delivery of the GP Cluster Network Action Plan.

The GP Cluster Network Action Plan will be subject to review at each meeting as outlined below in indicator CND 003W.

The GP Cluster Network Action Plan (at Annex 3) to be completed and shared with the LHB by 30 September 2014.

**Reviewing the implementation and delivery of the GP Cluster Network Action Plan**

CND 003W. The contractor participates in four GP cluster network meetings to review the implementation and delivery of the GP Cluster Network Action Plan.

The GP cluster network meetings will be facilitated by the LHB network lead or nominated person. This will ensure effective communication between the GP cluster network and the LHB and the alignment of the GP Cluster Network Action Plan with LHB strategic and operational priorities.

The GP Cluster Network Action Plan is a dynamic plan and will be updated to reflect the agreed outcomes of each cluster network meeting.

**Agreeing a GP Cluster Network Annual Report**

CND 004W. The contractor participates in one GP cluster network meeting to develop and agree a GP Cluster Network Annual Report (at Annex 4) and submits to the LHB by 31 March 2015.

**Improving Clinical Governance**

CND 005W. The contractor completes the Clinical Governance Practice Self Assessment Toolkit 169 (CGPSAT) and confirms completion to the LHB by 31 March 2015. Information on the completion of CGPSAT is at Annex 5.

The contractor will include appropriate actions resulting from this analysis within the Practice Development Plan and will consider whether any issues need to be discussed at GP cluster level.

### Participating in General Practice National Priority Areas

**CND 006W: Understanding cancer care pathways and identifying opportunities for service improvement (guidance at Annex 6).**

The contractor will:

1. Review the care of all patients newly diagnosed between 1\textsuperscript{st} January 2014 and 31\textsuperscript{st} December 2014 with lung (including mesothelioma) or digestive system cancer using a Significant Event Analysis tool.

2. Summarise learning and actions to be shared with the network and the wider LHB.

3. Identify and include any relevant actions to be addressed in the Practice Development Plan.

4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.

The outcomes of the GP cluster analysis to be included in the GP Cluster Network Annual Report.

It is anticipated that the GP cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year.

The contractor to provide a statement to the LHB, by 31 March 2015, that they have identified outcomes from the GP cluster analysis to be considered for inclusion in the GP Cluster Network Annual Report and any relevant actions to be included in the Practice Development Plan.

**CND 007W: Improving end of life care (guidance at Annex 7).**

The contractor will:

1. Identify all deaths \textsuperscript{170} (up to a maximum of 5/1000 registered patients) occurring between 1\textsuperscript{st} January 2014 and 31\textsuperscript{st} December 2014.

2. Use the individual case review to assess delivery of end of life care (at Appendix 2, Annex 7).

3. Identify and include actions to be addressed in the Practice Development Plan.

4. Summarise themes and actions for review with the cluster network at the meetings and share information with the LHB as required.

---

\textsuperscript{170} Exclude sudden deaths that could not have been anticipated e.g. due to accident
The outcomes of this work to be included within the GP Cluster Network Annual Report at indicator CND 004W.

It is anticipated that the GP cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year.

The contractor to provide a statement to the LHB, by 31 March 2015, that they have identified outcomes from the GP cluster analysis to be considered for inclusion in the GP Cluster Network Annual Report and any relevant actions to be included in the Practice Development Plan.

CND 008W :Minimising the harms of polypharmacy (guidance at Annex 8)  

The contractor will:

1. Identify and record number the % of patients aged 85 years or more receiving 6 or more medications.

2. Undertake face to face medication reviews, using the “No Tears” approach or similar tool as agreed within the cluster, for at least 60% of the cohort defined in 1 above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached)

3. Identify actions to be addressed in the Practice Development Plan.

4. Summarise themes and actions for review with the GP cluster network and share information with the LHB as required.

The outcomes of this work to be included within the GP Cluster Network Annual Report at indicator CND 004W.

It is anticipated that the GP cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year.

The contractor to provide a statement to the LHB, by 31 March 2015, that they have identified outcomes from the GP cluster analysis to be considered for inclusion in the GP Cluster Network Annual Report and any relevant actions to be included in the Practice Development Plan.

Total points 160

CND 001W

The contractor undertakes a review of local need and the provision of services within the practice, developing priorities for action to inform the production of a Practice Development Plan.
CND 001W.1 Rationale

The contractor completes the Practice Development Plan (using the proforma at Annex 2) to inform practice development and ensure that services are appropriate for the population served. The outcomes of this analysis as recorded (page 14/15 Annex 2) in the Practice Development Plan should inform discussions at GP cluster network meetings.

The Practice Development Plan will identify key health priorities, on-going development work and new priorities based on the practice population needs assessment. The Practice Development Plan should include consideration of access; care pathways and referral management currently in use; management of unscheduled care; practice initiatives; workforce development and estates plans.

The LHB network lead (or nominated person) and Local Public Health Teams will be important contacts. The LHB network lead or nominated person will work with the Public Health Team to facilitate access to relevant data (for example, planned referral data; admission/emergency attendance data; disease prevalence) to inform the development of the Practice Profile by 30 April.

The contractor will ensure patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal/informal feedback obtained from patients.

CND 001W.2 Reporting and Verification

The Practice Development Plan objectives and priorities (page 14/15 Annex 2) to be completed and shared with the LHB by 30 June 2014.

CND 002W

The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the GP Cluster Network, including relevant issues identified within Practice Development Plan that can be most effectively addressed as a GP cluster network action. The Contractor agrees the contents of a GP Cluster Network Action Plan to deliver against shared local objectives.

CND 002W.1 Rationale

The LHB network lead or nominated person will collate the agreed GP Cluster Network Action Plan.

The LHB network lead or nominated person will co-ordinate the GP cluster network meeting.

A GP and the practice manager/senior administrative employee will attend the GP cluster network meeting to discuss the population needs (assessed using the
resources outlined at Annex 1) and key themes and issues identified in each of the Practice Development Plans and to agree a GP Cluster Network Action Plan.

The LHB network lead or nominated person will facilitate the GP cluster network meeting and will ensure that the agreed prioritised actions identified in the GP Cluster Network Action Plan by contractors are consistent with the LHBs strategic objectives as well as ensuring that local needs are addressed. If there is a clear non-alignment of local needs with LHB strategic objectives, the LHB lead will facilitate further discussion with the GP cluster.

In particular, GP practices will engage in the GP cluster network agenda as outlined in the GP Cluster Network Action Plan. The minimum requirement will be one GP and practice manager / senior administrative employee per meeting. Single handed and small practices [2 or 3 partners] may discuss with the cluster network members and Health Board representatives the appropriateness of “buddying” arrangements to ensure the engagement of small practices and to minimise disruption to service delivery.

The themes and issues arising from the national priority areas at indicators CND 006W, CND 007W, and CND 008W may be considered for inclusion in the GP Cluster Network Action Plan for 2015/16 when the review of the national priority areas has been completed.

The agreed GP cluster actions should be supported by objectives with agreed timescales for delivery.

**CND 002W.2 Reporting and Verification**

The GP and the practice manager / senior administrative employee will be required to attend the GP cluster network meeting and to contribute to discussions agreeing a GP Cluster Network Action Plan.

The GP Cluster Network Action Plan to be completed and shared with the LHB by 30 September 2014.

**CND 003W**

The contractor participates in four cluster network meetings to review the implementation and delivery of the GP Cluster Network Action Plan.

**CND 003W.1 Rationale**

The GP cluster network meetings will be facilitated by the LHB network lead or nominated person. This will ensure effective communication between the cluster network and the LHB and the alignment of the GP Cluster Network Action Plan with LHB strategic and operational priorities where appropriate as well as enable local flexibilities for local needs.
The contractor will contribute to discussions on the progress of delivery of the agreed GP Cluster Network Action Plan and to identify any actions necessary to ensure delivery.

The extent to which the prioritised actions in the GP Cluster Network Action Plan can be achieved will be discussed and progress towards meeting these objectives will be documented during the year.

The GP Cluster Network Action Plan will be updated to include any new delivery actions after each meeting.

The LHB network lead or nominated person will facilitate each cluster network meeting and will proactively respond, ideally before the GP cluster network meeting, to issues raised by the cluster network in relation to any barriers and opportunities to delivery, and will record progress in service delivery.

CND 003W.2 Reporting and Verification

The contractor will participate in four cluster network meetings, will participate in discussions in reviewing the implementation, delivery and updating of the GP Cluster Network Action Plan

CND 004W

CND 004W.1 Rationale

The contractor participates in one cluster network meeting to develop and agree an GP Cluster Network Annual Report.

CND 004W.1 Rationale

The cluster network meeting will be facilitated by the LHB network lead / nominated person.

The contractor’s representatives will contribute to discussions on agreeing an GP Cluster Network Annual Report

The contractor should consider the extent of the delivery of the GP Cluster Network Action Plan and the impact of delivery on patient care.

CND 004W.2 Reporting and Verification

The GP Cluster Network Annual Report to be agreed and submitted to the LHB by 31 March 2015.

CND 005W

The contractor completes the Clinical Governance Practice Self Assessment Toolkit.
CND 005W.1 Rationale

The QOF indicator relates only for 2014/15. Completing the CGPSAT is for QOF purposes and is not for the purpose of attaining any specific tier for 2014/15.

The completion or updating of the Clinical Governance Practice Self Assessment Toolkit may be undertaken over the year and appropriate actions resulting from this analysis will be included in the Practice Development Plan for consideration if possible in 2014/15 or in 2015/16. The contractor will also need to consider whether any issues need to be discussed at GP cluster level.

CND 006W.2 Reporting and Verification

The contractor completes the Clinical Governance Practice Self Assessment Tool and confirms completion to the LHB by 31 March 2015. Payment is based on completion of the Clinical Governance Practice Self Assessment Toolkit and the identification of improvement priorities (if any).

CND 006W, 007W and 008W

The contractor is required to participate in three General Practice National Priority Areas: - Understanding cancer care pathways and identifying opportunities for service improvement; improving end of life care; minimising the harms of polypharmacy.

CND 006W, 007W and 008W 1 Rationale

The contractor participates in the three General Practice National Priority Areas in accordance with the guidance set out at Annex 6, Annex 7 and Annex 8.

The contractor will identify improvement actions for each national priority area to be considered within the Practice Development Plan for 2015/16 and the GP Cluster Network Action Plan for 2015/16, as appropriate.

The GP Cluster Network Annual Report should reflect key findings from this work and indicate any actions to be delivered in 2015/16. The report should highlight what, if any, further developments are needed to support patient needs.

In addition, local CPD programmes should give consideration to the learning needs identified through the national priority analysis and discussion.

CND 006W, 007W and 008W 2 Reporting and Verification

The contractor to provide a statement to the LHB, by 31 March 2015, that they have identified outcomes from the GP cluster analysis to be considered for inclusion in the GP Cluster Network Annual Report and any relevant actions to be included in the Practice Development Plan.
Section 7: 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, 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 has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where an issue relating to clinical indicators has arisen mid-year that cannot be resolved with simple clarification of the guidance, this will fall in to the NICE process of reviewing QOF indicators.

QOF queries should be directed as follows:

1. Queries relating to QOF Business Rules/coding should be sent to: NHS Wales Informatics Service via PrimaryCare.ServiceDesk@wales.nhs.uk
2. All other queries relating to QOF should in the first instance be sent to: Welsh Government via gmscontract@wales.gsi.gov.uk

NICE operate an online facility which allows stakeholders to comment on current QOF indicators. Comments will be used to review existing QOF indicators against set criteria which include:

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

Comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be fed in to negotiations between NHS Employers and the GPC. The online facility is available on the NICE website.\textsuperscript{171}

\textsuperscript{171} NICE website. QOF. \url{http://www.nice.org.uk/aboutnice/qof/qof.jsp}
Section 8: Exception reporting guidance

Purpose of guidance

Exception reporting was introduced into the QOF in 2004. It is intended to allow contractors to pursue the quality improvement agenda without being penalised for patient specific clinical circumstances or other circumstances beyond the contractor’s control which lead to failure to achieve the indicator. For example, where a medication cannot be prescribed due to a contra-indication or side-effect, where patients do not attend for review or where secondary care services are not available.

Since 2004, it became clear that a variety of interpretations and applications of the nationally defined exception reporting criteria are possible. NHS Employers and the BMA published guidance in October 2006 regarding what constitutes good practice in exception reporting. The 2006 guidance was designed to provide additional clarity, to the information contained in the QOF guidance, in order to help maintain a consistent approach to exception reporting.

From April 2013, the exception reporting guidance has been updated and supersedes any previous guidance issued. It is supplementary to the paragraphs included in section one of this document.

Principles

The overriding principles to follow in deciding to except a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.
Definitions

There is an important distinction to be made between “exclusions” and “exceptions”. This guidance is about “exceptions”.

Exclusions are patients on a particular clinical register, but who for definitional reasons are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Exceptions are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the SFE. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

The criteria under which a patient may be excepted from a QOF indicator are set out in the SFE and also in section one of this document.

Although the SFE sets out nine reasons why a patient may be exception reported, the national QOF achievement analysis systems (CQRS) identifies exception reporting against a limited number of codes. For example, criteria A and G are both coded as "informed dissent" or "patient refused". Any patient is only excepted once by the system for a given indicator, but any patient’s clinical record could contain more than one type of exception reporting Read code entered by the contractor. It is therefore not possible to extract completely accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE from the national systems. Therefore the HSCIC only reports the total numbers of patients excepted for each indicator.

For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient’s clinical record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient’s notes as well as the exception reporting code applied.

Detailed guidance on exception reporting

Each of the nine criteria for exception reporting are detailed below:

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months.

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient’s prescription requesting that they attend for review.
The three invitations need to have taken place within the financial year in question (e.g. 1 April 2014 to 31 March 2015 if applying to the year 2013/14/15). There should be three separate invitations at three unique periods of time. The only exception to this rule is indicator CS00, where the period in which the three invitations are sent reflects the timeframe of the indicator e.g. five years.

The telephone call invitation may lead to the application of exception criteria G, ‘informed dissent’, if the patient refuses to take up the invitation to attend.

The following are examples that are not acceptable as an invitation:

1. A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.

2. A notice in the waiting room inviting particular groups of patients to attend clinics or make appointments (e.g. influenza immunisation).

**Influenza immunisation indicators**

Exception reporting for influenza immunisation has caused some confusion because it is also remunerated through a DES. For the DES, payment is based on the number of at-risk patients immunised. The DES nevertheless requires the contractor to develop a proactive approach and a robust call and reminder system for the at-risk groups.

For QOF, the payment is based on the percentage of patients immunised in each relevant disease area. Exception reporting rules apply to the QOF indicators and patients need to have been personally invited on at least three occasions that year to be excluded from the denominator for achievement under criteria A.

**Cervical screening indicators**

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or

- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all
three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

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

The overriding principle is that blanket exception reporting is not acceptable and individual decisions based on clinical judgment should be made.

It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis e.g. dementia or cancer. However, age, diagnosis, co-morbidity, health and functional status should be taken into account when deciding whether to exception report individual patients under this criteria.

In each individual case there is a question of degree which requires clinical judgement to be exercised.

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

Exception reporting is done automatically through the national achievement analysis system. Where the contractor has delivered the appropriate clinical standard within the timeframe for the indicator, the achievement would automatically override the exception.

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

The over-riding principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment (see criteria B).

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action
has not been carried out. The patient should not be exception reported on the basis that they are under the care of a consultant. The contractor should either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, exception reporting will be allowed. This should be noted in the patient record.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contra-indication or have experienced an adverse reaction.

The nature of the contra-indication, allergy or adverse drug reaction should be recorded in the patient record as well as the exception reporting code applied.

F. Where a patient has not tolerated medication.

The nature of the intolerance should be recorded in the patient record as well as the exception reporting code applied.

G. Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

A personal contact or discussion should be documented in the patient's record for this criteria to apply. This can include either face-to-face or telephone contact between a health professional and the patient.

Patients not responding to invitations to attend or failing to arrive at appointments cannot be exception reported under criteria G, e.g. DNA alone does not fulfil the criteria for informed dissent. Patients failing to respond after three invitations can be exception reported under criteria A.

The informed dissent should have been given in the period 1 April 2013 to 31 March 2014 if applying to the year 2013/14) (except cervical screening where a patient has withdrawn from the call and recall system).

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

The nature of the supervening condition should be recorded in the patient’s notes as well as the exception reporting code applied.

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

The contractor would be expected to explore fully with their LHB whether or not a
suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the services was unavailable.
# Section 9: Glossary of terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABPI</td>
<td>Ankle Brachial Pressure Index</td>
</tr>
<tr>
<td>ABPM</td>
<td>Ambulatory Blood Pressure Monitoring</td>
</tr>
<tr>
<td>ACCORD</td>
<td>Action to Control Cardiovascular Risk in Diabetes</td>
</tr>
<tr>
<td>ACE-Inhibitor or ACE-I</td>
<td>Angiotensin Converting Enzyme Inhibitor</td>
</tr>
<tr>
<td>ACR</td>
<td>Albumin:Creatinine Ratio</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>ACTIVE-W</td>
<td>Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events</td>
</tr>
<tr>
<td>ADA</td>
<td>After Death Analysis</td>
</tr>
<tr>
<td>AED</td>
<td>Antiepileptic Drugs</td>
</tr>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
</tr>
<tr>
<td>ARB</td>
<td>Angiotensin Receptor Blocker</td>
</tr>
<tr>
<td>AST</td>
<td>Asthma</td>
</tr>
<tr>
<td>ATC</td>
<td>Antithrombotic Trialists Collaboration</td>
</tr>
<tr>
<td>BAFTA</td>
<td>Birmingham Atrial Fibrillation Treatment of the Aged</td>
</tr>
<tr>
<td>BDI-II</td>
<td>Beck Depression Inventory, second edition</td>
</tr>
<tr>
<td>BHSOC</td>
<td>British Hypertension Society</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>BMD</td>
<td>Bone Mass Density</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>BPA</td>
<td>Bio-psychosocial Assessment</td>
</tr>
<tr>
<td>BTS</td>
<td>British Thoracic Society</td>
</tr>
<tr>
<td>CABG</td>
<td>Coronary Artery Bypass Grafting</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>CAN</td>
<td>Cancer</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CHS</td>
<td>Child Health Surveillance</td>
</tr>
<tr>
<td>CHADS$_2$</td>
<td>Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CND</td>
<td>GP Cluster Network Development</td>
</tr>
<tr>
<td>CON</td>
<td>Contraception</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQRS</td>
<td>Calculating Quality Reporting Service</td>
</tr>
<tr>
<td>CRP</td>
<td>C-Reactive Protein</td>
</tr>
<tr>
<td>CS</td>
<td>Cervical Screening</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>CVD-PP</td>
<td>CVD Primary Prevention</td>
</tr>
<tr>
<td>DBP</td>
<td>Diastolic Blood Pressure</td>
</tr>
<tr>
<td>DCCT</td>
<td>Diabetes Control and Complications Trial</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DEM</td>
<td>Dementia</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>DEP</td>
<td>Depression</td>
</tr>
<tr>
<td>DM</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DRS</td>
<td>Diabetic Retinopathy Screening</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, fourth edition</td>
</tr>
<tr>
<td>DXA</td>
<td>Dual-Energy X-ray Absorptiometry</td>
</tr>
<tr>
<td>ED</td>
<td>Erectile Dysfunction</td>
</tr>
<tr>
<td>EHC</td>
<td>Emergency Hormone Contraception</td>
</tr>
<tr>
<td>eGFR</td>
<td>Estimated Glomerular Filtration Rate</td>
</tr>
<tr>
<td>EOLC</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>EP</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>EPIC</td>
<td>European Prospective Investigation into Cancer</td>
</tr>
<tr>
<td>ERJ</td>
<td>European Respiratory Journal</td>
</tr>
<tr>
<td>ESR</td>
<td>Erythrocyte Sedimentation Rate</td>
</tr>
<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>FEV₁</td>
<td>Forced Expiratory Volume in One Second</td>
</tr>
<tr>
<td>FVC</td>
<td>Forced Vital Capacity</td>
</tr>
<tr>
<td>GFR</td>
<td>Glomerular Filtration Rate</td>
</tr>
<tr>
<td>GMP</td>
<td>Good Medical Practice</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GOLD</td>
<td>The Global Initiative for Chronic Obstructive Lung Disease</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practitioners Committee</td>
</tr>
<tr>
<td>GPPAQ</td>
<td>GP Physical Activity Questionnaire</td>
</tr>
<tr>
<td>GPRD</td>
<td>General Practice Research Database</td>
</tr>
<tr>
<td>GPwSI</td>
<td>GP with a Special Interest</td>
</tr>
<tr>
<td>GSF</td>
<td>Gold Standards Framework</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>HAD-D</td>
<td>Hospital Anxiety and Depression Scale Depression Sub-Scale</td>
</tr>
<tr>
<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Glycated Haemoglobin</td>
</tr>
<tr>
<td>HBPM</td>
<td>Home Blood Pressure Monitoring</td>
</tr>
<tr>
<td>HDA</td>
<td>Health Development Agency</td>
</tr>
<tr>
<td>HF</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>HSCIC</td>
<td>NHS Health and Social Care Information Centre</td>
</tr>
<tr>
<td>HYP</td>
<td>Hypertension</td>
</tr>
<tr>
<td>IFCC</td>
<td>International Federation of Clinical Chemistry and Laboratory Medicine</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>IUS</td>
<td>Intrauterine System</td>
</tr>
<tr>
<td>JBS</td>
<td>Joint British Societies</td>
</tr>
<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination and Immunisation</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>LDL</td>
<td>Low Density Lipoprotein</td>
</tr>
<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>LVSD</td>
<td>Left Ventricular Systolic Dysfunction</td>
</tr>
<tr>
<td>MAT</td>
<td>Maternity</td>
</tr>
<tr>
<td>MCM</td>
<td>Major Congenital Malformation</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>mmHg</td>
<td>Millimetres of Mercury</td>
</tr>
<tr>
<td>mmol/l</td>
<td>Millimoles per Litre</td>
</tr>
<tr>
<td>MR</td>
<td>Modified Release</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>NAO</td>
<td>National Audit Office</td>
</tr>
<tr>
<td>NEJM</td>
<td>New England Journal of Medicine</td>
</tr>
<tr>
<td>NHANES</td>
<td>National Health and Nutrition Examination Survey</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>LHB</td>
<td>Local Health Board</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>NPV</td>
<td>Negative Predictive Value</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Non-Steroidal Anti-Inflammatory Drugs</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>OB</td>
<td>Obesity</td>
</tr>
<tr>
<td>OGTT</td>
<td>Oral Glucose Tolerance Test</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>OST</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>OTC</td>
<td>Over The Counter</td>
</tr>
<tr>
<td>PAD</td>
<td>Peripheral Arterial Disease</td>
</tr>
<tr>
<td>PC</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>PCR</td>
<td>Protein:Creatinine Ratio</td>
</tr>
<tr>
<td>PE</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>PEF</td>
<td>Peak Expiratory Flow</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Nine Item Patient Health Questionnaire</td>
</tr>
<tr>
<td>PCRJ</td>
<td>Primary Care Respiratory Journal</td>
</tr>
<tr>
<td>PVD</td>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>QMAS</td>
<td>Quality Management and Analysis System</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>QP</td>
<td>Quality and Productivity</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>RA</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nurses</td>
</tr>
<tr>
<td>RCTs</td>
<td>Randomised Controlled Trials</td>
</tr>
<tr>
<td>SCR</td>
<td>Supportive Care Register</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SMOK</td>
<td>Smoking</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>STIA</td>
<td>Stroke or Transient Ischemic Attack</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>THY</td>
<td>Thyroid</td>
</tr>
<tr>
<td>TPCR</td>
<td>Total Protein: Creatinine Ratio</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid Stimulating Hormone</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>WG</td>
<td>Welsh Government</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Annex 1

GP Cluster Network Development Domain

Local Health Board Support and Engagement

Introduction

The changes to the GP contract for 2014/15 include strengthening GP cluster networks as active agents for change in local services in the delivery of Setting the Direction and Delivering Local Health Care.

As part of a three year development programme, the new GP Cluster Network Development Domain sets out how GP cluster networks will collaborate to understand local health needs and priorities; develop an agreed local action plan; work with partners to improve the coordination of care and the integration of health and social care; and work with local communities and networks to reduce health inequalities.

The role of GP practices

GP practices play a central role in the delivery of local healthcare and will increasingly work with other partners to maximise the potential of local resources and expertise.

In particular, GP practices will engage in the GP cluster network agenda as outlined in the GP Cluster Network Action Plan. The minimum requirement will be one GP and practice manager / senior administrative employee per meeting. Single handed and small practices [2 or 3 partners] may discuss with the cluster network members and Health Board representatives the appropriateness of “buddying” arrangements to ensure the engagement of small practices and to minimise disruption to service delivery.

Practices should identify key issues from their own development plans to discuss at GP Cluster meetings to identify common themes that might be addressed through agreed actions.

The role of GP clusters

It is expected that over the next 3 years GP cluster networks will be supported by LHBs to mature and will have increasing autonomy and greater influence over local service improvement and delivery. The GP Cluster Network Development Domain will develop to support these changes.

Cluster networks will increasingly manage local resources to allow greater flexibility and more rapid local decision making. This will require robust governance and accountability frameworks together with engagement and confidence from the clusters and their partners.
The GP Cluster Network Development domain will enable:

- Individual practices to proactively plan their services to meet local needs and ensure sustainability
- Work on developing strategies, in conjunction with other practices in the GP cluster, to enable the primary healthcare team to be strengthened around the practice
- To “build the foundations” of collaborative working to ensure consistent and sustainable local systems of care and to take on wider responsibilities by the end of the 3 year plan.
- To ensure that services are developed to meet the needs of the local population.
- To develop professional networks and partnership working -specifically: public health; secondary care (co-opted where needed); pharmacy (community and LHB employed); voluntary sector; local authority and social care.
- To identify the areas which will have the biggest impact on improving healthcare, utilising a range of external resources such as:
  - Observatory resources such as the GP Cluster Profiles
  - QOF comparators of achievement
  - National Audit and Clinical Outcome Review findings
  - Welsh Government policy and strategy
  - PCQUIS products ; 1000 Lives Plus
  - Audit + data
- To develop a clear primary care quality improvement agenda.
- To improve patient access to services by developing collaborative working including cross referrals between practices and mapping where services are available.
- Develop more effective skill mix across practices and the community
- Reinvigorating the primary and secondary care relationship
- Maturing strategies that are built around the whole patient pathway from health promotion and prevention onwards into secondary / tertiary care.
- To address key priorities for Wales which for year one are:
  - Early detection of cancer (specifically - gastrointestinal and lung)
  - Further work to ensure consistent, high quality end of life care through an after death analysis
  - Minimising the harms of polypharmacy commencing with those aged over 85 on 6 or more medications
- To engage in the development of local workforce and CPD strategies that ensure sustainable delivery of primary and community care and support new service delivery models.

The role of Local Health Boards

Local Health Boards will:

- Provide proactive support to each GP cluster network through the locality clinical and managerial leads.
- Work with cluster representatives to enable single handed and small practices (2 or 3 partners) to engage fully either through having GP / Practice Manager attending or enabling “buddying ” of a small practice with a larger practice and
thus reducing attendance at each meeting. If “buddying” is implemented there will be an expectation the small practice will still engage in the full work of the cluster through email participation / directly feeding in comments etc to the “buddy” practice.

- Provide appropriate and timely information to support needs assessment and service improvement plans
- Facilitate appropriate links to enable GP cluster network development (e.g. secondary care consultants engaging in cluster work in high impact areas or when discussing referral data, public health).
- Ensure that GP cluster network meetings are effective and efficient, with agreed actions and regular review of progress
- Expand the delivery of community based services to support the delivery of care closer to home
- Promote a GP cluster network review of key priority areas: for example, early detection of cancer, unscheduled care, access and other aspects of work which will lead to significant improvements in health care.
- Ensure any issues in relation to GP cluster network delivery (barriers and constraints to progress) are considered by the LHB and responses provided at the next GP cluster network meeting.
- Ensure that progress and constraints highlighted by individual GP cluster networks and responses to those issues are collated into themes and specifically fed back to Welsh Government.
- Through active support of this agenda, address health inequalities and enable more integrated health and social care at a GP cluster network level.
- Resource any additional work over and above contractual requirements.

**Specific Local Health Board support in relation to the GP Cluster Network Development**

LHB’s are required to provide the following specific support:

- Identify the LHB network lead or nominated person to support contractors.

In relation to indicator CND001W: Agreeing a Practice Development Plan

- The LHB network lead or nominated person will support contractors by providing relevant information and responding to requests for data. The LHB network lead (or nominated person) and Local Public Health Teams will be important contacts. The LHB network lead or nominated person will work with the Public Health Team to facilitate access to relevant data (for example, planned referral data; admission /emergency attendance data; disease prevalence) to inform the development of the Practice Profile by 30 April

In relation to indicator CND002W: Agreeing a GP Cluster Network Action Plan.

- The LHB network lead or nominated person will collate and ensure the GP Cluster Network Action Plan is completed.
• Key themes and issues from Practice Development Plans should be discussed at GP cluster network meetings.

• The LHB network lead or nominated person will co-ordinate GP cluster network meetings.

• The LHB network lead or nominated person will facilitate the GP cluster network meetings and will ensure that the agreed prioritised actions identified in the GP Cluster Network Action Plan are consistent with the LHB’s strategic objectives. If there is clear non alignment of local needs with LHB strategic objectives, the LHB lead will facilitate further discussion with the GP practice.

• The LHB network lead or nominated person should proactively respond before the GP cluster network meeting to any issues raised by contractors.

• The LHB network lead or nominated person will work with single handed and small practices (2 or 3 partners) to enable them to engage fully either through having GP / Practice Manager attending or enabling “buddying” of a small practice with a larger practice and thus reducing attendance at each meeting. If “buddying” is implemented there will be an expectation the small practice will still engage in the full work of the cluster through email participation / directly feeding in comments etc. to the “buddy” practice.

In relation to indicator CND003W: Reviewing the implementation and delivery of the GP Cluster Network Action Plan

• The LHB network lead or nominated person will facilitate each GP cluster network meeting

In relation to indicator CND004W: Agreeing an GP Cluster Network Annual Report

• The LHB network lead or nominated person will facilitate the cluster network meeting

Other issues to be considered by the Local Health Board

The LHB should consider the extent to which the prioritised actions outlined in the GP Cluster Network Action Plan are aligned with the LHB’s strategic plans as well as allowing for local flexibilities based on local population need.

The LHB should consider, in partnership with the GP cluster network, the capacity for contractors to deliver the actions identified for inclusion in the GP Cluster Network Action Plan if there is a wide range of identified prioritised actions, and the extent to which some prioritised actions could be delivered in year 2 or year 3 of the work programme.

As indicated at CND 002W, the GP Cluster Network Action Plan will address the following key areas:
   h. Access arrangements - comparison of core access arrangements (including capacity, profiling the normal working week and usage analysis); exploration
of adjuvants to access (including telephone arrangements); user experience; the impact of *My Health On Line* where it is available to practices. The analysis should also consider how practices respond to urgent requests and same day requests from care homes, Welsh Ambulance Services and Hospital emergency departments.

i. Actions to foster greater integration of health and social care.

j. Consideration of how community resources can be maximised to meet local needs through the more effective use of local resources.

k. Consideration of how Third Sector support may be maximised

l. Mapping of local GP services to highlight where services are delivered across practices (for example, contraceptive services, minor surgery)

m. Consideration of how new approaches to the delivery of primary care might aid service delivery and ensure sustainability of local services. Developments might include new technologies, development of clinical roles, further development of cross referral and increased skill mix

n. Consideration of the impact of local care pathway work relating to previous QOF work.

LHB’s will need to consider the extent to which increased resources are made available to GP cluster networks given the requirements of CND 002W - for example, the requirements for responding to urgent requests and same day requests from care homes, Welsh Ambulance Services and Hospital Emergency departments.

LHB’s will need to consider the support it can offer to GP cluster networks to maximise community resources to meet local needs through the more effective use of local resources and actions to foster greater integration of health and social care.
GP Cluster Network Development Domain

GP Practice and Development Proforma

XXXXX XXXXXX XXXXXX XXXXX Health Board

Practice Development Plan

<table>
<thead>
<tr>
<th>Practice Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GP Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice W-Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Name of practice       |
| GP Lead:               |
|                        |

<table>
<thead>
<tr>
<th>Date submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

QOF Indicator CND 001W supports the GP contractor to undertake a review of local need and the provision of services by the practice and to create a Practice Development Plan with priorities for action. The Practice Development Plan will inform discussions at GP Cluster meetings.
The contractor should ensure that patient views are considered and that where possible, patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal / informal feedback processes.

This template is provided to ensure that Contractors fulfil the requirements of the CND1 indicator and should be completed and shared with the Health Board by 30 June 2014.

The practice retains ownership of the document. The practice development plan at page 14/15 is the section the practice will use for cluster discussions.

Suggestions for improvement of the document and this process should be shared with the LHB to ensure that this process drives the improvement of contractor services, ensures sustainability, informs the development of appropriate educational support and influences the redesign of services to more effectively address local needs.

Please Type the report:

All sections should be completed, please use “not applicable” where appropriate

Complete all the yellow shaded boxes - these will expand to fit entered text

<table>
<thead>
<tr>
<th>Our population: Demography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice List size</td>
</tr>
<tr>
<td><strong>Practice List Size:</strong></td>
</tr>
<tr>
<td>Is this increasing, decreasing or static?</td>
</tr>
<tr>
<td>How does this compare with local and national data and trends?</td>
</tr>
<tr>
<td>Consider the implications for workforce plans</td>
</tr>
<tr>
<td>Commentary (e.g. new housing developments)</td>
</tr>
</tbody>
</table>
### Particular population features

Indicate all population groups where particular service needs may apply such as high numbers of students; asylum seekers; rural isolation; Welsh language and other languages specific to the practice, high care home population; high mental health population etc.

This may be important for identifying opportunities for collaboration with other practices, community teams or voluntary sector organisations.

### Social Factors:

Consider any particular social factors that are relevant to your population, such as deprivations, unemployment, housing issues etc.

Consider partners who might provide advice and support for particular needs.
Disease Prevalence:

Compare patterns of disease with other local practices and identify variations.

Consider information from Public Health Wales in relation to prevalence of particular patterns of disease for your practice population and compare with the practice recorded prevalence patterns to ensure that case finding approaches are effective.

Consider local and national comparative data

Where recorded prevalence patterns are higher than prevalence patterns identified by Public Health Wales consider the potential for the development of practice or locality based support services

Practice Population Needs Assessment

| Key Health Priorities Identified by Practice |
(refer to data provided)

<table>
<thead>
<tr>
<th>Key health priorities identified from external sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access issues</td>
</tr>
<tr>
<td>Unscheduled care / admissions issues</td>
</tr>
<tr>
<td>Any ongoing issues from previous QOF QP work:</td>
</tr>
<tr>
<td>Planned referral/admission data- variation.</td>
</tr>
<tr>
<td>Accident and emergency admissions</td>
</tr>
<tr>
<td>Prescribing</td>
</tr>
<tr>
<td>Key issues arising from complaints/suggestions</td>
</tr>
</tbody>
</table>
and any formal investigations #

Key issues arising from Significant Event Analyses

Key issues arising from Practice Visits (LHB/CHC)

Key issues arising from practice profile (access, services, training etc)

Summary of agreed key issues and priorities arising from the above categories

Consider relevant documents such as Health Board plans, Welsh Government strategies e.g. Together for Health, NICE guidance

#Such as Ombudsman reports, Health Board investigations *(where relevant)*
Service provision

Having considered the needs of the population, the practice should summarise the current provision of services.

Development objectives should relate to the agreed priorities arising from the needs assessment.

Practices should consider issues in three areas: -

- Practice developments
- Priorities for action at the GP Cluster level
- System issues for consideration by the Local Health Board

At each level, consideration should be given to the potential for collaborative working to maximise the potential of community resources.

<table>
<thead>
<tr>
<th>Access arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening Hours</strong></td>
</tr>
<tr>
<td>Reception opens at:</td>
</tr>
<tr>
<td>Reception closes at:</td>
</tr>
<tr>
<td>Half-day closure: yes/no:</td>
</tr>
<tr>
<td>Lunchtime Closure yes/no:</td>
</tr>
<tr>
<td>Telephone to reception available 8am until 630pm: yes/no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of 1st bookable appointment: &lt; &gt;</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Appointments routinely available

- After 5pm yes/no
- After 530pm yes/no
- After 6pm yes/no

### Same Day Access

Summarise the process for urgent/same day requests for consultations such as telephone advice, open access surgeries

### Care Homes

Consider the population served.

- Is an enhanced service arrangement available? If so, does the practice participate?

Consider the process for responding to requests for urgent assessment.

### Support to A&E and Ambulance Services
Consider the processes in place in the practice for providing support to A&E or Ambulance services who are requesting urgent advice or a consultation in respect of your patients:

### Access Analysis

#### Consultation Rates

Summarise the consultation rates as set out below, *describing the numbers as rate/1000 registered patients per week*

<table>
<thead>
<tr>
<th>Type</th>
<th>Rate/1000 Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-bookable GP appointments with GP</td>
<td></td>
</tr>
<tr>
<td>Open-access consultations with GP</td>
<td></td>
</tr>
<tr>
<td>Pre-bookable GP appointments with Nurse/HCA</td>
<td></td>
</tr>
<tr>
<td>Open-access consultations with Nurse/HCA</td>
<td></td>
</tr>
</tbody>
</table>

#### Telephone Consultations:

Estimated number of telephone consultation per week:

Summarise any special arrangements for telephone consultations (for example, pre-bookable telephone consultations):
### Home Visits

Estimate the number of home visits per week: ( ) per 1000 registered patients

### Typical Waits

Consider the typical wait for an appointment booked in advance with

Any GP?

### Did Not Attends

Estimated DNA rate (%)

### Other issues affecting access

The team should reflect on the balance of capacity and demand and consider how services might be developed. Practices should consider:

- Examples of good practice such as from discussions with peers/ articles read / experience of systems in use in other practices
- Learning from discussions at cluster meetings
- Use of patient feedback to identify opportunities to improve practice systems
- Opportunities to maximise the potential of the whole team
- Identify barriers to the delivery of access to meet local needs

Where appropriate the Practice Development plan should identify any objectives for improvement and measures to monitor progress

### Service Provision

Additional Services\(^\text{172}\)

**Indicate which of the additional services are provided:**

---

\(^{172}\) Additional services are identified at Part 1 (2) NHS (General Medical Services Contracts) (Wales) Regulations 2004
<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cytology</td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
</tr>
<tr>
<td>Vaccinations and Immunisations (excluding childhood programme)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Childhood Immunisations</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Minor Surgery (Curettage &amp; Cautery)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Child Health Surveillance</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Enhanced Services**

*indicate which of the following enhanced services are provided:*

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Hours</td>
<td></td>
</tr>
<tr>
<td>Minor Surgery (excisions &amp; injections)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Near Patient Testing (please indicate which level)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>IUCD/IUS</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Depo-provera</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Contraceptive Implants</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Anticoagulation (indicate which level)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Asylum Seekers</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Childhood Immunisation target payments</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Services to violent patients:</strong> Yes/No</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Immunisation:</strong> Yes/No</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health:</strong> Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

**Others:**

**Review and actions:**

Practices should consider any gaps or duplications and will also wish to consider the potential for collaborative arrangements across cluster areas.

**Dispensing**

<table>
<thead>
<tr>
<th><strong>Does the practice provide dispensing services?</strong> Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of dispensing patients:</strong></td>
</tr>
<tr>
<td><strong>Dispensing Quality Scheme (Yes/No)</strong></td>
</tr>
</tbody>
</table>

**Comments:**

**Education & Training**

<table>
<thead>
<tr>
<th><strong>Is the practice recognised for GP training?</strong> Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placements offered</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Does the practice offer returner placements?</td>
</tr>
<tr>
<td>Does the practice offer retainer placements?</td>
</tr>
<tr>
<td>Is the practice an advanced training practice?</td>
</tr>
</tbody>
</table>

Comments (Including any plans to change provision):

| Does the practice provide educational supervision to GP registrars in hospital placements? | Yes/No |
| ST1 Yes/No | ST2 Yes/No |

| Does the practice provide placements to Foundation Doctors | Yes/No |

Comments:

| Does the practice provide placements to medical students from: |
| Cardiff University | Yes/No |
| Swansea University | Yes/No |
| Other medical schools | Yes/No |

Comments:

Nurse Training

| Does the practice provide educational placements for nurses at undergraduate or postgraduate level? | Yes/No |
Comments:

Other training:

Does the practice provide training to other professionals Yes/No

Comments

Other Roles

GPWSI (please indicate area of special interest)

Appraisal

Clinical Leadership\(^{173}\)

\(^{173}\) Clinical Leadership includes educational leadership, political leadership, managerial leadership and GP cluster leadership.
### Research

<table>
<thead>
<tr>
<th>Contractors should consider development priorities and actions</th>
</tr>
</thead>
</table>

### Data Collection

<table>
<thead>
<tr>
<th>Does the practice permit Data extraction by <strong>Audit Plus</strong> Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the practice permit Data extraction by <strong>SAIL</strong> Yes/No</td>
</tr>
<tr>
<td>If not, reasons for non-participation</td>
</tr>
</tbody>
</table>

### Private Services

---

174 GPC Wales supports the extraction of data from Audit Plus and SAIL and participates in the data governance approval process. There is a Focus on Welsh IM&T document available on the BMA website for practices wanting information / assurance around data governance of Audit +, SAIL, IHR.
Consider any private services provided to registered and non-registered patients by the practice e.g. occupational health, travel vaccines (non-GMS)

This information may be relevant to the practice Development Plan.
# Workforce

## Current Practice Workforce

<table>
<thead>
<tr>
<th>Role (name)</th>
<th>Name</th>
<th>Working Arrangements</th>
<th>Number of Clinical Sessions Worked in the practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor: Partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Salaried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Retainers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Returners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Trainees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Manager</td>
<td></td>
<td>Partner/Employee (indicate which)</td>
<td>Hours Worked</td>
</tr>
<tr>
<td>Practice Nurse: Practitioners</td>
<td></td>
<td></td>
<td>Hours Worked</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>Hours Worked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>Hours Worked</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Nurse Roles/Tasks</th>
<th>Wound Care (Y/N)</th>
<th>Respiratory Clinic (Y/N)</th>
<th>Cardiovascular (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetic Clinic (Y/N)</td>
<td>Wound Care (Y/N)</td>
<td>Child Immunisation (Y/N)</td>
</tr>
<tr>
<td></td>
<td>ECG (Y/N)</td>
<td>Contraception (Y/N)</td>
<td>Minor Ailments (Y/N)</td>
</tr>
</tbody>
</table>

Comments: e.g. any plans to reduce / increase staffing or change current staff mix because of funding concerns

Practices should consider short, medium and long term plans for their workforce

### Workforce (continued)

<table>
<thead>
<tr>
<th>HCSW</th>
<th>Number:</th>
<th>Total Hours worked:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles</td>
<td>Phelbotomy (Y/N)</td>
<td>ECG (Y/N)</td>
</tr>
<tr>
<td></td>
<td>Spirometry (Y/N)</td>
<td></td>
</tr>
<tr>
<td>BP monitoring (Y/N)</td>
<td>Injections (Y/N)</td>
<td>Wound Care</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other employed staff

190
<table>
<thead>
<tr>
<th>(e.g. counsellors, therapists etc.)</th>
<th>Predictions on workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Changes in Next 12 months</td>
</tr>
<tr>
<td></td>
<td>Changes in next three years</td>
</tr>
<tr>
<td>Other workforce concerns e.g. recruitment difficulties:</td>
<td></td>
</tr>
</tbody>
</table>

**Partnership working**

Contractors should consider key contacts and the potential for provision of services within the practice or through local network arrangements, such as:

- District Nurses
- Health visitors
- Phlebotomists
- Counsellors
Voluntary sector

Communities First
## Premises*

<table>
<thead>
<tr>
<th>Main Surgery</th>
<th>Purpose-Built (Y/N)</th>
<th>Adapted (Y/N)</th>
<th>Health Centre (Y/N)</th>
<th>Shared Building (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Owned (Y/N)</td>
<td>Health Board Owned (Y/N)</td>
<td>Privately Owned (Y/N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of consulting Rooms</td>
<td>No of Treatment Rooms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Branch Surgery</th>
<th>Purpose-Built (Y/N)</th>
<th>Adapted (Y/N)</th>
<th>Health Centre (Y/N)</th>
<th>Shared Building (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Owned (Y/N)</td>
<td>Health Board Owned (Y/N)</td>
<td>Privately Owned (Y/N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of consulting Rooms</td>
<td>No of Treatment Rooms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concerns Regarding premises</th>
<th>Space (Y/N)</th>
<th>Disability Access (Y/N)</th>
<th>State of Repair (Y/N)</th>
<th>Suitable consulting spaces (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Room Facilities (Y/N)</td>
<td>Waiting Room (Y/N)</td>
<td>Office Space (Y/N)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other concerns

<table>
<thead>
<tr>
<th>Other agencies using premises</th>
<th>Carer Support (Y/N)</th>
<th>Counselling (Y/N)</th>
<th>Benefits Advice (Y/N)</th>
<th>Employment support (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comments on premises;</td>
<td>E.g. requested or put in bid for improvement grant / need new premises etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Completeness of this section depends on practice need. As a result there could be additional sections or some sections are not appropriate
## The Practice Development Plan

### Services

<table>
<thead>
<tr>
<th>Priority</th>
<th>The issues</th>
<th>Aims and objectives</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care:-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral management and care pathways</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unscheduled care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Developments</td>
<td>End of life care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. New clinical services</td>
<td>National Clinical priorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching and training</td>
<td>Cancers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative arrangements</td>
<td>Frailty and polypharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Workforce Plan**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Background</th>
<th>What will be done?</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
</table>
### Premises Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Why?</th>
<th>What will be done?</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster Network issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHB Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 5

GP Cluster Network Development Domain

The Clinical Governance Practice Self Assessment Toolkit

Clinical governance is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”175

The GP contract requires that:

‘the contractor shall have an effective system of clinical governance...The system of clinical governance means a framework through which the contractor endeavors continuously to improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish” 176

The Clinical Governance Practice Self Assessment Tool (CGPSAT) supports practices to undertake a systematic, comprehensive review of practice systems to ensure that all contractual and statutory obligations are satisfied.

The toolkit follows a maturity matrix approach, enabling practices to identify areas for improvement and to include actions in an holistic practice development plan.

The introduction of a QOF indicator to support the use of the CGPSAT should ensure high levels of participation across Wales. This consistent approach will allow peer review, shared learning and common development through GP Cluster Action Plans, where appropriate.

The Public Health Wales website will be updated from April 2014 to include new versions of all CGPSAT background information and to support GP practices and Health Boards http://howis.wales.nhs.uk/sitesplus/888/CGPSAT

176 Part 9 (119 ) NHS ( General Medical Services Contracts) ( Wales ) Regulations 2004
When completing the CGPSAT, practices may identify areas for development. Key strengths and needs or constraints can be noted in each section and these will be amalgamated to produce a single document which can be saved and/or printed for inclusion in the practice’s development plan. The CGPSAT tutorial gives instructions for generating this report

http://howis.wales.nhs.uk/sitesplus/888/CGPSAT

Matrix 2.6 Planning Future Services also assists a practice to take an overall look at their maturity in practice development planning.

Practices should consider key issues from the CGSAT for discussion at GP cluster meetings where there may be potential to identify common themes that might be addressed through agreed actions.
GP Cluster Network Development Domain

GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR GENERAL PRACTICE 2014/15-
TARGETTING THE PREVENTION AND EARLY DETECTION OF CANCER

Introduction

Cancer is one of the three leading causes of death in Wales, lung and digestive system cancers being the major contributors. Cancer also makes a large contribution to the gap in healthy life expectancy between the most and least deprived populations. This gap is widening. There is a range of work being undertaken in Wales to prevent, diagnose and treat cancers, including initiatives to encourage healthy behaviours and to increase uptake of screening programmes (Chief Medical Officer for Wales Annual Report 2012-13) (1+2).

In 2012 the Welsh Government set out its ambition for cancer services in Wales (Together for Health- Cancer Deliver Plan; Our Vision) (3). This identified the need to ‘improve our efforts to prevent cancer and further develop services in all parts of Wales to close the gap between the most and least deprived communities, and compare better with the best in Europe’(4).

Aim

To support the delivery of the Cancer Delivery Plan this national priority will support practice teams to:

- Look at problems and best practice in relation to the prevention and early detection of cancer
- Address barriers and improve services through the development, delivery and monitoring of actions.
- Share learning with members of their network, and, through networks, support Health Boards and NHS Wales in progressing the Cancer Delivery Plan.

Action

The Actions required for this priority are:

- To carry out Significant Event Analyses
- To summarise learning and identify appropriate actions for inclusion in the Practice Development Plan
- To share analyses and progress with the network and the wider health board
- To propose actions for the GP Cluster Network Action Plan where appropriate

For this priority GP Practices will review the care of patients newly diagnosed, with lung (including mesothelioma ) or digestive system cancer ( stomach cancer; lung cancer; liver cancer; pancreatic cancer; bowel cancer ), using a Significant Event Analysis tool (Appendix 1). The care of all patients diagnosed between 1/1/2014 and 31/12/2014 with these conditions should be reviewed.177

---

177 Where practices do not identify Lung or GI cancers within the specified time period, they should discuss alternative analyses with the Health Board.
The Significant Event Analysis tool encourages broad discussion of cancer detection and prevention. Reference to the National Awareness and Early Diagnosis Initiative Pathway (NAEDI) (Appendix 2) may be helpful for structuring reviews and discussions. General Practitioners should ensure that this wider picture is considered, in particular how individual cases reflect the aims of Outcome 1 and Outcome 2 of the Cancer Delivery Plan (outlined below). General Practice and the wider community network have key roles to play in both outcome areas.

**Outcome 1- People are aware of and are supported in minimising their risk of cancer through healthy lifestyle choices (5, 6- appendix 3)**

- More people are supported to quit smoking
- More people are aware of the health harms of smoking, above limits alcohol consumption, the broader benefits of physical activity and healthy eating
- More people achieve a healthy weight through weight management support
- More people are physically active as a natural part of their everyday life and undertake sufficient physical activity to benefit their health

**Outcome 2- Cancer is detected quickly where it does occur or recur (7,8,9)**

- Easier access to GPs, pharmacists, dentists and opticians
- More information and support services and easier to find such as through local pharmacies
- More doctors and nurses available 24 hours a day, 365 days a year
- More direct access to diagnostic tests for the GP to refer to
- A greater range of local services meaning less need to travel, particularly for diagnosis and care after treatment
- Reduced travel costs for patients
- Better take up of population screening
- Prompt and appropriate access to assessment and treatment known to work to increase the chance of cure and reduce side effects
- More information on reducing the risk of developing cancer, recognising the symptoms suggestive of early cancer and what services to expect available by telephone and on-line
- More men going sooner to their GP or other health services

Practices may find it helpful to schedule these reviews as part of their multi-disciplinary practice meetings.

Themes should be gathered and shared with the wider network through Cluster meetings. Where appropriate actions should inform the GP Cluster Network Annual Report. Actions may include dialogue with the health board to address issues such as timely access to specialist investigations and advice.

Serious incidents and significant barriers to patient care should be highlighted immediately through local governance processes. Agreed actions to address such issues should be included in local plans.

Progress across the cluster should be summarised in the GP Cluster Network Annual Report. This will help to inform the assessment of health board progress against the Cancer Delivery Plan and will enable monitoring of actions for this National Priority.
References/ Resources


7. http://www.cancerresearchuk.org/cancer-info/spotcancerearly/naedi/ CRUK information on the National Awareness and Early Diagnosis Initiative


This guide produced by Macmillan provides a helpful summary of NICE guidance for different types of cancer and the referral criteria. This may be helpful when looking at the significant event audit.
Appendix 1

[INSERT NAME of PRACTICE]

Cancer Diagnosis Significant Event Audit (SEA), 2014/15

INIDIVIDUAL CASE REPORT TEMPLATE

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diagnosis</td>
<td></td>
</tr>
<tr>
<td>Age of patient at diagnosis</td>
<td></td>
</tr>
<tr>
<td>Is the patient currently alive?</td>
<td></td>
</tr>
<tr>
<td>(if not alive, please give date of death)</td>
<td></td>
</tr>
<tr>
<td>Date of SEA review</td>
<td></td>
</tr>
</tbody>
</table>

1. What happened?

Describe the process to diagnosis for the patient, including dates of consultations, referral and diagnosis. Consider (for instance): The key consultation at which diagnosis was made. Consultations for this patient in the practice in the year prior to diagnosis and the referral process. How often had the patient been seen and for what reason(s)? Had he/she been seen by the Out of Hours service, at A&E or in secondary care clinics? Was there any delay on the part of the patient in presenting with their symptoms? Where there any risk factors for cancer and had any steps been taken to address these?) Is there any record that presentation was prompted by information/ or advice from other agencies- such as community pharmacists or the third sector? Had appropriate screening taken place?
2. Why did it happen?

Reflect on the process of diagnosis. Was this as good as it could have been? If so, what were the factors that contributed to speedy and/or appropriate diagnosis in primary care? If there was some delay in diagnosis, what were the underlying factors that contributed to this? Were the reasons for any delay acceptable or appropriate? Was the referral made through the appropriate route? Did referral make use of an appropriate template or include the required information? Where appropriate tests carried out or would improved access to investigations have aided the diagnostic pathway?

3. What has been learned?

Describe the discussion at the team meeting. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in considering the process of diagnosis. Consider, for instance: a lack of education or training; the need to follow systems of procedures; the importance of team working or effective communication. Consider the role
of the NICE Referral guidelines for suspected cancer and their usefulness to primary care teams.

Learning point 1:

Learning point 2:

Learning point 3:

Learning point 4:

4. What has been changed?

Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how this was done, who it will involve, and how this change will be monitored. Are there things individuals or the practice will do differently? Consider both administrative and clinical issues.

What was effective about this SEA?

Developed from the Cancer SEA Template- Durham University in conjunction with the RCGP- Professor Greg Rubin ((2010)https://www.dur.ac.uk/school.health/erdu/cancer_audit/cancersea/)
Appendix 2

NAEDI (National Awareness and Early Diagnosis Initiative) Pathway- (7)
Top six causes of all cancers in men and women
Risk factors of the 158,700 cancers diagnosed in men and 155,600 cancers diagnosed in women each year

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Risk factor</th>
<th>Men Risk Factor %</th>
<th>Women Risk Factor %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tobacco</td>
<td>23</td>
<td>15.6</td>
</tr>
<tr>
<td>2</td>
<td>Lack of fruit &amp; vegetables</td>
<td>6.1</td>
<td>6.9</td>
</tr>
<tr>
<td>3</td>
<td>Occupational hazard</td>
<td>4.9</td>
<td>3.7</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol</td>
<td>4.6</td>
<td>3.6</td>
</tr>
<tr>
<td>5</td>
<td>Overweight</td>
<td>4.1</td>
<td>3.4</td>
</tr>
<tr>
<td>6</td>
<td>Exposure to sun &amp; sunbeds</td>
<td>3.5</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: Cancer Research UK
Annex 7

GP Cluster Network Development Domain

GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR QUALITY AND PRODUCTIVITY INDICATORS- END OF LIFE CARE

Introduction

“Dying is a social matter; how well we care for people who are dying reflects on how we care as a society. Where death can be expected we must be prepared to have honest and open conversations about the end of life. It should not be a taboo subject. Preparing and planning for the end of life with the involvement of family, carers and professionals is essential to the delivery of high quality care. We must reach into communities to support people, if they wish, to remain in their home or place of care at the end of life.”

Professor Mark Drakeford (Minister for Health and Social Services)- Together for Health-Delivering End of Life Care (2013)(1).

The primary care team is central to the delivery of high quality end of life care. Primary care teams have longitudinal relationships with patients and their carers, and essential skills in patient centred, holistic care. They are ideally placed to co-ordinate care with other service providers, and manage the worry and stress present at the end of life. Having open and honest conversations, where they are wanted, is essential to giving patients and their carers the time to adjust and make plans for death. This can help ensure effective planned care at difficult times and reduce the risk of crisis management. (2,3)

Many General Practitioners and their teams will have already carried out work to improve end of life care. However, evidence would still suggest that too many people are not dying in their place of choice. Most patients continue to die in hospital even though many could have been supported to die elsewhere (Appendix 1 illustrates this pattern). There is further potential to redesign End of Life care to provide more efficient and effective services which better meet the needs of patients and their carers.

Aim

The Aim of this priority is:

- To support general practitioners to review the experience of patients at End of Life
- To support general practitioners to identify and address issues in relation to delivering high quality end of life care.
- To support general practitioners to share information with members of their network, and, through networks, to support Health Boards/ NHS Wales to progress the End of Life Delivery Plan.
- To encourage general practitioners to monitor progress (or maintenance of high quality) in the delivery of End of Life Care through further reviews.

Action

The Action required for this priority is:

- To review the delivery of End of Life Care using Individual Case Review (as developed by the Primary Care Quality and Information Service (4) ( Appendix 2)
To summarise case review data, and any arising issues and actions identified, for sharing with the network and the wider health board.

To establish a review cycle, to monitor progress (or maintenance of high quality), with further submission of reports to the GP cluster and wider health board as appropriate.

For this priority, general practitioners will review the care of patients who have died through a retrospective Individual Case Review.

Practices should review deaths that occur between the 1st of January 2014 and the 31st of December 2014, with a particular focus on deaths that might reasonably have been anticipated, to a maximum of a number equivalent to 0.5% of the registered practice list (as of the 1st April 2014).

Practices should use the template developed by the Primary Care Quality and Information Service (Appendix 2).

The resource also contains other activities, including a service review template, which practices may also find useful in delivering service improvement in relation to end of life care.

Practices should identify:

- Any appropriate actions to be included in the Practice Development Plan.
- Themes for discussion in the GP cluster network
- Issues to be raised with local partners and the Health Board

The practice should contribute outcomes of this work to the GP Cluster Network Annual Report including: summary of key themes, actions and outcomes for the local community.

Practices may find the following resources helpful in developing this work:

- http://www.e-lfh.org.uk/projects/end-of-life-care/e-lfh-account-no/ E-Learning for Health site- End of Life Care for All (useful educational resource)
- http://www.macmillan.org.uk/Cancerinformation/Endoflife/Endoflife.aspx Macmillan site for End of Life Care (good source of information for patients relating to many end of life issues)
- http://wales.pallcare.info/ All Wales Palliative Care website- valuable source of templates (Integrated Care Priorities/ Advanced Care Plans/ DNACPR forms etc) and other information in relation to palliative care

References/ Resources

2. http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Matters%20of%20Life%20and%20Death%20FINAL.a shx Matters of Life and Death RCGP/RCN
## Deaths by Place of Occurrence: - ONS 2011

<table>
<thead>
<tr>
<th>Indicator</th>
<th>All Wales</th>
<th>HES / England</th>
<th>Abertawe Bro Morgannwg</th>
<th>Amman Beran</th>
<th>Betsi Cadwaladr</th>
<th>Cardiff and the Vale</th>
<th>Cwm Taf</th>
<th>Hywel Dda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality Indicators</strong> (Data source - PAS Jan - Dec 2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAIR 2012</td>
<td>165</td>
<td>92</td>
<td>105</td>
<td>108</td>
<td>109</td>
<td>107</td>
<td>111</td>
<td>92</td>
</tr>
<tr>
<td>RAIR 2013</td>
<td>130</td>
<td>96</td>
<td>116</td>
<td>118</td>
<td>115</td>
<td>129</td>
<td>129</td>
<td>118</td>
</tr>
<tr>
<td>% Mortality</td>
<td>1.69%</td>
<td>1.73%</td>
<td>1.69%</td>
<td>1.83%</td>
<td>1.60%</td>
<td>1.63%</td>
<td>1.66%</td>
<td>1.68%</td>
</tr>
<tr>
<td>% Uncoded</td>
<td>4.42%</td>
<td>0.78%</td>
<td>1.37%</td>
<td>4.63%</td>
<td>0.23%</td>
<td>16.62%</td>
<td>3.87%</td>
<td>1.40%</td>
</tr>
<tr>
<td>Average Diagnosis</td>
<td>3.9</td>
<td>4.2</td>
<td>4.1</td>
<td>3.8</td>
<td>4.0</td>
<td>3.9</td>
<td>3.7</td>
<td>3.5</td>
</tr>
<tr>
<td>% Deaths Palliative Care</td>
<td>18.99%</td>
<td>15.50%</td>
<td>17.09%</td>
<td>21.29%</td>
<td>14.51%</td>
<td>21.77%</td>
<td>23.21%</td>
<td>28.70%</td>
</tr>
<tr>
<td>% FCEs Palliative Care</td>
<td>1.96%</td>
<td>0.63%</td>
<td>0.78%</td>
<td>0.87%</td>
<td>0.81%</td>
<td>1.19%</td>
<td>1.86%</td>
<td>1.04%</td>
</tr>
<tr>
<td><strong>Deaths by Place of Occurrence</strong> (Data source - ONS 2011 calendar year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals (acute or community not psychiatric)</td>
<td>18.0%</td>
<td>61.0%</td>
<td>61.2%</td>
<td>58.5%</td>
<td>56.5%</td>
<td>58.1%</td>
<td>65.0%</td>
<td>55.3%</td>
</tr>
<tr>
<td>Care Home (Local Authority and Non Local Authority)</td>
<td>14.0%</td>
<td>13.4%</td>
<td>12.4%</td>
<td>12.2%</td>
<td>17.0%</td>
<td>14.0%</td>
<td>8.0%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Hospices</td>
<td>2.7%</td>
<td>5.6%</td>
<td>0.1%</td>
<td>2.2%</td>
<td>4.1%</td>
<td>2.2%</td>
<td>2.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other Communal Establishments</td>
<td>0.5%</td>
<td>0.3%</td>
<td>1.7%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>At home</td>
<td>22.0%</td>
<td>21.0%</td>
<td>22.1%</td>
<td>24.6%</td>
<td>20.2%</td>
<td>18.7%</td>
<td>21.8%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Elsewhere</td>
<td>2.3%</td>
<td>1.9%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.1%</td>
<td>1.7%</td>
<td>2.6%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Place of death is defined using a revised place of death classification.

* Deaths at home are those at the usual residence of the deceased (according to the informant), where this is not a commuting establishment.
* Care homes includes homes for the chronically sick, nursing homes, homes for people with mental health problems and non-nhs multi function sites.
* Hospices include Sue Ryder homes; Marie Curie centres; oncology centres; voluntary hospice units; and palliative care centres.
* Other Communal Establishments include schools for people with learning disabilities; holiday homes and hotels; common lodging houses; aged persons’ accommodation; assessment centres; schools; convents and monasteries; nurses’ homes; university and college halls of residence; young offender institutions; secure training centres; detention centres; prisons and remand homes.
* Elsewhere includes all places not covered above such as deaths on a motorway, at the beach, climbing a mountain, walking down the street, at the cinema, at a football match, while out shopping, or in someone else’s home. This category also includes people who are pronounced dead on arrival at hospital.
## Appendix 2- CASE REVIEW TOOL

### Pt ID:

<table>
<thead>
<tr>
<th>END OF LIFE CARE INDIVIDUAL CASE REVIEW AUDIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detecting and identifying patients early</td>
</tr>
<tr>
<td>Was the patient on the primary care practice Palliative Care Register six months prior to death</td>
</tr>
<tr>
<td>Was the patient on the primary care practice palliative care register at the time of death</td>
</tr>
<tr>
<td>Preferred place of death discussed and recorded</td>
</tr>
<tr>
<td>Anticipatory care considered and recorded</td>
</tr>
<tr>
<td>The patient or carer received a completed copy of their care plan</td>
</tr>
</tbody>
</table>

### Last days of life

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
</table>

#### Coordinating care in last days of life - Was the patient entered onto the all Wales Integrated Care priorities for the Last Days of Life (ICP)


- Was a home visit made by a GP at the practice, before the patient was entered onto the all Wales Integrated Care priorities for the Last Days of Life (ICP) or alternative EOLC pathway

- OOH informed of patient entering onto the all Wales Integrated Care priorities for the Last Days of Life or other End Of Life pathway (See appendix D)

#### Ongoing management - PRN (Only when required)

- Medications available for the following symptoms in anticipation of; Pain / Nausea & Vomiting / Agitation / Respiratory Tract Secretions

- Were there any unplanned/unscheduled admissions during the final days?

- All Wales DNACPR Orange form (signed) present in patient notes

- DNACPR discussed with Next of kin

- DNACPR confirmed from Medical notes

#### Patient assessment content; Physical needs assessed and documented

- Social needs assessed and documented

- Mental state assessed and recorded

- Spiritual needs discussed and recorded (i.e. signpost family for spiritual guidance if required)

#### After Death

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
</table>

- The preferred place of death was achieved

- The practice offered bereavement support following death of family member

- Death was discussed at the following MDT meeting

- The family and carers were informed as to what to do / who to contact when death occurred

http://www.patient.co.uk/showdoc/145/

---

*1. This criteria aims to ensure that clinicians have considered the need for advanced care planning. Not all patients would wish to discuss or have an ACP.
*2 This criteria aims to ensure “face to face” clinical review before a decision is made to place the patient on ICP- this would normally be within a few days of the decision being made.

*3 The DNACPR form will often be in the patient held record at their house. This criteria is met where either the medical record contains a code that a signed DNA CPR form is present at the house or a scanned copy is present in the records held at the surgery.

*4 These elements form part of the ICP and may have been carried out by other members of the MDT. The ICP will often be in the patient held record at their house. This criteria is met where either the medical record contains reference to this or a scanned copy of ICP is present in the records held at the surgery.
Annex 8

GP Cluster Network Development Domain: 2014/15

GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR GENERAL PRACTICE
2014/15- MINIMISING THE HARMS OF POLYPHARMACY

Introduction

The 2013/14 QOF QP indicators supported the identification of patients most at risk of unscheduled episodes of urgent care, to encourage collaboration between services to meet the needs of the most vulnerable patients. This work included the development of anticipatory care plans and multidisciplinary team working to improve the coordination of care.

It is estimated that between 5-17% of hospital admissions may be associated with adverse drug reactions\(^1\). Effective medicines management plays a significant role in minimising the risk of adverse events and hospital admission.

QOF Indicator Medicines 11 rewards the delivery of high quality systems of care that offer regular medication review.

For 2014/15 Contractors are supported to compliment this work and further develop medicines management systems to more effectively identify and manage medication related risks.

This approach will be further developed in subsequent years.

Background

Elderly patients are often at high risk for significant morbidity or mortality and may have the potential to benefit most from many treatments and preventive therapies. However it is also widely recognised that the concurrent use of multiple medications or ‘poly-pharmacy’ may increase risks for this group.

Routine prescribing data does not provide information in relation to the prevalence of poly-pharmacy for different population groups. However a study by Guthrie and Makubate (2012) found that 16.4 per cent of older patients (65 years and above) were receiving 10 or more medications and the PRACtIcE Study, of English general practices found 9.7 per cent were receiving more than 10 medications (Avery et al 2012b).

Prudent medicine and patient centred care
The prudent healthcare approach seeks to avoid the administration of more medicine than is clinically indicated whilst also ensuring that appropriate preventive therapies are considered at all ages.

The aim is not to simply reduce the numbers of medicines being taken, but to ensure that prescribing choices are well informed, likely to benefit the patient and that any risks are understood and appropriately monitored. It is estimated that up to 50% of medications are not taken as prescribed. The medication review is an opportunity to ensure that the most effective treatments are prioritised and used effectively.

For many elderly patients there are a number of issues for consideration, including poly-pharmacy, the use of high-risk medicines, transition between services, medicines management in Care Home settings and end of life care.

The ‘No Tears’ tool (Appendix 1) is a simple, structured approach, designed for use in General Practice. All tools have limitations and do not replace careful clinical decision-making. However, structured, systematic review can highlight inappropriate prescribing and identify opportunities to improve individual care and local medicines management systems.

For 2014/15 Contractors will:

1. Identify and record numbers and rates for patients aged 85 years or more receiving 6 or more medications
2. Undertake face to face medication reviews, using the ‘No Tears’ approach (Appendix 1) for at least 60% of the cohort defined in 1. above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached.)
3. Identify any actions to be addressed in the Practice Development Plan.
4. Summarise themes and actions for review with the cluster network and share information with the Health Board as required.
Resources

Polypharmacy and medicines optimization: Making it safe and sound
Martin Duerden, Tony Avery and Rupert Payne. Kings Fund 2013

Wales polypharmacy guidance (AWPTC- in development)


Using the NO TEARS tool for medication review

BMJ 2004; 329 doi

http://dx.doi.org/10.1136/bmj.329.7463.434

STOPP (Screening Tool of Older Persons’ potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers’ criteria

Medication Comprehension and Safety in Older Adults

NHS Scotland Polypharmacy Guidance

Prescribing for Older People. WeMeReC Bulletin, June 2011 www.wemerec.org


Ten principles for medicines use in older people
Appendix 1

The ‘NO TEARS’ tool

Dr Tessa Lewis: *BMJ* 2004;329:434

Issue to consider:

- Need and indication
- Open questions
- Tests and monitoring
- Evidence and guidelines
- Adverse events
- Risk reduction or prevention
- Simplification and switches

*Need and indication*—Does the patient know why he/she takes each drug? Is the drug still needed? Was long term treatment intended? Is the dose appropriate? Has the diagnosis been refuted? Would non-pharmacological treatments be better?

*Open questions*—Give the patient the opportunity to express their views by asking questions: “I realise a lot of people don't take all their tablets. Do you have any problems?” “Can I check that we both agree what you're taking regularly?” or “Do you think your tablets work?” Compare replies with the number of prescription requests.

*Tests and monitoring*—Assess disease control. Are any of his conditions undertreated? Get advice on appropriate monitoring from prescribing guidelines such as the *British National Formulary* or the US *Physicians’ Desk Reference* and other primary care documents.

*Evidence and guidelines*—Has the evidence base changed since the prescription was initiated? Do the prescribing guidelines indicate that any of his drugs are now less suitable for prescribing? Is the dose appropriate? (For example, dose optimisation of angiotensin converting enzyme inhibitors in cardiac failure.) Are other investigations now advised, such as echocardiography or testing for *Helicobacter pylori*? 
**Adverse events**—Does the patient have any side effects? Are complementary medicines or over the counter preparations being taken? Check for interactions, duplications, or contraindications. Remember the “prescribing cascade” (misinterpreting an adverse reaction as a new medical condition).