

Revisions to the GMS contract 2006/07

Delivering investment in general practice



A part of the NHS Confederation
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This document gives primary care organisations and practices an overview of the changes to the GMS contract for 2006/07 and detailed information that they will need to implement the changes. Chapters 1 to 3 are relevant to all four countries in the UK, chapter 4 is relevant to England and Wales, and chapters 5 to 12 are applicable to England only.

Further detail about elements of the agreement in Scotland, Wales and Northern Ireland, including information that primary care organisations and practices will need to implement the changes, will be agreed between the health departments and their respective GPCs and published separately as soon as possible.

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Foreword

The implementation of the new GMS contract in April 2004 represented a significant step in the development of primary care, supported by an unprecedented level of new investment.

Over the past 20 months, the contract has provided a range of new services for patients and continued to drive improvements in the quality of patient care. Additionally, it has provided demonstrable benefits for GPs, other primary care professionals and the NHS.

Practices have demonstrated the quality of the care they provide and we also believe that the changes have given primary care organisations the opportunity to take a more strategic view of how healthcare is delivered locally, and to improve convenience and choice for their patients.

As part of the original contract negotiations, it was agreed that we would review the contract for 2006/07. This document outlines the changes that have been agreed by NHS Employers, the General Practitioners Committee (GPC) and the health departments of England, Scotland, Wales and Northern Ireland, in the first stage of that process, which will come into effect on 1 April 2006.

Throughout the process our key focus has been to ensure that the contract continues to deliver better services for patients, whilst being fair to the profession and representing good value for public money.

The agreed changes aim to build on the achievements of the new GMS contract, focusing on health and service priorities to continue to benefit patient care. The key changes include:

- a review of the Quality and Outcomes Framework (QOF), with several new or revised areas
- in England, new directed enhanced services for practice based commissioning, access, information management and technology, and patient choice and booking
- in England, the introduction of a new patient experience survey
- in Scotland, new directed enhanced services for cardiovascular disease risk database, learning disabilities, carers and cancer referral, and re-badging of the 50 QOF points for access into a new directed enhanced service
- in Wales, new directed enhanced services for access, information technology, learning disabilities and severe mental health
- in Northern Ireland, new directed enhanced services for access and long-term chronic disease

- in England and Wales, a new system for paying dispensing doctors and more transparent arrangements for reimbursing VAT.

This document gives primary care organisations and practices an overview of the agreement and the detailed information that they will need to implement the changes.

Looking ahead to stage two of our negotiations, for April 2007 onwards, emerging evidence on the patient benefits of the existing GMS contract, patient feedback, the implications of *Our health, our care, our say: a new direction for community services* in England, together with similar developments in Scotland, Wales and Northern Ireland, and the recommendations from the Formula Review Group, will inform our approach.

We hope that these revisions will help you, in your continued efforts to improve patient care.

**Dr Barbara Hakin, Chair of NHS Employers negotiating team, and
Dr Hamish Meldrum, GPC Chairman**

CHAPTER 1:
INTRODUCING THE CHANGES TO THE
GMS CONTRACT FOR 2006/07 – SUMMARY OF
THE UK AGREEMENT



Chapter 1: Introducing the changes to the GMS contract for 2006/07 – summary of the UK agreement

Introduction

- 1.1 This chapter represents a summary of the agreement reached between NHS Employers and the British Medical Association's General Practitioners Committee (GPC) on the changes to be made to the GMS contract for 2006/07.
- 1.2 NHS Employers and the GPC agreed that they are committed to ensuring a contract that:
 - is better for patients
 - is fair to the profession
 - represents good value for public money.

Extra investment and new initiatives

- 1.3 NHS Employers and the GPC agreed that it was more appropriate for the current 50 access points in QOF to be moved and the finance associated with them to be utilised on access awards outside QOF as appropriate for each country. It was also agreed that the new funding for each country (equivalent to the value of 100 QOF points) would be used to establish additional directed enhanced services (DESS) which may be specific to each country.
- 1.4 Subject to take up and delivery of new DESS, Scotland has identified a total of £12.6m new investment, Wales £6.7m and Northern Ireland £4m. England is making significant additional investments over and above the value of 100 QOF points.
- 1.5 It had already been agreed that England would invest a further £132m in premises and IT in 2006/07.
- 1.6 It was agreed that future uplifts to the global sum should seek to reduce the reliance upon correction factor payments and, therefore, release an element of the correction factor envelope.

Inflationary cost pressures

- 1.7 The negotiating parties agreed that there would be no uplift to any existing element of the contract for inflation or cost pressures in 2006/07, and that all new investment would be via the new DESS.

Efficiency savings

- 1.8 It was agreed that, in addition to the efficiency savings that could be presented through the absence of inflation or cost pressure increase, the agreement included the release of 138 points worth of QOF funding to be reinvested in new QOF indicators and a redistribution of a further 28 points within the existing QOF.
- 1.9 The negotiating parties agreed, with the full support of the four health departments, that the 2006/07 GMS review contract package addresses the perceived value for money issues associated with the original nGMS contract. These will not be revisited in future negotiations.
- 1.10 All parties recognised the responsibility of the four health departments and NHS Employers to achieve and demonstrate on-going improvements in efficiency and value for money as part of normal on-going negotiations or commissioning processes within the NHS. This normal process of refinement, revision and improving value for money and efficiency will apply to future GMS negotiations as it applies to other NHS services.

Normalisation (England and Wales only)

- 1.11 Normalisation of weighted practice populations will now take place quarterly on a national basis, rather than at primary care organisation (PCO) level. Quarterly normalisation already applies in Northern Ireland and Scotland.

Contractor Population Index (England only)

- 1.12 The Contractor Population Index (CPI) reflects the national average practice list size. It is used primarily to allocate QOF payments to practices relative to their list size. With the following proviso, the Statement of Financial Entitlements (SFE) will be amended so that from 1 April 2007 the CPI mechanism becomes an in-year resource-neutral redistributive tool based on an average list size updated in January each financial year. Such a change in the SFE would be dependent upon a separate mechanism being agreed and funded as appropriate as an integral element of future GMS negotiations to recognise changes to the QOF workload as a result of an increase or decrease in population numbers.

Gross Investment Guarantee

- 1.13 NHS Employers and the GPC acknowledged that the current Gross Investment Guarantee (GIG) expires on 31 March 2006. It was agreed that the GIG would not be renewed for 2006/07 and beyond.

Enhanced services floor

- 1.14 Enhanced services floors will be frozen at 2005/06 levels. Expenditure on the new 2006/07 DESs will be monitored over and above the 2005/06 floor but as

practices may elect not to provide services under these DESs, or they may fail to achieve target payment levels, the 2006/07 enhanced services are only an indicative figure.

- 1.15 Expenditure on the new access DES should be apportioned so that the 2005/06 enhanced service floor still includes the full value of the previous access DES and that expenditure on the 2006/07 access DES above this level (i.e. utilising the funding transferred from the 50 QOF access points) should be recorded against the new 2006/07 indicative DES levels.
- 1.16 Any local disputes regarding investment in GMS should, if all local routes have been exhausted, be referred by strategic health authorities (or equivalent) and Local Medical Committees (LMCs) to the NHS Employers/GPC Implementation Co-ordination Group (ICG), or equivalent.

Maternity cover

- 1.17 It was agreed to lift the maximum amount payable for maternity, paternity and adoptive leave to £1500 per week from week three of the potential entitlement. All such payments remain discretionary. It was also agreed to review the extent to which PCOs are exercising discretion. The PCO's protocol in respect of locum cover payments (as detailed in the SFE) should be updated.

Employer's superannuation contributions

- 1.18 The negotiating parties agreed that 14% (7% in Northern Ireland) employer's superannuation contributions were included in all funding envelopes for 2006/07 unless specifically stated otherwise.

Quality and Outcomes Framework

- 1.19 NHS Employers and the GPC agreed to release 138 QOF points for new indicators mainly in clinical areas. A further 28 points have been reallocated to existing indicators where data suggested the potential for further improvement.
- 1.20 The following new clinical areas were agreed: heart failure, palliative care, dementia, depression, chronic kidney disease, atrial fibrillation, obesity and learning disabilities.
- 1.21 The following clinical indicator sets were amended: mental health, asthma, stroke and transient ischaemic attack, diabetes, chronic obstructive pulmonary disease, epilepsy, cancer and smoking.
- 1.22 The negotiators agreed, in the light of 2005 achievement data, that all lower thresholds for existing indicators should be raised to 40%. The upper threshold will remain at 90% for the majority of indicators. For those indicators which had an upper threshold of less than 90%, the upper threshold will be raised in line with average UK 2005 achievement.

- 1.23 There will be no changes to the exception reporting criteria for 2006. However, the negotiating parties agreed to issue further guidance to PCOs regarding what constitutes good practice in exception reporting (see chapter 2).
- 1.24 Details of the new QOF indicators for 2006/07, including technical supporting guidance, can be found in annex 1. Details about current QOF indicators that will change or be removed can be found in annex 2.
- 1.25 The negotiating parties agreed and recognised that the QOF is a “living thing” which will be subject to a process of change and improvement over time as part of the negotiation process. It is expected that changes will be negotiated with references to those elements of the QOF where science and evidence has moved on, or which are no longer necessary, or where the workload has been shown to have changed, and in the context of the value for money agreement described above. Equally, the negotiating parties agreed that for the on-going success of the QOF, it should have a reasonable degree of stability, be evidence-based, be able to be supported by information management and technology software and be governed by an agreed process of evidence review and refinement.

Directed enhanced services (DESS)

Access to general practice services – England only

- 1.26 There will be four main components to the new access DES: the opportunity to consult a GP within two working days, the opportunity to book appointments in advance, ease of telephone access to the surgery, and the opportunity for the patient to consult their practitioner of preference.
- 1.27 The awards to practices for delivering access will be split into two parts:
 - One third of this investment will be provided on an aspirational basis up-front to assure practices’ commitment to deliver the first three of the above four components and to continue to participate in the Primary Care Access Survey (PCAS). PCTs will make an award on agreement of a written practice plan.
 - The remaining two thirds will be earned according to the results of a new independent patient experience survey. The survey will include a yes/no question covering each of the four components. The results of this survey will determine the level of award made.
- 1.28 There will be a total investment of up to £108m in England, assuming full uptake and achievement. This comprises £55m from QOF access payments and £53m from the former access DES. The specification for this DES is in annex 4.

Choice and booking – England only

- 1.29 This one-year DES, outlined in annex 5, is designed to provide an incentive to practices both to offer choices to patients who are referred for a consultant outpatient appointment by a GP and to utilise the Choose and Book system.
- 1.30 In 2006/07 PCTs will have a duty to make payments to practices at the end of the year in respect of this DES, providing that the results of a new patient experience survey and/or electronic booking validation are sufficient to trigger an award. An

award of component one is not dependent on an award of component two and vice versa. Aspiration payments will be made in-year and final payment for delivering booking arrangements will be made by PCTs upon receipt of national data.

- 1.31 This DES is valued at 96p per registered patient, which is split equally between the following two components:
- Component one is an award for offering choice to patients through a discussion between the GP and patient about the range of a clinically appropriate choice of providers which should include some clinical information to help patients make an informed decision. Patients and GPs should also have access to meaningful information in the practice to support their choice decision, e.g. patient information booklets and posters. Payment for offering choice will be based on feedback from a new patient experience survey on whether patients recall a conversation about choice.
 - Component two is an award made in response to the practice's utilisation of the Choose and Book systems. This will include bookings made in the GP surgery, by the appointments line, on the internet, through a local booking service or via indirectly bookable services (IBS). Payment for utilising the Choose and Book systems will be based on the percentage of referrals to first consultant outpatient appointments (i.e. converted UBRNs) that are made using these systems.

Towards practice based commissioning (PBC) – England only

- 1.32 This one-year DES provides encouragement to practices to engage in PBC. It directs PCTs to offer this enhanced service to all of their general practices from April 2006. The specification can be found in annex 6.
- 1.33 Practices will be entitled to an award for component one (95p per registered patient) of this DES when a plan to deliver the DES has been agreed with the PCT. This payment reflects the practice's time involved in developing and implementing the practice plan. Practices must receive the award for component one to be eligible for component two.
- 1.34 Practices who successfully deliver the agreed plan and its objectives will be able to reallocate either the resources associated with component two of the DES or any freed-up resource made against the agreed PBC budget. Component two resources will not be available in addition to any resources freed up from the PBC budget where they already equal or exceed the equivalent value of component two.

Information management and technology (IM&T) – England only

- 1.35 This DES, outlined in annex 7, is designed to facilitate IM&T adoption to support the delivery of the National Programme for IT. It requires PCTs to award practices specified, non-recurring payments following successful preparation for and adoption of IT systems and processes. There will be variations in the timing of roll-out of these systems across the country. Therefore, timing of payments in respect of this DES will also vary across the country. In some cases the implementation of an area of work might not take place until 2007 or later and PCTs will need to ensure, for budgetary purposes, that they plan for the likely local timescales of implementation.

- 1.36 This DES will support practices to become properly equipped for the innovative new IT approaches to patient service delivery. Practices will be required to:
- actively implement the key national initiatives
 - ensure that all appropriate practice staff, clinical and non-clinical, receive adequate training to equip them to adopt new methods and systems
 - provide adequate support to ensure smooth service delivery during installation of new systems and their adaptation to new ways of working
 - acquire accreditation of the quality of electronic record keeping.

- 1.37 The value of this DES is £1.33 per registered patient. This has been split into four components:
- Component one: in order to receive an upfront, first component payment practices will need to agree a written practice plan with the PCT. This payment acknowledges the commitment and planning the practice will need to invest ahead of programme deployments.
 - Component two: practices will receive a further payment following data accreditation, as set out in the standards identified in annex 7.
 - Component three: practices will receive a further payment for successful completion of the requirements set out in paragraphs 13 and 14 of annex 7.
 - Component four: practices will receive a further payment following migration to a Connecting for Health accredited hosted system.

Directed enhanced services – Wales

- 1.38 Subject to agreement, in Wales PCOs will be required to commission four new directed enhanced services: access, information technology, learning disabilities and severe mental health. Further information about each of these will be made available shortly.

Directed enhanced services – Scotland

- 1.39 In Scotland the investment described in paragraph 1.4 above will be used to commission four new directed enhanced services. Subject to final agreement, these focus on:

- cardiovascular risk registers for patients aged 45 to 64
- services for adults with learning disabilities
- services for carers
- cancer referrals.

- 1.40 A fifth DES will be introduced for access, re-badging the 50 QOF points for access, as described in paragraph 1.3, above. Further information about each of these will be available shortly.

Directed enhanced services – Northern Ireland

- 1.41 Subject to agreement, in Northern Ireland PCOs will be required to commission a new directed enhanced service to improve the management of prescribed

long-term chronic diseases as well as a directed enhanced service for access to general practice services. Further information about each of these will be made available shortly.

National patient experience survey – England only

1.42 A new national, patient experience survey will be introduced. This is expected to be in quarter four of 2006/07. It will help the Government understand, from the patient's perspective, how well national priorities are being implemented. In its first year the focus of the survey will be on primary care and the delivery of access and choice through general practice. Patients' responses to the survey will trigger practice awards on:

- opportunity to consult a GP within two working days
- opportunity to make advance bookings
- ease of telephone access to the surgery
- opportunity to book with a practitioner of preference
- where relevant, recalling a conversation with a GP about choice of secondary care provider.

Managing practice lists

1.43 The negotiating parties recognised that in certain circumstances there are difficulties in managing practice lists and have prepared advice for practices and PCOs to follow. Through open and transparent list management, both practices and PCOs will find it easier to meet patients' access requirements to register with a primary medical care provider of choice. This advice can be found in annex 9.

Arrangements for dispensing doctors (England and Wales only)

- 1.44 NHS Employers and the GPC agreed a new resource-neutral fee scale for dispensed items which includes an additional £1.4m towards the costs of compliance with the Disability Discrimination Act. This removes the direct link between drug costs and remuneration for dispensing doctors.
- 1.45 It was agreed that the Department of Health in England and the Welsh Assembly Government would not pay a VAT allowance on dispensed items from 1 April 2006 and that to continue to receive VAT reimbursement from this date, dispensing practices should register for VAT purposes with HM Revenue and Customs.
- 1.46 From 1 April 2006 the Department of Health in England and the Welsh Assembly Government will pay a VAT allowance on personally administered items for all practices, as these are an exempt supply for VAT purposes.

- 1.47 There will be a budget of up to £8m in England for extending the range and quality of dispensary services under a new dispensing quality payments scheme. An equivalent scheme will be developed in Wales.
- 1.48 Guidance which outlines what might be considered excessive or inappropriate prescribing has been developed for PCOs and health professionals. This should help ensure that prescribing decisions are based on clinical appropriateness. It is available in annex 8.

Vaccinations and immunisations

- 1.49 From April 2006 the weighting for childhood vaccinations and immunisations targets for all four countries will be:
- 50% for the Pentavalent Vaccine
 - 25% for MMR
 - 25% for Meningitis C.

Stage two negotiations

- 1.50 Negotiations for stage two will now follow the publication of *Our health, our care, our say: a new direction for community services* in England and similar documents in the other three countries, for implementation in 2007, following discussions about the implications for primary care and general practice.
- 1.51 Discussions between NHS Employers and the GPC on the future of the GMS allocation formula have been underway since the start of 2005. As part of the two-stage process, the Formula Review Group will report the outcome of the review and any recommendations during 2006.
- 1.52 Scotland has its own formula, the Scottish Allocation Formula (SAF). A review process has also been underway in Scotland since the start of 2005 and will report and make recommendations during 2006.

CHAPTER 2: IMPROVING QUALITY IN THE UK

2

Chapter 2: Improving quality in the UK

- 2.1 From April 2006, a revised Quality and Outcomes Framework (QOF) will continue to provide financial rewards for GMS providers to provide high quality care.
- 2.2 The revised QOF measures achievement against a set of evidence-based indicators, allowing a possible maximum score of 1000 points. The reduction from the 2005/06 total of 1050 points is due to the reallocation of the resources associated with the access bonus points to become part of an access DES in each of the countries.
- 2.3 Annex 1 provides detailed guidance about the revised QOF. In summary, the revised QOF comprises:
- the clinical domain: coronary heart disease, heart failure, stroke and transient ischaemic attacks, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, epilepsy, hypothyroidism, cancer, palliative care, mental health, asthma, dementia, depression, chronic kidney disease, atrial fibrillation, obesity, learning disabilities, smoking (totalling 655 points)
 - the organisational domain: records and information, information for patients, education and training, practice management, medicines management (totalling 181 points)
 - the patient experience domain: length of consultations, patient surveys (totalling 108 points)
 - the additional services domain: cervical screening, child health surveillance, maternity services, contraceptive services (totalling 36 points)
 - a holistic care payment: based on achievement across the clinical domain (totalling 20 points)
- 2.4 Annex 2 provides specific detail of the changes to individual indicators and highlights the 166 indicators that have been removed. There are 138 points for new work and 28 points have been redistributed amongst the existing indicator sets.
- 2.5 As part of PCOs' clinical governance responsibilities, they should note that many of the removed indicators are part of Good Medical Practice.
- 2.6 In light of 2004/05 achievement data, all lower thresholds will be raised to 40%. The upper threshold will remain at 90% for the majority of indicators. For those indicators with an upper achievement threshold of less than 90%, this will be raised in line with 2004/05 average achievement and expert advice.

- 2.7 As previously, participation in the QOF is entirely voluntary for GMS contractors.
- 2.8 Achievement against indicators will continue to be measured by the Quality Management and Analysis System (QMAS) or its equivalent. Further information about changes to QMAS or its equivalent will be available at a later date.
- 2.9 PCOs will need to make a manual calculation of QOF aspiration monies for 2006/07. This will need to reflect the change in overall available points in QOF from 1050 in 2005/06 to 1000 points in 2006/07. The aspiration payment can be calculated in one of two ways:
- (i) For practices aspiring using the Aspiration Points Total method, the method has not changed and is set out in the 2006/07 SFE.
 - (ii) For practices aspiring using the 60% method, which is based on previous achievement, the aspiration payment will be calculated as normal and adjusted, as described in the 2006/07 SFE, to reduce it proportionally.
- 2.10 There will be no change to the mechanism for calculating the prevalence adjustment which is explained in chapter three of *Delivering investment in general practice: implementing the new GMS contract* (Department of Health, December 2003) and *Implementing the new GMS contract in Scotland* (February 2004). However, due to the small numbers involved it has been agreed that palliative care points will not be adjusted by prevalence.
- 2.11 There will be no change to the criteria for exception reporting. New guidance will be issued to PCOs to assist them in their assessment of the appropriateness of the use of exception reporting during QOF visits and pre-payment verification. This guidance will be issued during 2006.
- 2.12 *Delivering investment in general practice 2003* makes clear that PCOs should visit their contractors annually to review each contractor's achievement against the QOF indicators. However, the frequency and intensity of visits may decrease if the PCO is confident of the contractor's performance against the QOF indicators, subject to the mandatory requirements for financial audit. Equally, the frequency of visits may increase where there is serious concern about data accuracy or quality of patient care.
- 2.13 PCOs in England are asked to note that guidance was released in 2005 to assist with the QOF review process. This guidance, *Establishing accuracy in QOF data*, is available at:
www.primarycarecontracting.nhs.uk/uploads/QOF/Establishing_accuracy_in_QOF_data%20v1.0%2018th%20Oct.pdf
- 2.14 PCOs in Scotland are asked to note that guidance was released in 2005 to assist with the QOF review process. This guidance, *Introduction to the QOF review: guidance for practices*, is available at:
www.paymodernisation.scot.nhs.uk/gms/quality/docs/qof%20_practice_guidance.doc
- 2.15 During the QOF review the negotiators were supported by an expert panel, hosted by the University of Birmingham. It is anticipated that the expert panel reports will be published in spring/summer 2006.

CHAPTER 3: VACCINATIONS AND
IMMUNISATIONS IN THE UK

3

Chapter 3: Vaccinations and immunisations in the UK

Amendment to childhood immunisation two-year-old target payments

- 3.1 Prior to the introduction of a Pentavalent vaccine (Pediaceal '5 in 1' vaccine) in September 2004, the target payment scheme consisted of four separate vaccine lines. Achievement in each vaccine line described below contributed equally in determining whether the target had been achieved and the level of payment awarded:
 - group 1: diphtheria, tetanus, polio
 - group 2: pertussis
 - group 3: measles, mumps, rubella (MMR)
 - group 4: haemophilus influenza type B.
- 3.2 The Pentavalent vaccine reduced the total number of vaccine lines to two. Thus MMR vaccine contributed towards 50% of the overall total in determining the calculation of achievement, making it more difficult for some practices to reach the targets and earn the target payment.
- 3.3 With effect from April 2006 we have agreed to introduce the meningitis C vaccine into the target payment system to redistribute the weighting between three groups instead of two:
 - group 1: diphtheria, tetanus, polio, pertussis, haemophilus influenza type B (Pentavalent) (50%)
 - group 2: measles, mumps, rubella (MMR) (25%)
 - group 3: meningitis C (25%).
- 3.4 Achievement in the MMR domain will therefore contribute to the calculation of target payments in line with original scheme intentions. The Statement of Financial Entitlements will be amended to reflect this new calculation methodology and the payments system will be updated to ensure practices' target payments are calculated in line with these new arrangements.
- 3.5 The Statement of Financial Entitlements will be effective from 1 April 2006 and will include details of the calculation of the new target payments.
- 3.6 The GPC and NHS Employers will be negotiating arrangements to implement the recently announced inclusion of the pneumococcal vaccine in the childhood immunisation scheme.

CHAPTER 4: CHANGING THE ARRANGEMENTS
FOR DISPENSING DOCTORS IN ENGLAND
AND WALES

4

Chapter 4: Changing the arrangements for dispensing doctors in England and Wales

Removal of the link between pay and drug costs

- 4.1 A new system for the remuneration of dispensing doctors has been developed. Under the new system, the on-cost allowance has been abolished. This removes the direct link between drug costs and remuneration. Dispensing doctors will receive a fee for each item that they dispense. The new fee scale is calculated by dividing the dispensing doctors' remuneration envelope by the number of items expected to be dispensed in 2006/07.
- 4.2 The Prescription Pricing Authority (PPA) in England (which will be known from April 2006 as the Prescription Pricing Division of the Business Services Authority) and the Prescribing Services Unit (PSU) in Wales, will continue to calculate the amounts due to doctors in fees and allowances for dispensing and personal administration, and these are paid through the Exeter system. The PPA system will be changed to implement the new fees from 1 April 2006 onwards. The new calculations will be applied to prescriptions submitted to the PPA for April 2006 (these will be submitted by 5 May). The PPA will calculate an interim payment which is due on 1 June and the actual entitlement (less interim payment) will be due on 1 July.

Calculating the envelope for dispensing doctors' remuneration for 2006/07

- 4.3 The remuneration envelope is based on the actual payments made to dispensing doctors for both fees and on-cost allowance, appropriately adjusted to reflect anticipated payment levels for 2006/07.
- 4.4 In calculating the remuneration envelope for 2006/07:
- it was also agreed that the container cost allowance of 3.8p per dispensed item was no longer appropriate as most drugs are now pre-packed by suppliers. Instead, 10% of the current container cost allowance envelope was included in the overall remuneration envelope
 - £1.4m was included to support dispensing practices in meeting their responsibilities under the Disability Discrimination Act 1995.

Support for people with disabilities

- 4.5 Under the Disability Discrimination Act 1995 (DDA), dispensing doctors as service providers have a duty to make reasonable adjustments to enable someone with a

disability to utilise the service. Reasonable adjustment may include the provision of an auxiliary or compliance aid to enable a person who is disabled to obtain and take their medicines. In determining what is reasonable, consideration needs to be given to the individual circumstances of the patient and the dispensing practice, and a judgement made by the specific provider, the dispensing practice.

Discount enquiry and full pay review

- 4.6 The Technical Steering Committee has been asked to oversee a full pay review covering dispensing doctors and a review of the discount factor applied to the drug tariff when reimbursing dispensing doctors for the purchase of drugs dispensed.

VAT reimbursement

- 4.7 In England and Wales, from 1 April 2006, the Department of Health will not pay a VAT allowance on dispensed items. This means that practices will need to register for VAT purposes with HM Revenue and Customs (HMRC) if they require VAT reimbursement after 31 March 2006.
- 4.8 From 1 April 2006 the Department of Health will pay a VAT allowance on personally administered items for all practices, as these are an exempt supply for VAT purposes and are therefore not re-claimable from HMRC. Previously, the Department of Health had excluded VAT-registered practices from this reimbursement.
- 4.9 The PPA system will be changed to implement the changes in VAT allowances for all items dispensed and personally administered from 1 April 2006 onwards. This means that practices which are not currently registered for VAT will be able to claim VAT allowance on dispensed items through the PPA system for all items dispensed up to and including 31 March 2006. These prescriptions should be submitted by 5 April. The PPA will calculate an interim payment due on 1 May and actual entitlement (less interim payment) due on 1 June.
- 4.10 Assuming that a practice registers for VAT with HMRC with an effective date of 1 April 2006, VAT can be reclaimed from HMRC on items purchased on or after 1 April 2006 which the practice intends to dispense.
- 4.11 Practices will be able to audit stock in hand on 1 April in order to reclaim VAT on items purchased before 1 April but not dispensed until that date or later. Entitlement to VAT recovery will be governed by the intent to make taxable supplies with the goods in question, once VAT registration has been effected.
- 4.12 An information sheet about the VAT registration process for dispensing practices has been developed by HMRC and is available via the GPC and NHS Employers websites. This information sheet provides:
- advice about how practices can register for VAT
 - information about the VAT treatment of goods and services
 - advice about how much VAT can be recovered on purchases.

- 4.13 For general information, practices should contact HMRC on 0845 010 9000 or look on the HMRC website: www.hmrc.gov.uk
- 4.14 PCOs need to be aware that all dispensing practices are likely to register with HMRC for VAT from 1 April 2006. This may have implications for any reimbursement provided by PCOs to contractors for premises and IT if the reimbursement is gross of VAT. If contractors are registered for VAT they may be able to claim reimbursement of some of the VAT costs of capital expenditure from HMRC. PCOs therefore need to be aware of the VAT status of practices and what sums they can reclaim from HMRC in order to avoid double payments of VAT costs.

Dispensary Quality Payments Scheme

- 4.15 Dispensing practices will be paid for providing a high quality of dispensary services under a new Dispensing Quality Payments Scheme. Details about this scheme are still being negotiated and will be published as soon as possible.

Maintaining clinically cost-effective prescribing

- 4.16 Guidance which outlines what might be considered to be excessive or inappropriate prescribing has been developed for PCOs and health professionals. It is available in annex 8.

CHAPTER 5: FINANCIAL IMPLICATIONS
IN ENGLAND

5

Chapter 5: Financial implications in England

Introduction

5.1 This chapter summarises the financial impact of the changes to the GMS contract for 2006/07.

Overview of changes

- 5.2 Chapter 1 outlines the changes agreed to the contract for 2006/07 and these include:
- no uplift to any element of the contract for inflation or cost pressures in 2006/07
 - changes to the QOF, which include several new or revised clinical areas and higher thresholds. 166 points have been recycled of which 138 go into new areas and 28 are incorporated into existing indicators
 - a new directed enhanced service for access which recycles the current QOF access points and the current access DES funding
 - additional investment for new directed enhanced services for practice based commissioning, choice and booking and adopting information management and technology systems in England
 - an increase in the maximum discretionary locum reimbursement for maternity, paternity and adoption leave from week three
 - changes in payments to dispensing doctors.

Inflation/cost pressures

- 5.3 There will be no uplift to any element of the contract for inflation or cost pressures in 2006/07 (unless otherwise specified in this chapter).
- 5.4 NHS Employers and GPC negotiating teams agree, with the full support of the four health departments, that the 2006/07 GMS review contract package addresses the perceived value for money issues associated with the original nGMS contract. These will not be revisited in future negotiations.

Funding

- 5.5 NHS Employers and the GPC have agreed that all future negotiations will explicitly include consideration of efficiency consistent with all other commissioning arrangements across the NHS.
- 5.6 Importantly, **all financial values and resource envelopes quoted in this chapter include the effect of any current associated superannuation payments**, i.e. the 14% employer's superannuation contribution is included within the figures quoted.

Global sum and Carr-Hill formula

- 5.7 Global sum and MPIG payment will continue to be payable from PCTs' unified resource allocation.
- 5.8 There will be no change to the amount per patient payable to practices under existing global sum and correction factor payment arrangements. Therefore, global sum payments to practices remain at 2005/06 levels.

Normalisation

- 5.9 For England and Wales, arrangements covering global sum payments to practices from April 2006 will be subject to normalisation nationally, rather than just at PCT level, on a quarterly basis. Such an approach should help prevent the significant fluctuations to income experienced by some practices in the first quarter of a new financial year. No action is required of PCTs or practices as the new normalisation process will be taken forward automatically through the Exeter system.

Formula review

- 5.10 The GMS Formula Review Group is continuing its work and will report the outcome of the review and any recommendations during 2006.

Quality and Outcomes Framework (QOF)

Efficiency savings

- 5.11 PCTs remain responsible for meeting the full cost of payments due to providers under the QOF in 2006/07. The value of each point remains at 2005/06 levels.
- 5.12 The equivalent of a further 166 points is provided within the QOF through the re-use of existing indicators or (for 138 of these points) re-focusing them in more critical, clinical areas. For PCTs this means that the new clinical areas identified within the 2006/07 QOF are financed through the redistribution of the 138 QOF points.

Access points

- 5.13 The 50 points which have related to access have been removed from the QOF and amalgamated within the access DES. The 2006/07 QOF will therefore be 1000 points.

Contractor Population Index (CPI)

5.14 The Contractor Population Index (CPI) reflects the national average practice list size. It is used primarily to allocate QOF payments to practices relative to their list size. With the following proviso, the SFE will be amended so that from 1 April 2007 the CPI mechanism becomes an in-year resource-neutral redistributive tool based on an average list size updated in January each financial year. Such a change in the SFE would be dependent upon a separate mechanism being agreed and funded as appropriate as an integral element of future GMS negotiations to recognise changes to the QOF workload as a result of an increase or decrease in population numbers.

2006/07 central budget allocation

5.15 The Department of Health in England will be issuing guidance on how the QOF central budget will be distributed on a fair shares basis to PCTs in 2006/07. However, it is likely that the approach taken will replicate that taken in allocating the QOF central budget in 2005/06, i.e. PCT allocations will be based on the previous year's achievement. However, the methodology will need to take into account the removal of the 50 points relating to access (that are now amalgamated into the new access DES). For planning purposes only, PCTs should assume that they will receive the same level of funding in 2006/07 as they received in 2005/06.

Enhanced services

Introduction

5.16 PCTs must offer as a minimum, the funding levels indicated, to practices choosing to provide the required service levels under the directed enhanced services set out within the new arrangements.

2006/07 enhanced services floors

- 5.17 A number of additional DESs have been agreed for 2006/07. The arrangements that relate to these new DESs, and their supporting financial framework, supersede previous guidance, issued alongside the 2006/07 allocations, regarding the level of uplift to be applied to enhanced services floors.
- 5.18 Enhanced services floors will be frozen at 2005/06 levels. Expenditure on the new 2006/07 DESs will be monitored over and above the 2005/06 floor but as practices may elect not to provide services under these DESs, or they may fail to achieve target payment levels, the 2006/07 enhanced services are only an indicative figure.
- 5.19 Expenditure on the new access DES should be apportioned so that the 2005/06 enhanced services floor still includes the full value of the previous access DES and that expenditure on the 2006/07 access DES above this level (i.e. utilising the funding transferred from the 50 QOF Access Points) should be recorded against the new 2006/07 indicative DES levels.
- 5.20 Any local disputes regarding investment in GMS should, if all local routes have been exhausted, be referred by strategic health authorities (or equivalent) and

Local Medical Committees (LMCs) to the NHS Employers/GPC Implementation Co-ordination Group (ICG), or equivalent.

- 5.21 Consequently, the Department of Health will be monitoring PCT spend on enhanced services in 2006/07 based on a combination of:
- individual PCTs' enhanced services floors set for 2006/07, i.e. frozen at 2005/06 levels
 - take-up at PCT level of the additional DESs agreed for 2006/07.
- 5.22 In practice, PCTs will be asked to separately account within their normal 2006/07 Financial Information Management Systems (FIMS) and annual accounts returns for:
- all spend on enhanced services excluding that which relates to the new DESs (2005/06 floor)
 - the additional expenditure on each of the new DESs.
- 5.23 The established criteria according to which a service can be funded from the enhanced services floor, for example that it directly provides patient services, remains unchanged. This criterion is detailed in chapter 2 of *Delivering investment in general practice* (December 2003).
- 5.24 Details of each of the new directed enhanced services in England, including financial arrangements, can be found in other chapters of this guidance. A payment summary for the new DESs can be found in annex 3.

Premises and IT

- 5.25 For 2006/07, £132 million is available for locally agreed investment into premises (£111m) and IT (£21m) and this is already included, on a weighted capitation basis, in PCTs' growth allocations for 2006/07.
- 5.26 The distribution of these monies are matters best decided upon and managed by PCTs in a way that makes the most effective use of resources in meeting locally agreed priorities.
- 5.27 However, PCTs may wish to adopt a multi-PCT approach to the development and improvement of primary care premises. Clearly, it is important that PCTs continue to invest in order to improve the quality and capacity of the primary care estate.

Maternity

- 5.28 Through the Statement of Financial Entitlements (SFE), PCTs currently have discretionary powers to fund locum cover for maternity, paternity and adoptive leave for GP principals. The SFE currently recommends a maximum amount payable of £978.91 per week for such payments.
- 5.29 The SFE for 2006/07 will be amended to recommend a maximum discretionary amount payable of £1,500 for such locum costs from week three of the potential entitlement.

- 5.30 The PCT's protocol in respect of locum cover payments (as detailed in the SFE) should be updated.
- 5.31 In deciding on the level of payment to a practice, PCTs should also take into account the ability of the practice to reclaim statutory maternity payments from HM Revenue and Customs (HMRC).
- 5.32 The likely costs of this change will vary according to local circumstances. The Department of Health will monitor, as part of the normal FIMS returns, the extent of PCT discretion exercised in making these payments in 2006/07.

VAT allowance for personally administered items

- 5.33 There is more detailed information in chapter 4 about the changes to the arrangements for dispensing doctors; however, as part of these changes VAT costs relating to all personally administered items will be paid through the Prescription Pricing Authority and the Department of Health. This will result in a small increase in such charges to PCTs' prescribing budgets for both dispensing and non-dispensing practices.

Gross Investment Guarantee

- 5.34 The Gross Investment Guarantee will cease at the end of March 2006.

In-year financial monitoring

- 5.35 The Department of Health will continue to undertake normal in-year monitoring of PCT positions (through the FIMS returns) and the results will be reported to the Technical Steering Committee of the health departments, British Medical Association (GPC) and NHS Employers. The Department of Health will issue guidance on the timetable and format for collecting such information in due course. Whilst the Department of Health will look to rationalise the collection of financial information, changes to the current financial monitoring arrangements are likely to be minimal.

CHAPTER 6: IMPROVING ACCESS IN ENGLAND

6

Chapter 6: Improving access in England

- 6.1 From April 2006, a new access directed enhanced service (DES) will replace the current 2005/06 access DES and the 50 QOF access points. Local payments to practices in respect of these two existing schemes should cease following payments for the 2005/06 financial year. The specification for the new access DES can be found in annex 4.
- 6.2 The potential or actual cost of the new DES locally may not equal the same value that PCTs in England have historically paid through the QOF access points and the existing access DES for 2005/06. Any resultant variation will need to be managed on an individual PCT basis. PCTs should note that the full financial envelope for component two will be payable only if all practices achieve the highest thresholds in each of the four dimensions set out in component two of the DES.
- 6.3 The first component of the new DES will be payable to practices who commit to participate in the monthly Primary Care Access Survey (PCAS) and work towards delivery of the first three dimensions of component two.
- 6.4 Practices which provide the required commitment through a written practice plan agreed with the PCT should be paid the equivalent of 69p per registered patient (as measured by the Exeter system on 1 April 2006). The practice plan should describe the action they will be taking to deliver improvements to the areas which are rewarded under component two.
- 6.5 Following confirmation by the PCT that the practice is eligible for component one, payment must be made as soon as possible. Should a practice subsequently fail to achieve a lowest threshold level for one of the first three dimensions of component two, or not take part in the monthly PCT survey (PCAS), the associated aspiration payment(s) will become repayable by the practice.
- 6.6 Reward for the second component of the new DES will be payable on the outcome of the new patient experience survey and will be calculated according to how a practice scores in each of the four access dimensions, as outlined in the specification. Payments to practices for 2006/07 will be based on the practice list size as at 1 January 2007 and will be made by PCTs as soon as responses to the survey have been returned and validated.
- 6.7 The new survey is expected to be in place during quarter four of 2006/07. Collecting, processing and analysing the individual returns will take time so PCTs (and practices) should plan on the basis that payments for component two may be made in the first quarter of the following financial year (i.e. from April 2007).
- 6.8 There is further information about the patient experience survey in chapter 8.

CHAPTER 7: IMPROVING CHOICE AND BOOKING
IN ENGLAND

7

Chapter 7: Improving choice and booking in England

- 7.1 This one-year directed enhanced service (DES) supports the delivery of two key priorities:
- to provide patients with an offer of choice where it has been decided they need a first consultant outpatient appointment
 - to deliver patients booked appointments in secondary care by delivering booking arrangements through the national Choose and Book system.
- 7.2 A specification for the DES can be found in annex 5.
- 7.3 The award to practices comprises two components:
- 7.4 The first component of this DES is an award for offering choice to patients via an initial discussion between the patient and their GP about the providers on offer. The overall value of this component is 48p per registered patient as per the practice's list size at 1 April 2006:
- For practices to receive an aspiration payment representing 50% of this value (24p), they will need to provide the PCT with a written statement that demonstrates their commitment to ensure the referring clinician delivers the offer of clinically appropriate choice to relevant patients. PCTs should then make prompt payment to practices.
 - The remainder of this award (24p per registered payment) will be triggered if at least 60% of patients who respond to the new national patient experience survey recall a conversation about choice with their GP. The total value of this remaining award will be determined by the practice's list size at 1 January 2007.
- 7.5 The DES specification provides details about the practice responsibility to support choice and the practical support and information that needs to be provided to help patients make decisions on choice, including the role of the GP in the process. In some instances, PCTs will provide support via patient care advisers where patients require additional information about non-clinical aspects of their choice decision.
- 7.6 Component two is a reward for utilising the Choose and Book system. The overall value of this component is 48p per registered patient:
- For practices to receive an aspiration payment worth 24p per registered patient (according to list size at 1 April 2006), practices will need to provide their PCT with a written statement that demonstrates a commitment to utilising the Choose and Book system. PCTs should then make prompt payment to

practices. Practices will be able to retain this aspiration payment providing the number of referrals Unique Booking Reference Numbers (UBRNs) converted made through the Choose and Book system reaches or exceeds a threshold of 25% of all referrals to first consultant outpatient appointments in June 2006.

- The remainder of this award (24p per registered payment according to list size at 1 January 2007) will be triggered on a sliding scale based on the percentage of first consultant outpatient referrals made using Choose and Book by the practice (UBRNs converted) in the period 1 September 2006 to 28 February 2007. The minimum achievement in order for practices to receive any payment is 50% and is worth 60% of the value of this component of the DES. The full value of this award will only be due if the practice achieves 90% or more. National systems will monitor and report practices' usage to PCTs so that PCTs can make prompt payments to practices.
- 7.7 The specification outlines a fall-back position should practices fail to implement and use the booking system due to circumstances beyond their control (e.g. due to national or regional difficulties).
- 7.8 If at the end of the DES period practices fail to achieve the minimum level in either component one, component two or both components, PCTs should initiate arrangements for managing repayment of aspirational funding or for a balancing mechanism which offsets this repayment against other income due to the practice.

CHAPTER 8: MEASURING THE PATIENT
EXPERIENCE IN ENGLAND

8

Chapter 8: Measuring the patient experience in England

- 8.1 A new national, patient experience survey will be introduced. This is expected to be in quarter four of 2006/07. It will, over time, help the Government understand, from the patient's perspective, how well action to deliver national priorities is being implemented. In its first year, the focus of the survey will be on primary care and the delivery of access and choice through general practice. Patients' responses to the survey will trigger practice payments on:
- opportunity to consult a GP within two working days
 - opportunity to make advance bookings
 - ease of telephone access to the surgery
 - opportunity to book with a practitioner of preference
 - where relevant, recalling a conversation with a GP about choice of secondary care provider.
- 8.2 The final wording of the survey is currently being developed by the Department of Health. The GPC and NHS Employers will shape development of the survey and ensure that drafting reflects the spirit of GMS negotiations for 2006/07.
- 8.3 The current wording is:
- (i) When you last contacted the practice, were you able to consult with a GP within two working days?
 - (ii) When you last contacted the practice to make an appointment for a problem which was not urgent, could you book ahead?
 - (iii) Are you satisfied with the ability to get through to your practice on the telephone?
 - (iv) When you last contacted the practice with a problem that was not urgent, were you able to make an appointment with a particular GP if you were prepared to wait?
 - (v) Do you recall a conversation with your GP about choice when you were referred for your first consultant outpatient appointment?

The final wording is subject to validation by polling experts.

- 8.4 It is expected that the survey will be issued to patients and the results collated by a third party who will protect patient confidentiality and ensure practices and PCTs are not burdened with unnecessary administration. PCTs and practices will be

notified of the results. PCTs will then be able to make payments to practices. Where practice IT systems cannot support the automated extraction of samples of patients, alternative arrangements will be made. These arrangements will be designed to minimise, and ideally eliminate, any workload for practices and PCTs. They will be finalised and tested in a pilot phase managed by polling experts and involving all parties. This pilot phase will be concluded by the end of summer 2006.

- 8.5 More information about the survey and its deployment will be available later in the year.

CHAPTER 9: TOWARDS PRACTICE BASED
COMMISSIONING IN ENGLAND

9

Chapter 9: Towards practice based commissioning in England

- 9.1 This one-year directed enhanced service (DES) has been developed to support engagement in practice based commissioning (PBC), to encourage practices that have either yet to engage in developing PBC or yet to finalise their plans to do so ahead of the Department of Health's commitment for universal coverage by 31 December 2006. It also encourages practice engagement through guaranteed resources where deficits in local health economy budgets make the prospect of identified resource even against reduced activity unavailable. This DES complements the latest guidance from the Department of Health published in January 2006. A detailed specification for this DES can be found in annex 6.
- 9.2 The first component of the DES will be payable to practices which prepare and implement a practice based commissioning plan. The payment is in recognition of the practice time needed to develop and implement the practice plan. Practices which agree a written plan with the PCT will be paid the equivalent of 95p per registered patient based on the practice list size as at 1 April 2006. The specification in annex 6 describes the information and support that PCTs will need to provide their practices in order for the DES plan to be developed and implemented.
- 9.3 Practices can sign up to this DES any time during 2006/07. However, ideally this should be before the end of April 2006. The expectation is that practices' DES plans will be agreed and therefore payments awarded by the end of the first quarter of 2006/07. Where this is not possible, for example because a new practice sets up mid year or there is a delay by the PCT in providing data to the practice, PCTs and practices should agree a prompt date to finalise the DES plan.
- 9.4 Where practices achieve their DES plan objectives, they will be eligible for payment of component two at 95p per registered patient (based on the practice list size at 1 January 2007) to be reinvested in practice activity to ensure the continued or improved achievement against the agreed objectives as identified in the plan. Component two will not be available in addition to other freed-up resource that already exceeds the value of component two.
- 9.5 Practices may work alone or in partnership with other practices in taking up this DES. Each practice remains eligible for the award under component one and for either component two or other freed resource to reinvest in practice activity to continue delivering their plan's objectives.
- 9.6 This DES need not necessarily replace any similar or alternative, locally-agreed PBC schemes already in place. This will be for practices and their PCT to decide. However, this DES does describe the minimum amounts that are available to all practices in any PBC scheme in which they engage.

- 9.7 The DES specification includes an appendix that suggests what the plan for this DES should include. It will be for practices and PCTs to agree on the content and local objectives to be set and for PCTs with their practices to monitor achievement in order for component two to be awarded. Where PCTs and practices agree additional workload for practices, additional resource to this DES should be made available.

CHAPTER 10: SUPPORTING INFORMATION
MANAGEMENT AND TECHNOLOGY IN ENGLAND

10

Chapter 10: Supporting information management and technology in England

- 10.1 The specification for the information management and technology directed enhanced service (DES) can be found in annex 7.
- 10.2 The first component of the new DES will be payable to practices who agree a practice plan with the PCT. Practices should be paid the equivalent of 40p per registered patient (as measured by the Exeter system on 1 April 2006). Following agreement between a practice and a PCT that the practice is eligible for this component, payment should occur as soon as possible.
- 10.3 Award for the second component should be payable to practices who acquire accreditation of their practice data. As outlined in annex 7, there will be a three-part process for data accreditation, which culminates in a visit by the PCT. PCTs will need to plan these visits and will want to:
 - (i) nominate a lead who is responsible for planning the visits and ensuring consistency of the visiting approach and reporting of visits
 - (ii) bear in mind that their visits will require workforce capacity involving assessors.
- 10.4 Further guidance about the data accreditation process, in particular information that PCTs and practices will need to complete the assessment visit, will be developed by NHS Employers, the GPC and Connecting for Health, and will be available by the end of March 2006.
- 10.5 Practices should receive payment for the second component as soon as possible following accreditation. Practices should be paid the equivalent of 44p per registered patient as measured at the start of the quarter in which accreditation is achieved. (For example, if a practice achieves data accreditation in March 2007, payment should be based on the number of registered patients on 1 January 2007.)
- 10.6 Practices should receive an award for component three of this DES once they have successfully completed the requirements set out in paragraph 8 of annex 7, which includes maintenance of patients' addresses with opportunistic regular validation with patients and preparation for, and utilisation of, EPS Release 1 software.
- 10.7 Practices should be paid the equivalent of 27p per registered patient as measured at the start of the quarter in which this component is achieved.
- 10.8 Practices should receive an award for component four of this DES following migration to a Connecting for Health accredited server. Connecting for Health will provide PCTs with electronic evidence of those practices that have successfully migrated to an accredited server. Practices should be paid the equivalent of 22p per registered patient as measured at the start of the quarter in which this component is achieved.

CHAPTER 11: IMPLEMENTATION IN ENGLAND

11

Chapter 11: Implementation in England

11.1 This guidance aims to update and replace previous contract guidance but only so far as the 2006/07 changes are concerned. Where no change has occurred the original nGMS guidance applies.

Legislative changes and implications for local GMS contracting

Regulations

11.2 There are no changes to the GMS Regulations required by virtue of the 2006/07 agreement; however, as normal, a set of routine amending regulations will be issued in the spring, possibly May, though no final date has been set at the time of finalising this guidance.

11.3 A variation notice produced by the Department of Health will support those GMS regulatory changes. This notice will be published alongside the planned amending regulations and a consolidated copy of the GMS standard contract on the Department's website. However, these amendments are not due to changes from this agreement.

Statement of Financial Entitlements

11.4 A revised Statement of Financial Entitlements (SFE) for 2006/07 will be published by the Department of Health to enact the appropriate payment changes for 1 April 2006. These will not affect the local GMS contracts entered into between practices (contractors) and PCTs where the GMS standard contract has been used.

11.5 Where the standard contract has not been used PCTs will need to consider whether SFE changes lead to contractual changes, but this is a local matter.

11.6 Those SFE changes will not include any changes that are necessary as a consequence of the new directed enhanced services or directions as to payment.

Directed enhanced services directions

11.7 The main element of the 2006/07 agreement which impacts on local GMS contracting are changes arising from the introduction of the four new directed enhanced services. Directions covering these new services, including directions as to payment, are planned to be in place by 1 July 2006.

11.8 As with current directed enhanced services, contractors who are to participate in these schemes will require either a stand-alone contract or a variation to their

main contract reflecting not only the requirements of the directions but also any elements that fall to be locally determined.

Implementing directed enhanced services

11.9 Directions on PCTs to implement the new directed enhanced services are expected to be in place by 1 July 2006. However, it is agreed these schemes will apply and be implemented from 1 April 2006.

11.10 PCTs should therefore work with their practices to develop and implement plans in line with the published DES specifications for implementation from 1 April 2006. PCTs should therefore seek to:

- (i) **by end of February** – offer all practices the opportunity to participate in access, practice based commissioning, choice and booking and IM&T DESs, and have provisional agreements in place
- (ii) **by end of March** – have agreed initial plans in place for action from 1 April.

11.11 PCTs will wish to note that Directions applying by 1 July will give full-year effect to payments due under the agreed schemes. PCTs will therefore wish to ensure that practices are able to participate in these new arrangements from 1 April by undertaking the necessary agreed actions.

Implementing revised Quality and Outcomes Framework

11.12 A revised QOF for 2006/07 has been published.

11.13 From April 2006, QMAS will not display achievement reports for the year 2006/07 whilst the system is being upgraded to reflect the revised QOF indicator set. Practices will be able to continue to make submissions and complete the approval process to ensure payments are made for the year 2005/06.

11.14 Following the completed implementation of changes, QMAS will commence displaying achievement reports for the year 2006/07.

Implementation Co-ordination Group

11.15 The Implementation Co-ordination Group (ICG) provides Local Medical Committees (LMCs) and strategic health authorities (SHAs) with a route for determining local disagreements on GMS contract implementation issues where these cannot be resolved locally and which are inappropriate for formal dispute resolution procedures.

11.16 The ICG, in considering cases on the information presented, makes a final recommendation to the parties concerned. The ICG meets monthly and comprises a negotiator from the three key stakeholders – the Department of Health, NHS Employers and the GPC.

11.17 LMCs should direct concerns via the GPC-LMC liaison officers in the first instance and PCTs should direct concerns via their SHA with the support of their local Primary Care Contracting advisor.

Implications of this agreement for other providers

11.18 Separate guidance is being prepared by the Department of Health for PCTs on the implications of this agreement for PMS, APMS and PCTMS providers, whose contracts continue to be locally negotiated.

CHAPTER 12: SUPPORT ARRANGEMENTS FOR
PCTS AND PRACTICES

12

Chapter 12: Support arrangements for PCTs and practices

Support for commissioners to implement changes to the GMS contract

- 12.1 NHS Primary Care Contracting (NHS PCC) is working as the implementation arm of NHS Employers to support the implementation of the agreements reached through stage 1 of the GMS contract negotiations in England.
- 12.2 A range of support is available, including national learning exchange events, a helpdesk and local support through NHS PCC's network of advisors. Useful information on the support programme and all the latest editions of the relevant documents can also be accessed via their website at:
www.primarycarecontracting.nhs.uk

Local support

- 12.3 NHS PCC has nine geographically-based Primary Care Contracting advisors providing support to every SHA and PCT area in England. The Advisors have a breadth and depth of experience across all areas of primary care contracting, with the ability to share practical implementation experience. The advisors can:
- attend and support local networks
 - arrange and facilitate local and regional events
 - respond to queries raised locally
 - provide one-to-one support where appropriate
 - provide support and advice on technical areas of GMS
 - spread implementation examples
 - keep the area up to date with the latest guidance and information to support implementation.
- 12.4 The advisors work with SHA primary care leads to agree the priorities in the area and will increasingly focus on supporting PCTs to realise the benefits of the new contract.

Help desk and website

- 12.5 An online question and answer facility is available. Through the website, PCTs and SHAs can search the frequently asked questions database, and where an answer is not yet available email an advisor with the question. Questions will be forwarded

to the Primary Care Contracting advisor who has specialist knowledge in the area of the question. They will aim to respond as quickly as possible and within five days. However, where the question is complex and requires NHS Employers or Department of Health advice, responses may take slightly longer. This facility is available to PCT and SHA employees only. Practices and other primary care providers should raise questions via their PCT contact.

Frequently asked questions

- 12.6 Using questions raised through the help desk and questions received from other sources, such as the learning events, a frequently asked questions database will be developed and maintained. This will act as a reference source for PCTs, SHAs and other users of the NHS PCC website. This database will be quality checked by both NHS Employers and the Department of Health prior to publication on the website.

Event presentations

- 12.7 Presentations from the National Learning Exchange and other local events that were run to support implementation are now available on the PCC website as a reference source for delegates and for those unable to attend the events.

Briefings and information

- 12.8 In conjunction with NHS Employers, NHS PCC will publish briefings and provide links to the latest guidance and other helpful documents direct from the NHS PCC website. If a common area is identified where PCTs need further information and advice, factsheets will also be developed.

New@PCC newsletter

- 12.9 New@PCC is the weekly email newsletter collated by the NHS PCC team to keep the NHS up to date with new information across all primary care contracting and related policy areas. This newsletter will alert managers to new documents, information, events and resources as they are made available. To subscribe to new@PCC, please visit www.primarycarecontracting.nhs.uk and click on the link on the home page.
- 12.10 For more information on any of the above, or to find information on any area of support for primary care contracting, please contact your local Primary Care Contracting advisor. See: www.primarycarecontracting.nhs.uk/82.php

Support for practices to implement changes to the GMS contract

- 12.11 The GPC will produce a series of guidance notes to help UK GPs and LMCs manoeuvre around the new contract documents and explain how various aspects of the contract will work. There will be a number of 'Focus on...' publications, along with frequently asked questions, available on the BMA website at www.bma.org.uk/ap.nsf/Content/Hubgeneralpractitioners. This information will cover the contract in all four countries of the UK.

12.12 If you have any queries regarding the implementation of the new contract, please contact your LMC, ask BMA on 0870 60 60 828 or askbma@bma.org.uk (for members) or the GPC directly by emailing info.gpc@bma.org.uk

Further resources

12.13 On-going updates on implementation and negotiations on stage two, as well as this guidance document, are available on the NHS Employers website at: www.nhsemployers.org

12.14 Contract documentation including policy, guidance and legislation for all primary medical care contracting routes (nGMS, PMS, APMS, PCTMS) can be found on the Department of Health website at: www.dh.gov.uk

ANNEXES

Annex 1: Quality and Outcomes Framework guidance 2006/07

Section 1. Principles

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

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

Section 2. Clinical indicators

1. General format

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

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

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

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

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

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

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

1.1 Rationale

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

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

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

In many of the indicators an additional time factor is incorporated, recognising that in practice it may be difficult to ensure that all patients have attended for review and have completed the review process within any particular timescale. For example, concerning indicator BP5, national guidance recommends that all patients with hypertension should have their blood pressure measured every six months. The actual indicator looks at the number of patients with hypertension who have had a blood pressure measured in the last nine months.

1.2 Read codes

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

strategies to ensure that they are utilising appropriate Read codes in advance of producing their achievement report.

1.3 Reporting and verification

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

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

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

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

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

(Key documents: *Winter report*; *Introduction to the QOF review – a guide for practices*; *Final QOF guidance reviewers manual*)

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

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

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

2. Exception reporting

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

The following criteria have been agreed for exception reporting:

- A) patients who have been recorded as refusing to attend a review who have been invited on at least three occasions during the preceding 12 months
- B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty
- C) patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and

delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels

- D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- E) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contraindication or have experienced an adverse reaction
- F) where a patient has not tolerated medication
- G) where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- H) where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease
- I) where an investigative service or secondary care service is unavailable.

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

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

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

3. Disease registers

An important feature of the QOF is the establishment of disease registers. While it is recognised that these may not be 100% accurate, it is the responsibility of the practice to demonstrate that it has systems in place to maintain a high-quality register.

Verification visits may involve asking how the practice constructed the register and how the register is maintained. PCOs will compare the reported prevalence with the expected prevalence. This is a relatively blunt instrument and there are likely to be good reasons for variations but it is anticipated these will be discussed with practices. An explanation on how points are calculated and how prevalence will be applied can be found in the Statement of Financial Entitlements for 2006/07.

Summary of indicators

Clinical domain

Secondary prevention of coronary heart disease

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

Heart failure

Indicator	Points	Payment stages
Records		
HF 1: The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF 2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40–90%
On-going management		
HF 3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contraindication	10	40–80%

Stroke and TIA

Indicator	Points	Payment stages
Records		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	2	
STROKE 11. The percentage of new patients with a stroke who have been referred for further investigation	2	40–80%
On-going management		
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	40–90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	5	40–70%

STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	40–90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	5	40–60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40–90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40–85%

Hypertension

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

Diabetes mellitus

Indicator	Points	Payment stages
Records		
DM 19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
On-going management		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40–90%
DM 5. The percentage of diabetic patients who have a record of HbA _{1c} or equivalent in the previous 15 months	3	40–90%
DM 20. The percentage of patients with diabetes in whom the last HbA _{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40–50%
DM 7. The percentage of patients with diabetes in whom the last HbA _{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	11	40–90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40–90%
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	40–90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40–90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40–90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40–60%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	40–90%

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

Chronic obstructive pulmonary disease

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

Epilepsy

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

Hypothyroid

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

Cancer

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

Palliative care

Indicator	Points	Payment stages
Records		
PC 1: The practice has a complete register available of all patients in need of palliative care/support	3	
On-going management		
PC 2: The practice has regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	

Mental health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
On-going management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40–90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40–90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months	2	40–90%
MH 6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25–50%
MH 7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40–90%

Asthma

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

Dementia

Indicator	Points	Payment stages
Records		
DEM 1: The practice can produce a register of patients diagnosed with dementia	5	
On-going management		
DEM 2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25–60%

Depression

Indicator	Points	Payment stages
Diagnosis and initial management		
DEP 1: The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40–90%
DEP 2: In those patients with a new diagnosis of depression, recorded between the preceeding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40–90%

Chronic kidney disease

Indicator	Points	Payment stages
Records		
CKD 1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial management		
CKD 2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40–90%
On-going management		
CKD 3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40–70%
CKD 4: The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	4	40–80%

Atrial fibrillation

Indicator	Points	Payment stages
Records		
AF 1: The practice can produce a register of patients with atrial fibrillation	5	
Initial diagnosis		
AF 2: The percentage of patients with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis	10	40–90%
On-going management		
AF 3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	15	40–90%

Obesity

Indicator	Points	Payment stages
Records		
OB 1: The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months	8	

Learning disabilities

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

Smoking indicators

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

Organisational domain

Records and information

	Indicator
Records 3 1 point	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours
Records 8 1 point	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded
Records 9 4 points	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%
Records 11 10 points	The blood pressure of patients aged 45 and over is recorded in the preceding five years for at least 65% of patients
Records 13 2 points	There is a system to alert the out-of-hours service or duty doctor to patients dying at home
Records 15 25 points	The practice has up-to-date clinical summaries in at least 60% of patient records
Records 17 5 points	The blood pressure of patients aged 45 and over is recorded in the preceding five years for at least 80% of patients
Records 18 8 points	The practice has up-to-date clinical summaries in at least 80% of patient records
Records 19 7 points	80% of newly registered patients have had their notes summarised within eight weeks of receipt by the practice
Records 20 12 points	The practice has up-to-date clinical summaries in at least 70% of patient records
Records 21 1 point	Ethnic origin is recorded for 100% of new registrations
Records 22 11 points	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once (Payment stages 40–90%)

Information for patients

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

Education and training

	Indicator
Education 1 4 points	There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months
Education 4 3 points	All new staff receive induction training
Education 5 3 points	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
Education 6 3 points	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
Education 7 4 points	<p>The practice has undertaken a minimum of 12 significant event reviews in the past three years which could include:</p> <ul style="list-style-type: none"> • any death occurring in the practice premises • new cancer diagnoses • deaths where terminal care has taken place at home • any suicides • admissions under the Mental Health Act • child protection cases • medication errors. <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different</p>
Education 8 5 points	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal
Education 9 3 points	All practice-employed non-clinical team members have an annual appraisal
Education 10 6 points	The practice has undertaken a minimum of three significant event reviews within the last year

Practice management

	Indicator
Management 1 1 point	Individual healthcare professionals have access to information on local procedures relating to child protection
Management 2 1 point	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
Management 3 0.5 points	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
Management 4 1 point	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
Management 5 3 points	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
Management 6 2 points	Person specifications and job descriptions are produced for all advertised vacancies
Management 7 3 points	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment, including: <ul style="list-style-type: none"> • a defined responsible person • clear recording • systematic pre-planned schedules • reporting of faults
Management 8 1 point	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
Management 9 3 points	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
Management 10 2 points	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Medicines management

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

Patient experience domain

Patient experience
<p>PE 1 Length of consultations 33 points</p> <p>The length of routine booked appointments with the doctors in the practice is not less than ten minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment).</p> <p>For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least eight minutes.</p> <p>Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p>
<p>PE 2 Patient surveys (1) 25 points</p> <p>The practice will have undertaken an approved patient survey each year.</p>
<p>PE 5 Patient surveys (2) 20 points</p> <p>The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:</p> <ol style="list-style-type: none"> 1. summarises the findings of the survey 2. summarises the findings of the previous year's survey 3. reports on the activities undertaken in the past year to address patient experience issues.
<p>PE 6 Patient surveys (3) 30 points</p> <p>The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:</p> <ol style="list-style-type: none"> 1. sets priorities for the next two years 2. describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative) 3. describes the plans for achieving the priorities, including indicating the lead person in the practice 4. considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

Additional services

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

Cervical screening

	Indicator
CS 1 11 points	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years. Standard 40–80%
CS 5 2 points	The practice has a system for informing all women of the results of cervical smears
CS 6 2 points	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every two years
CS 7 7 points	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates

Child health surveillance (CHS)

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

Maternity services (MAT)

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

Contraceptive services (CON)

	Indicator
CON 1 1 point	The team has a written policy for responding to requests for emergency contraception
CON 2 1 point	The team has a policy for providing pre-conceptual advice

Secondary prevention of coronary heart disease

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

CHD – rationale for inclusion of indicator set

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

CHD indicator 1

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

CHD 1.1 Rationale

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

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

CHD 1.2 Reporting and verification

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

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

CHD indicator 2

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

CHD 2.1 Rationale

Diagnosis of coronary heart disease

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

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

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

Reference Grade B Recommendation SIGN Guideline 51

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

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

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

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

Patients should not be referred for an ETT if:

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

Reference Grade B Recommendation SIGN Guideline 51

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

Specialist referral:

An alternative to referral for exercise-testing is referral to a specialist for evaluation. Referral would normally be to a cardiologist, general physician or GP with a special interest. For the purposes of the QOF an appropriate referral being undertaken between three months before and 12 months after a diagnosis of angina has been made would be considered as having met the requirements of this indicator.

CHD 2.2 Reporting and verification

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

In verifying that this information has been correctly recorded, a number of approaches could be taken by the primary care organisation:

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

CHD indicator 5

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

CHD 5.1 Rationale

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

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

CHD 5.2 Reporting and verification

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

CHD indicator 6

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

CHD 6.1 Rationale

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

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% in patients with coronary heart disease (Collins et al. *Lancet* 1990; 335: 827–38).

CHD 6.2 Reporting and verification

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

CHD indicator 7

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

CHD 7.1 Rationale

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

Grade C Recommendation SIGN Guideline 51

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

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

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

CHD 7.2 Reporting and verification

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

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

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

CHD indicator 8

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

CHD 8.1 Rationale

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

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

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

CHD 8.2 Reporting and verification

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

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

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

- ii. inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol 5 mmol/l or less
- iii. inspection of a sample of records of patients for whom a record of serum cholesterol at 5 mmol/l is claimed, to see if there is evidence of this in the medical records.

CHD indicator 9

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

CHD 9.1 Rationale

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

Grade A Recommendation SIGN Guidelines 41/51

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

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

- Clopidogrel alone (within its licensed indications) is recommended for people who are intolerant of low-dose aspirin and either have experienced an occlusive vascular event or have symptomatic peripheral artery disease. NICE defines aspirin intolerance as either of the following: proven hypersensitivity to aspirin-containing medicines or history of severe dyspepsia induced by low-dose aspirin.
- Clopidogrel, in combination with low-dose aspirin, is recommended for use in the management of non-ST-segment-elevation acute coronary syndrome (ACS) in people who are at moderate to high risk of myocardial infarction (MI) or death. NICE recommends that treatment with clopidogrel in combination with low-dose aspirin should be continued for up to 12 months after the most recent acute episode of non-ST-segment-elevation ACS. Thereafter, standard care, including treatment with low-dose aspirin alone, is recommended. Moderate to high risk of MI or death in people presenting with non-ST-segment-elevation ACS can be determined by clinical signs and symptoms, accompanied by one or both of the following:
 - i. the results of clinical investigations, such as new ECG changes (other than persistent ST-segment-elevation), indicating ongoing myocardial ischaemia, particularly dynamic or unstable patterns
 - ii. the presence of raised blood levels of markers of cardiac cell damage such as troponin.

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

CHD 9.2 Reporting and verification

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

CHD indicator 10

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

CHD 10.1 Rationale

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

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

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

Grade A Recommendation SIGN Guidelines 41/51

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

CHD 10.2 Reporting and verification

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

CHD indicator 11

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

CHD 11.1 Rationale

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

Grade A Recommendation SIGN Guideline 41

Grade A Recommendation NICE Guideline A

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

CHD 11.2 Reporting and verification

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

CHD indicator 12

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

CHD 12.1 Rationale

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

CHD 12.2 Reporting and verification

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

Heart failure

Indicator	Points	Payment stages
Records		
HF 1: The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF 2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40–90%
On-going management		
HF 3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contraindication	10	40–80%

Heart failure – rationale for inclusion of indicator set

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

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

Heart failure (HF) indicator 1

The practice can produce a register of patients with heart failure

Heart failure 1.1 Rationale

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

Heart failure 1.2 Reporting and verification

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

Heart failure (HF) indicator 2

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

Heart failure 2.1 Rationale

From April 2006, all patients with suspected heart failure should be investigated (Senni et al. *J Am Coll Cardiol.* 1999; 33(1): 164-70; *NICE clinical guideline 5.* National Institute for Health and Clinical Excellence, London: 2003) and this is expected to involve, as a minimum, specialist investigation (such as echocardiography or natriuretic peptide assay) and often specialist opinion. Specialists may include GPs identified by their PCO as having a special clinical interest in heart failure. Many heart failure patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintigraphy or angiography rather than echocardiography. Current guidance (Remme et al. *Eur Heart J* 2001; 22: 1527-60) requires either echocardiography or specialist assessment for all patients with suspected heart failure, regardless of presumed aetiology.

Further information: www.nice.org.uk/pdf/Full_HF_Guideline.pdf

Heart failure 2.2 Reporting and verification

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

Heart failure (HF) indicator 3

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

Heart failure 3.1 Rationale

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

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

Further information:

www.clinicalevidence.com/cweb/conditions/cvd/0204/0204_I13.jsp

Heart failure 3.2 Reporting and verification

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

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

Stroke and TIA

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

Stroke/TIA – rationale for inclusion of indicator set

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

Stroke indicator 1

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

Stroke 1.1 Rationale

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

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

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

Stroke 1.2 Reporting and verification

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

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

Stroke indicator 11

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

Stroke 11.1 Rationale

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

For the purposes of the QOF, an appropriate referral being undertaken between three months before and 12 months after a diagnosis of presumptive stroke being made would be considered as having met the requirements of this indicator.

Stroke 11.2 Reporting and verification

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

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

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

Stroke indicator 5

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

Stroke 5.1 Rationale

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

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

Grade A Recommendation RCP Stroke Guideline 2004

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

Stroke 5.2 Reporting and verification

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

Stroke indicator 6

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

Stroke 6.1 Rationale

See Stroke 5.1

Stroke 6.2 Reporting and verification

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

Stroke indicator 7

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

Stroke 7.1 Rationale

The Heart Protection Study demonstrated that all cause mortality, vascular and stroke risk was significantly reduced by treating people at high risk of vascular disease with a statin (Heart Protection Study Collaborative Group, *Lancet* 2002; 360;7-22). Subsequent sub-group analyses demonstrated that in patients with prior stroke or TIA, statin therapy reduced risk of subsequent vascular events (Heart Protection Study Collaborative Group,

Lancet 2004; 363:757-767). An economic analysis of this trial concluded that it was highly cost-effective to treat such patients (Heart Protection Study Collaborative Group, *Lancet* 2005; 365:1779-85).

Stroke 7.2 Reporting and verification

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

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

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

Stroke indicator 8

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

Stroke 8.1 Rationale

See Stroke 7.1

Stroke 8.2 Reporting and verification

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

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

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

Stroke indicator 12

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

Stroke 12.1 Rationale

Long-term antiplatelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. Antiplatelet therapy, normally aspirin, should be prescribed

for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

Grade A recommendation SIGN 13

Further information: www.sign.ac.uk/pdf/sign13.pdf

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

Grade A Recommendation RCP Stroke Guideline

Further information:

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

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

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

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

Grade A recommendation SIGN 13

Stroke 12.2 Reporting and verification

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

Stroke indicator 10

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

Stroke 10.1 Rationale

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

Stroke 10.2 Reporting and verification

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

Hypertension

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

Hypertension – rationale for inclusion of indicator set

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

Hypertension (BP) indicator 1

The practice can produce a register of patients with established hypertension

BP 1.1 Rationale

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

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

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

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

British Hypertension Society guidelines 2004

Further information: www.bhsoc.org (see 'Guidelines')

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

BP 1.2 Reporting and verification

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

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

Hypertension (BP) indicator 4

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

BP 4.1 Rationale

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

British Hypertension Society guidelines 2004

Further information: www.bhsoc.org

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

BP 4.2 Reporting and verification

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

Hypertension (BP) indicator 5

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

BP 5.1 Rationale

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

BP 5.2 Reporting and verification

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

Diabetes mellitus

Indicator	Points	Payment stages
Records		
DM 19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
On-going management		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40–90%
DM 5. The percentage of diabetic patients who have a record of HbA _{1c} or equivalent in the previous 15 months	3	40–90%
DM 20. The percentage of patients with diabetes in whom the last HbA _{1c} is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40–50%
DM 7. The percentage of patients with diabetes in whom the last HbA _{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	11	40–90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40–90%
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	40–90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40–90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40–90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40–60%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	40–90%

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

Diabetes – rationale for inclusion of indicator set

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

The indicators for diabetes are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK (see www.diabetes.org.uk/catalogue/reports.htm) and by SIGN – the Scottish Intercollegiate Guidelines Network (see www.sign.ac.uk/guidelines/published/index.html#Diabetes).

The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for diabetes is available at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en – this site also includes details of the evidence behind a range of recommendations. NICE has also published guidance on a number of aspects of diabetic control (www.nice.nhs.uk).

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

Rather than including a substantial number of individual indicators, there has been discussion about whether a composite indicator such as “the percentage of diabetic patients who have had an annual check” would suffice. The view taken was that this would not make data collection any easier for GPs, since they would still have

to satisfy their PCO at periodic visits that annual checks had included those items recommended in national guidance.

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

Diabetes (DM) indicator 19

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

DM 19.1 Rationale

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

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

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

- **random glucose test:** a glucose level above 11.1 mmol/l taken at a random time on two occasions is a diagnosis of diabetes
- **fasting glucose test:** a glucose level above 7.0 mmol/l measured without anything to eat and on two different days is also a diagnosis of diabetes
- **glucose tolerance test:** a blood glucose test is taken two hours after a glucose drink is given to the patient. A level above 11.1 mmol/l is a diagnosis of diabetes, while a level below 7.8 is normal. However, if the level falls between these values the patient may have a decreased tolerance for glucose (known as impaired glucose tolerance or IGT).

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

Separate coding of Type 1 and Type 2 diabetes allows the development of QOF indicators that are more closely aligned to NICE guidance.

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

DM 19.2 Reporting and verification

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

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

Verification – in order to ensure that patients with diabetes are not 'lost' due to the change in read codes, PCOs may wish to compare reported practice prevalence not only with national prevalence but with the practice prevalence for 2004/05.

Diabetes (DM) indicator 2

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

DM 2.1 Rationale

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

DM 2.2 Reporting and verification

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

Diabetes indicator (DM) 5

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

DM 5.1 Rationale

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

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

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

Grade D Recommendation NICE Inherited Guideline G (2002)

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

DM 5.2 Reporting and verification

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

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

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

Diabetes (DM) indicator 20

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

DM 20.1 Rationale

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

Grade B Recommendation NICE Inherited Guideline G (2002)

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

$$\text{Fructosamine} = (\text{HbA}_{1c} - 1.61) / 0.017 = 346 \text{ umol/l}$$

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

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

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

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

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

DM 20.2 Reporting and verification

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

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

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

Diabetes (DM) indicator 7

The percentage of patients with diabetes in whom the last HbA_{1c} is 10 or less (or equivalent)

DM 7.1 Rationale

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

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

DM 7.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA_{1c} measurement was 10 or less. The test must have been carried out in the previous 15 months.

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

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

Diabetes (DM) indicator 21

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

DM 21.1 Rationale

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

Grade B Recommendation SIGN 55

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

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

DM 21.2 Reporting and verification

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

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

Diabetes (DM) indicator 9

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

DM 9.1 Rationale

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

DM 9.2 Reporting and verification

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

Diabetes (DM) indicator 10

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

DM 10.1 Rationale

See DM 9.1

The measurement of foot sensation should be carried out as recommended in the SIGN Guideline 55 on the management of diabetes. Foot sensation should be considered abnormal if monofilament and/or vibration sensation are impaired.

DM 10.2 Reporting and verification

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

Diabetes (DM) indicator 11

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

DM 11.1 Rationale

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

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

Grade D Recommendation NICE Inherited Guideline H

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

DM 11.2 Reporting and verification

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

Diabetes (DM) indicator 12

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

DM 12.1 Rationale

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

Grade A Recommendation SIGN 55

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

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

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

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

www.bhsoc.org/Latest_BHS_management_Guidelines.htm

NICE inherited guideline H

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

DM 12.2 Reporting and verification

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

Diabetes (DM) indicator 13

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

DM 13.1 Rationale

Diabetic patients are at risk of developing nephropathy. Measurements of urinary albumin loss and serum creatinine are the best screening tests for diabetic nephropathy. All patients with diabetes should have their urinary albumin concentration and serum creatinine measured at diagnosis and at regular intervals, usually annually.

Grade D Recommendation SIGN 55

Grade C Recommendation NICE Inherited Guideline F

Further information: www.sign.ac.uk/guidelines/fulltext/55/index.html
www.nice.org.uk/article.asp?a=27964

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

DM 13.2 Reporting and verification

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

Diabetes (DM) indicator 22

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

DM 22.1 Rationale

See DM 13.1

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

DM 22.2 Reporting and verification

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

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

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

Diabetes (DM) indicator 15

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

DM 15.1 Rationale

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

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

Grade A Recommendation SIGN 55

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

DM 15.2 Reporting and verification

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

Diabetes (DM) indicator 16

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

DM 16.1 Rationale

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

Grade C Recommendation SIGN Guideline 55

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

It is unclear from the literature how frequently this should be undertaken, but the English NSF recommends annually. In addition there is no indication as to at what age cholesterol above 5 should be treated. At this stage it is recommended that all patients with diabetes on the register (which is those 17 and over) should have an annual cholesterol measurement.

DM 16.2 Reporting and verification

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

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

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

Diabetes (DM) indicator 17

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

DM 17.1 Rationale

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

The age when a statin should be initiated is unclear. It is pragmatically suggested that all diabetic patients over the age of 40 with a cholesterol of greater than 5 mmol/l should be treated with a statin. Below the age of 40 a decision needs to be reached between the doctor and the patient and may involve assessment of other risk factors and the actual age of the patient.

Further information:

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

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

DM 17.2 Reporting and verification

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

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

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

- ii. inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol less than 5 mmol/l
- iii. inspection of a sample of records of patients for whom a record of serum cholesterol is less than 5 mmol/l is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 18

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

DM 18.1 Rationale

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

DM 18.2 Reporting and verification

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

Chronic obstructive pulmonary disease

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

COPD – rationale for inclusion of indicator set

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

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

COPD indicator 1

The practice can produce a register of patients with COPD

COPD 1.1 Rationale

A register is a prerequisite for monitoring patients with COPD.

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

See COPD 9.1

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

COPD 1.2 Reporting and verification

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

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

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

COPD indicator 9

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

COPD 9.1 Rationale

COPD is diagnosed if:

- the patient has an FEV1 of less than 70% of predicted normal
- and has an FEV1/FVC ratio of less than 70%
- and there is a less than 15% response to a reversibility test.

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

While it is recognised that there may be an element of reversibility in patients with COPD, the definition centres on the lack of reversibility. Patients with reversible airways obstruction should be included in the asthma disease register. Patients with co-existing asthma and COPD should be included on the register for both conditions.

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

Further information:

BTS COPD Guidelines 1997

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

GOLD Guidelines September 2005
www.goldcopd.com/

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

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

COPD 9.2 Reporting and verification

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

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

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

COPD indicator 10

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

COPD 10.1 Rationale

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

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

Further information:

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

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

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

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

Grade A Evidence GOLD Guidelines

Further information:
GOLD Guidelines September 2004
www.goldcopd.com/

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

COPD 10.2 Reporting and verification

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

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

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

COPD indicator 11

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

COPD 11.1 Rationale

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

BTS COPD Guidelines 1997

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

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

COPD 11.2 Reporting and verification

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

COPD indicator 8

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

COPD 8.1 Rationale

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

COPD 8.2 Reporting and verification

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

Epilepsy

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

Epilepsy – rationale for inclusion of indicator set

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

Epilepsy indicator 5

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

Epilepsy 5.1 Rationale

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

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

Epilepsy 5.2 Reporting and verification

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

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

Epilepsy indicator 6

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

Epilepsy 6.1 Rationale

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

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

Grade C Recommendation SIGN 70 (2003)

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

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

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

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

Epilepsy 6.2 Reporting and verification

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

Epilepsy indicator 7

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

Epilepsy 7.1 Rationale

See Epilepsy 6.1

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

Epilepsy 7.2 Reporting and verification

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

Epilepsy indicator 8

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

Epilepsy 8.1 Rationale

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

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

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

Epilepsy 8.2 Reporting and verification

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

Hypothyroid

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

Hypothyroidism – rationale for inclusion of indicator set

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

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

Monitoring of hypothyroidism is almost entirely undertaken in primary care.

Thyroid indicator 1

The practice can produce a register of patients with hypothyroidism

Thyroid 1.1 Rationale

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

Thyroid 1.2 Reporting and verification

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

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

Thyroid indicator 2

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

Thyroid 2.1 Rationale

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

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

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

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

Cancer

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

Cancer – rationale for inclusion of indicator set

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

Cancer indicator 1

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

Cancer 1.1 Rationale

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

Cancer 1.2 Reporting and verification

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

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

Cancer indicator 3

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

Cancer 3.1 Rationale

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

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

Further information: www.show.scot.nhs.uk/sehd/cancerinscotland/

Cancer 3.2 Reporting and verification

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

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

Palliative care

Indicator	Points	Payment stages
Records		
PC 1: The practice has a complete register available of all patients in need of palliative care/support	3	
On-going management		
PC 2: The practice has regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	

Palliative care – rationale for inclusion of indicator set

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

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

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

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

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

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

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

Palliative care (PC) indicator 1

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

Palliative care 1.1 Rationale

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

A patient should be included if:

1. their death in the next 12 months can be reasonably predicted
and/or
2. they have clinical indicators of need for palliative care that are prognostic clinical indicators of advanced or irreversible disease and include one core and one disease specific indicator in accordance with the GSF
www.goldstandardsframework.nhs.uk/gp_contract.php
and/or
3. they are the subject of a DS 1500 form. (The DS 1500 form is designed to speed up the payment of the Disability Living Allowance, Attendance Allowance or Incapacity Benefit. It is usually issued when the patient is considered to be approaching the terminal stage of their illness. In social security law a patient is terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months.)

The register is prospective from 1 April 2006 and applies to adults over the age of 18 years.

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

Palliative care 1.2 Reporting and verification

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

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

Palliative care indicator 2

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

Palliative care 2.1 Rationale

The aims of the case review meetings are to:

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

Palliative care 2.2 Reporting and verification

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

Mental health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
On-going management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40–90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40–90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months	2	40–90%
MH 6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25–50%
MH 7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40–90%

Mental Health – rationale for inclusion of indicator set

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

For many patients with mental health problems, the most important indicators relate to the inter-personal skills of the doctor, the time given in consultations and the

opportunity to discuss a range of management options. Within the 'patient experience' section of the quality framework, there exists the opportunity to focus patient surveys on particular groups of patients. This would be one way in which a practice could look in more detail at the quality of care experienced by people with mental health problems.

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

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

Mental health (MH) indicator 8

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

MH 8.1 Rationale

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

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

MH 8.2 Reporting and verification

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

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

Mental health (MH) indicator 9

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

MH 9.1 Rationale

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

Health promotion and health prevention advice is particularly important for people with serious mental illness. However, there is good evidence that they are much less

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

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

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

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

See also Disability Rights Commission *Equal treatment: closing the gap. Interim report of a formal investigation into health inequalities*.

www.drc-gb.org/documents/interim_report_final.doc

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

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

MH 9.3 Reporting and verification

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

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

Mental health (MH) indicator 4

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

4.1: Rationale

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

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

See:

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

MH 4.2 Reporting and verification

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

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

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

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

Mental health (MH) indicator 5

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

MH 5.1 Rationale

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

The therapeutic range for patients on lithium therapy is normally 0.4–1.0 mmol/l (see the British National Formulary). If the range differs locally, the PCO will be required to allow for this.

See:

www.nhslothian.scot.nhs.uk/primarycarelibrary/2_ClinicalPractice/2_Guidelines/Guidelines/Lithium.pdf

MH 5.2 Reporting and verification

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

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

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

Mental health (MH) indicator 6

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

MH 6.1 Rationale

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

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

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

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

- i. patient's current health status and social care needs, including how needs are to be met, by whom, and the patient's expectations
- ii. how socially supported the individual is, e.g. friendships/family contacts/voluntary sector organisation involvement

People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40% of people with on-going mental health problems had no social contacts outside mental health services (See Ford et al. *Psychiatric Bulletin* 1993; 17(7): 409-411

and Office of the Deputy Prime Minister *Mental health and social exclusion* (Social Exclusion Unit Report). London, ODPM, 2004).

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

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

- v. early warning signs

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

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

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

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

Further information:

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

Mental health 6.2 Reporting and verification

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

Mental health (MH) indicator 7

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

MH 7.1 Rationale

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

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

MH 7.2 Reporting and verification

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

Asthma

Indicator	Points	Payment stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous 12 months	4	
Initial management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40–80%
On-going management		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	40–80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40–70%

Asthma – rationale for inclusion of indicator set

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

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

Asthma indicator 1

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

Asthma 1.1 Rationale

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

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

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

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

Children

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

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

The diagnosis of asthma in children should be based on:

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

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

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

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

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

Asthma 1.2 Reporting and verification

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

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

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

Asthma indicator 8

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

Asthma 8.1 Rationale

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

Objective measurement of variability either spontaneously over time or in response to therapy is thus fundamental to the diagnosis of asthma, and may be conveniently achieved in primary care with serial peak flow measurements. Significant variability in peak flow is defined as a change of 20% or greater with a minimum change of at least 60 l/min ideally for three days in a week for two weeks seen over a period of time and may be demonstrated by monitoring diurnal variation, demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks inhaled steroids, two weeks oral steroids) or a reduction after exercise or when the patient next meets his/her trigger. Spirometry (>15% and 200ml change in FEV1) may still be used to confirm variability, though the limitation imposed by a surgery-based measurement means that changes over time may be missed.

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

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

Asthma 8.2 Reporting and verification

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

Asthma indicator 3

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

Asthma 3.1 Rationale

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

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

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

Asthma 3.2 Reporting and verification

Practices should report the percentage of patients on the asthma register between the ages of 14 and 19 where smoking status has been recorded in the previous 15 months.

Asthma indicator 6

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

Asthma 6.1 Rationale

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

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

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

"In the last month:

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

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

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

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

Summary of asthma review:

- assess symptoms (using RCP 3 questions)
- measure peak flow

- assess inhaler technique
- consider personalised asthma plan.

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

Asthma 6.2 Reporting and verification

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

Dementia

Indicator	Points	Payment stages
Records		
DEM 1: The practice can produce a register of patients diagnosed with dementia	5	
On-going management		
DEM 2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25–60%

Dementia – rationale for inclusion of indicator set

Dementia is a syndrome characterised by 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% at 80 years of age. The annual incidence of vascular dementia is 1.2/100 overall person years at risk, and is the same in all age groups. Alzheimer’s disease accounts for 50–75% of cases of dementia. The annual incidence of senile dementia of the Alzheimer type rises to 34.3/100 person years at risk in the 90 year age group; the incidence is higher in women than in men. Other types of dementia such as Lewy Body dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is not a good indicator of dementia; altered functioning is a more important symptom.

Dementia (DEM) indicator 1

The practice can produce a register of patients diagnosed with dementia

Dementia 1.1 Rationale

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

Dementia 1.2 Reporting and verification

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

Dementia (DEM) indicator 2

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

Dementia 2.1 Rationale

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

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

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

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

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

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

and the NSF for older people

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

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

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

Dementia 2.2 Reporting and verification

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

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

Depression

Indicator	Points	Payment stages
Diagnosis and initial management		
DEP 1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40–90%
DEP 2: In those patients with a new diagnosis of depression, recorded between the preceeding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40–90%

Depression – rationale for inclusion of the indicator set

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

Further information:

Depression. *Management of depression in primary and secondary care*. Clinical Guideline 23. NICE, London 2004.

www.nice.org.uk/pdf/CG023NICEguideline.pdf

Depression (DEP) indicator 1

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

Depression 1.1 Rationale

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

There is a 24% lifetime prevalence of co-morbid depression in individuals with diabetes mellitus (Goldney et al. *Diabetes Care* 2004; 27(5): 1066-70), a prevalence rate three times higher than the general population. A recent meta-analysis of 42 studies found that depression is clinically relevant in nearly one in three patients with diabetes (Anderson et al. *Diabetes Care* 2001; 24: 1069-78). There is also some trial-based evidence to suggest that treatment of depression may improve glycaemic control (Lustman et al. *Psychosomatic Medicine* 1997; 59: 241-50; Lustman et al. *Annals of Internal Medicine* 1998; 129: 613-621; Lustman et al. *Diabetes Care* 2000; 23: 618-23). Psychological well-being has also been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

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

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
and
- During the last month, have you often been bothered by having little interest or pleasure in doing things?”

(NICE Grade B)

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

Depression 1.2 Reporting and verification

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

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

Depression (DEP) indicator 2

In those patients with a new diagnosis of depression recorded between the preceding 1 April to 31 March, the percentage of patients who have had an

assessment of severity at the outset of treatment using an assessment tool validated for use in primary care

Depression 2.1 Rationale

This is a prospective indicator and applies to adults aged 18 years and over with a new diagnosis of depression after 1 April 2006. It does not include women with postnatal depression.

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

A measure of severity at the outset of treatment enables a discussion with the patient about relevant treatment interventions and options, guided by the stepped care model of depression described in NICE guidance. The guidance states, for example, that antidepressants are not recommended for the initial treatment of mild depression (grade C evidence) but should be routinely considered for all patients with moderate or severe depression (grade B evidence). The British Association of Psychopharmacology guidelines state that antidepressants are a first-line treatment for major depression irrespective of environmental factors (grade A evidence) and that antidepressants are not indicated for acute milder depressions (grade B evidence) (Anderson et al. *Journal of Psycho-pharmacology* 2000; 14: 3-20).

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

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

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a nine question self-report measure of severity that takes approximately three minutes to complete. It uses DSM-IV criteria and scores are categorised as minimal (1–4), mild (5–9), moderate (10–14), moderately severe (15–19) and severe depression (20–27).

It was developed and validated in the US and can be downloaded free of charge from: www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/

For further information, see:

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

Hospital Anxiety and Depression Scale (HADS)

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

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

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

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

For further information, see:

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

Beck Depression Inventory Second Edition (BDI-II)

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

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

For further information, see:

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

Depression 2.3 Reporting and verification

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

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

Chronic kidney disease

Indicator	Points	Payment stages
Records		
CKD 1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial management		
CKD 2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40–90%
On-going management		
CKD 3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40–70%
CKD 4: The percentage of patients on the CKD register with hypertension who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	4	40–80%

Chronic kidney disease – rationale for inclusion of indicator set

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

This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m² for over three months). 5% of the population have stage three to five CKD (Webb et al. *Am J Kidney Disease* 2004: 43 (5): 25-35).

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

Further Information:

National Service Framework for Renal Services, February 2005

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4101902&chk=6Tjqb8

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

Chronic kidney disease (CKD) indicator 1

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

Chronic kidney disease 1.1 Rationale

Patients aged 18 years and over with a last estimated GFR or GFR of <60ml/min/1.73m² should be included in the register. From 2006, eGFR will be included with creatinine testing. Studies of general practice computerised medical records show that it is feasible to identify people with CKD (de Lusignan et al. *Fam Pract* 2005; 22(3): 234-41) and that computer records are a valid source of data (Anandarajah et al. *Nephrol Dial Transplant* 2005; 20(10): 2089-96).

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

Chronic kidney disease 1.2 Reporting and verification

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

Chronic kidney disease (CKD) indicator 2

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

Chronic kidney disease 2.1 Rationale

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

Chronic kidney disease 2.2 Reporting and verification

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

Chronic kidney disease (CKD) indicator 3

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

Chronic kidney disease 3.1 Rationale

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

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

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

Chronic kidney disease 3.2 Reporting and verification

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

Chronic kidney disease (CKD) indicator 4

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

Chronic kidney disease 4.1 Rationale

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

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

Chronic kidney disease 4.2 Reporting and verification

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

Atrial fibrillation

Indicator	Points	Payment stages
Records		
AF 1: The practice can produce a register of patients with atrial fibrillation	5	
Initial diagnosis		
AF 2: The percentage of patients with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis	10	40–90%
On-going management		
AF 3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	15	40–90%

Atrial fibrillation – rationale for inclusion of indicator set

Atrial fibrillation (AF) is common, and an important cause of morbidity and mortality. The age-specific prevalence of atrial fibrillation is rising, presumably due to improved survival of people with coronary heart disease (the commonest underlying cause of AF (Psaty et al. *Circulation* 1997; 96: 2455-61). 1% of a typical practice population will be in AF; 5% of over 65s, and 9% of over 75s. Atrial fibrillation is associated with a five-fold increase in risk of stroke (Wolf et al. *Stroke* 1991; 22: 983-88).

Atrial fibrillation (AF) indicator 1

The practice can produce a register of patients with atrial fibrillation

AF 1.1 Rationale

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

AF 1.2 Reporting and verification

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

Atrial fibrillation indicator 2

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

AF 2.1 Rationale

AF is, historically, too often inaccurately coded. Patients with an irregular pulse have been given an AF code even though the accuracy of AF diagnosed in this way is only approximately 30%. The introduction of this indicator will enable the compilation of a more accurate register and help to ensure that treatments are targeted more appropriately.

The act of referral for a specialist opinion (e.g. cardiology out patient or ECG technician report) is insufficient to achieve this indicator.

AF 2.2 Reporting and verification

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

Atrial fibrillation indicator 3

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

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

NICE Grade A evidence.

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

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

AF 2.3 Reporting and verification

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

Obesity

Indicator	Points	Payment stages
Records		
OB 1: The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months	8	

Rationale for inclusion of indicator set

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

Obesity (OB) indicator 1

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

OB 1.1 Rationale

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

OB1.2 Reporting and verification

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

Learning disabilities

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

Rationale for inclusion of indicator set

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

Further information:

Valuing people: a new strategy for learning disability in the 21st century. London, Department of Health, 2001.

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

The same as you? Scottish Executive (2001)

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

Northern Ireland Strategy on Learning Disability

www.rmhdni.gov.uk/learning_disability.asp

Learning disability strategy section 7 guidance on service principles and service responses. Welsh Assembly Government, 2004

www.wales.gov.uk/subisocialpolicy/content/guidance/sp-response-guide-e.pdf

Learning disability (LD) indicator 1

The practice can produce a register of patients with learning disabilities

LD 1.1 Rationale

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

Learning disability is defined in *Valuing people* (and *The same as you*) as the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning)

- which started before adulthood (18 years), with a lasting effect on development.

The definition encompasses people with a broad range of disabilities. It includes adults with autism who also have learning disabilities, but not people with a higher-level autistic spectrum disorder who may be of average or above average intelligence. The presence of an Intelligence Quotient below 70, should not, in isolation, be used in deciding whether someone has a learning disability.

The definition does not include all those people who have a “learning difficulty”.

For most people, there is no difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multidisciplinary team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality learning disability teams have expanded and these, working along with primary care organisations, have provided expertise and data about and for people with learning disabilities. Some hold ‘special needs registers’, increasingly renamed ‘learning disability databases.’ Learning disabilities nurses from the community learning disability team are thus likely to know the names of patients and the practice with whom they are registered and may also be able to assist in the construction of a primary care database (see Martin and Martin. *Journal of Learning Disabilities*, 2000; 4(1): 37-48).

Further information:

www.bild.org.uk/factsheets/what_is_learning_disability.htm

The creation of a full register of patients aged 18 years and over with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

LD1.2 Reporting and verification

Practices report the number of patients aged 18 years and over on its learning disability register and the number of patients with learning disabilities as a proportion of total list size.

Smoking indicators

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

Smoking indicator 1

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis

Smoking 1.1 Rationale

- CHD
Smoking is known to be associated with an increased risk of coronary heart disease.
Reference: SIGN Guideline 41; European Task Force European Society of Cardiology
Further information: www.sign.ac.uk/guidelines/fulltext/41/index.html
www.escardio.org/knowledge/guidelines/CVD_Prevention_in_Clinical_Practice.htm
- Stroke/TIA
There are few randomised clinical trials of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However, inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated.
Grade C Recommendation SIGN 13
Further information: www.sign.ac.uk/pdf/sign13.pdf

3. Hypertension
The British Hypertension Society recommends that all patients with hypertension should have a thorough history and physical examination and a smoking history is taken.
British Hypertension Society Guidelines 2004

Further information: Journal of Human Hypertension 2004; 18(3): 139-185.
www.bhsoc.org/Latest_BHS_management_Guidelines.htm

Formal estimation of CHD risk using a recognised chart, e.g. Joint British Societies Recommendations should be undertaken.

Risk calculators are available at: www.hyp.ac.uk/bhs/resources/guidelines.htm
4. Diabetes
The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.
5. COPD
Smoking cessation is the single most effective – and cost-effective – intervention to reduce the risk of developing COPD and stop its progression.
Grade A Evidence GOLD Guidelines

Further information: GOLD guidelines, www.goldcopd.com/
6. Asthma
The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. New grade A evidence suggests that smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome. See Tomlinson et al. *Thorax* 2005; 60: 282-7. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. *Clin Exp Allergy* 2005; 35: 282-287.
7. Non-smokers
It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients need only be recorded once since diagnosis.

Smoking 1.2 Reporting and verification

Practices report the percentage of patients on any or any combination of the named registers in whom smoking status has been recorded in the previous 15 months.

Smoking indicator 2

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months

Smoking 2.1 Rationale

Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of individual and group smoking cessation advice, and assistance reinforced on multiple occasions – initially during cardiac rehabilitation and reinforced by primary care teams – gave the highest success rates.

Reference Grade B recommendation SIGN Guidelines 41/51

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

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

Further information: www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf

In a significant number of PCOs across the UK, specialist smoking cessation clinics are now available. Referral to such clinics, where they are available, can be discussed with patients. This should also be recorded as giving smoking cessation advice.

The recording of advice given does not necessarily reflect the quality of the intervention. It is therefore proposed that only smoking advice should be part of the reporting framework. Clinicians may choose to record advice given in relation to other modifiable risk factors.

Smoking indicator 2.2 Reporting and verification

Practices should report the percentage of patients on any or any combination of the named registers who smoke who have a record of having been offered smoking cessation advice in the previous 15 months.

Section 3. Organisational domain

1. Format

Organisational indicators are split into five domains:

- records and information about patients (A)
- information for patients (B)
- education and training (C)
- practice management (D)
- medicines management (E)

For each indicator (x), four descriptions are given unless it is reported electronically:

X.1 Practice guidance

This section contains a number of things, dependent on the indicator, including:

- justification for the indicator
- a more detailed description of the indicator
- references which practices may find useful
- some helpful guidance on how practices may go about meeting the requirements of the indicator.

X.2 Written evidence

This specifies the written evidence which a practice would be expected to produce for an assessment visit. The evidence generally should be available in the practice and need not be submitted in advance. However, some written evidence will be required in advance and this is indicated in the document. In some instances no written evidence will be required but may be requested if there is an appeal.

In summary, written evidence is categorised as follows:

Grade A – to be submitted in advance of a visit.

Grade B – to be available in the practice at the visit.

Grade C – optional or used in the event of an appeal.

X.3 Assessment visit

This section describes how a visiting assessment team will verify the written evidence.

X.4 Assessors' guidance

This section contains more detailed guidance for assessors to use during practice assessment visits. This guidance has been produced to ensure that practices are being judged to the same standard across the UK.

2. Equivalence – other schemes

It is recognised that a number of schemes are currently in place across the UK to encourage practice development. Other practice-based accreditation schemes may apply to the National Reference Group to be recommended as equivalent to appropriate aspects of the organisational indicators of the QOF.

These schemes must involve the practice in meeting indicators considered by the Reference Group to be equivalent to a relevant indicator in the framework. Any scheme which is to be considered must include as part of its process a visit to the practice.

The RCGP Quality Practice Award has been approved for all organisational indicators in the framework. Version 7 of QPA, to be published in August 2003, has been modified to meet the requirements of the Framework in relation to the organisational framework.

Records and information

	Indicator
Records 3 1 point	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours
Records 8 1 point	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded
Records 9 4 points	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum standard 80%
Records 11 10 points	The blood pressure of patients aged 45 and over is recorded in the preceding five years for at least 65% of patients
Records 13 2 points	There is a system to alert the out-of-hours service or duty doctor to patients dying at home
Records 15 25 points	The practice has up-to-date clinical summaries in at least 60% of patient records
Records 17 5 points	The blood pressure of patients aged 45 and over is recorded in the preceding five years for at least 80% of patients
Records 18 8 points	The practice has up-to-date clinical summaries in at least 80% of patient records
Records 19 7 points	80% of newly registered patients have had their notes summarised within eight weeks of receipt by the practice
Records 20 12 points	The practice has up-to-date clinical summaries in at least 70% of patient records
Records 21 1 point	Ethnic origin is recorded for 100% of new registrations
Records 22 11 points	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once (payment stages 40–90%)

Records indicator 3

The practice has a system for transferring and acting on information about patients seen by other doctors out of hours

Records 3.1 Practice guidance

Good medical practice for general practitioners (2002) states that the excellent GP “can demonstrate an effective system for transferring and acting on information from other doctors about patients.” Out-of-hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

If the practice undertakes its own out-of-hours cover, there needs to be a system to ensure that out-of-hours contacts are entered in the patient’s clinical record.

If out-of-hours cover is provided by another organisation, for example a co-operative, deputising service, PCO-provided service or shared rota, there needs to be a system for:

- transferring information to the practice
- transferring that information into the clinical record
- identifying and actioning any required follow-up.

Records 3.2 Written evidence

There must be a written procedure for the transfer of information. (Grade B)

Records 3.3 Assessment visit

Inspection of the procedure for the transfer of information may be carried out on an assessment visit.

Records 3.4 Assessors’ guidance

Receptionists and doctors will be questioned on the system for the transfer of information.

Records indicator 8

There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded

Records 8.1 Practice guidance

It is important that a clinician avoids prescribing a drug to which the patient is known to be allergic. Not all patients can recall this information and hence records of allergies are important.

All prescribing clinicians should know where such information is recorded. Ideally, the place where this information is recorded should be limited to one place and not more than two places.

Records 8.2 Written evidence

There should be a statement as to where drug allergies are recorded. (Grade C)

Records 8.3 Assessment visit

The practice should be able to demonstrate where drug allergies are recorded.

Records 8.4 Assessors’ guidance

The place where drug allergies are recorded can be on the computer or in the paper

records. This information should be easily available to the prescribing clinician at the time of consultation.

Records indicator 9

For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)

Minimum standard 80%

Records 9.1 Practice guidance

When reviewing medication, it is important to know why a drug was started. This information in the past has often been difficult to identify in GP records, particularly if a patient has been on a medication for a long time or has transferred between practices. It is proposed that this information needs to be recorded clearly in the clinical records.

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

Records 9.2 Written evidence

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80% of repeat medications commenced after 1 April 2004. (Grade A)

Records 9.3 Assessment visit

The records should be inspected.

Records 9.4 Assessors' guidance

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of 20 patients for whom repeat medication has been started since that date should be surveyed. If the standard is not achieved then a further 20 clinical records should be surveyed and the cumulative total should be used. The minimum standard is that 80% of the indications for repeat medication drugs can be identified.

Records indicator 11

The blood pressure of patients aged 45 and over is recorded in the previous five years for at least 65% of patients

Records 11.1 Practice guidance

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 and over has been pragmatically chosen as

the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is proposed as Records Indicator 17 but a higher standard must be achieved.

Records 11.2 Written evidence

A survey of the records of patients aged 45 and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in the previous five years. (Grade A)

Records 11.3 Assessment visit

A random sample of 20 notes or computerised records of patients aged 45 and over should be inspected, to confirm that blood pressure has been recorded in the previous five years.

Records 11.4 Assessors' guidance

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

Records indicator 13

There is a system to alert the out-of-hours service or duty doctor to patients dying at home

Records 13.1 Practice guidance

Good medical practice (2001) states that when off duty the doctor ensures there are arrangements which "include effective hand-over procedures and clear communication between doctors". It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out-of-hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out-of-hours period. If a practice does its own on-call duties then a system should ensure that all doctors in the practice are aware of these patients. A single-handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice, e.g. on holiday.

Records 13.2 Written evidence

The system for alerting the out-of-hours service or duty doctor to patients dying at home should be described. (Grade C)

Records 13.3 Assessment visit

The doctors in the practice should be questioned on the system that is in place.

Records 13.4 Assessors' guidance

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill and/or dying at home and what information was passed to the out-of-hours service or duty doctor.

Records indicator 15

The practice has up-to-date clinical summaries in at least 60% of patient records

Records 15.1 Practice guidance

Good medical practice for general practitioners (2002) states: "Important information in records should be easily accessible, for example, as part of a summary."

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in the summary. All significant past and continuing problems should be included.

If a computer is used the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data.

Similar indicators are proposed as Records 18 and Records 20 but higher standards must be achieved.

Records 15.2 Written evidence

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date. (Grade A)

Records 15.3 Assessment visit

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

Records 15.4 Assessors' guidance

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess this indicator based on their own experience and beliefs.

Records indicator 17

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

Records 17.1 Practice guidance

See Records 11.1

Records 17.2 Written evidence

See Records 11.2 (Grade A)

Records 17.3 Assessment visit

See Records 11.3

Records 17.4 Assessors' guidance

See Records 11.4

Records indicator 18

The practice has up-to-date clinical summaries in at least 80% of patient records

Records 18.1 Practice guidance

See Records 15.1

Records 18.2 Written evidence

See Records 15.2 (Grade A)

Records 18.3 Assessment visit

See Records 15.3

Records 18.4 Assessors' guidance

See Records 15.4

Records indicator 19

80% of newly registered patients have had their notes summarised within eight weeks of receipt by the practice

Records 19.1 Practice guidance

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year, achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

Records 19.2 Written evidence

A survey should be carried out of the records of newly-registered patients whose notes have been received between eight and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively, a computer print-out should be examined, showing the patients registered where the records have been received between eight and 26 weeks previously, to confirm whether the computer record contains a clinical summary. (Grade A)

Records 19.3 Assessment visit

A sample of 20 records of patients whose records were sent to the practice between nine and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

Records 19.4 Assessors' guidance

A list of patients registered in the past 12 months and whose records have been forwarded between nine and 26 weeks ago to the practice will be obtained from the PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least 10%) from the practice survey a further 20 records will be checked if appropriate.

Records indicator 20

The practice has up-to-date clinical summaries in at least 70% of patient records

Records 20.1 Practice guidance

See Records 15.1

Records 20.2 Written evidence

See Records 15.2 (Grade A)

Records 20.3 Assessment visit

See Records 15.3

Records 20.4 Assessors' guidance

See Records 15.4

Records indicator 21

Ethnic origin is recorded for 100% of new registrations

Records 21.1 Practice guidance

The UK is an increasingly ethnically diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.

The experience of the UK census now means that there are nationally-used ethnic categories that have been thoroughly tested and that are known to be acceptable to the majority of the population.

Further information:

A practical guide to ethnic monitoring in the NHS and social care. London, Department of Health, 2005.

www.dh.gov.uk/PublicationsAndStatistics/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4116839&chk=xfG3pr

National Resource Centre for Ethnic Minority Health and ISD ethnic monitoring toolkit
www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

See also Gill et al. *Health care needs assessment: black and minority ethnic groups*.
<http://hcna.radcliffe-oxford.com/bemgframe.htm>

It should be noted that the census codes enable the patient to refuse to divulge their ethnicity and, therefore, this will not affect the practice's ability to achieve 100% on this indicator.

Records 21.2 Written evidence

A survey of written records or a computer search of new registrations should be carried out to determine the percentage where ethnicity is recorded. (Grade A)

Records 21.3 Assessment visit

A random sample of notes or computerised records of new registrations should be inspected, to confirm that ethnicity is recorded.

Records 21.4 Assessors' guidance

The practice's own survey is verified by inspecting a number of new patient registration records at the visit.

Records indicator 22

The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months, except those who have never smoked where smoking status need be recorded only once.

Payment stages: 40–90%

Records 22.1 Practice guidance

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record. Dependent upon how practices record smoking status, the survey can be undertaken by computer search or a survey of the written records.

Records 22.2 Written evidence

A survey of written records or a computer search of patients aged from 15 to 75 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded at least once. (Grade A)

Records 22.3 Assessment visit

A random sample of 20 notes or computerised records of patients aged from 15 to 75 should be inspected, to confirm that smoking status is recorded at least once.

Records 22.4 Assessors' guidance

The practice's own survey is verified by inspecting 20 patient records at the visit. If the result differs from the practice survey then a further 20 patient records should be checked.

Information for patients

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

Information indicator 3

The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day

Information 3.1 Practice guidance

Good medical practice for general practitioners (2002) states that the excellent GP "has a system for receiving or returning phone calls from patients" and that the unacceptable GP "provides no opportunity for patients to talk to a doctor or a nurse on the phone."

Some practices have specific times to speak to a clinician and others make arrangements for the clinician to phone the patient back.

It is useful for this information to be advertised to patients e.g. through the practice leaflet, notices in the practice, slips given to patients when being asked to phone back for a result, the tear-off side of a prescription, the practice newsletter etc.

Information 3.2 Written evidence

The practice has a written policy on telephone availability. (Grade A)

Information 3.3 Assessment visit

The assessors should seek out evidence on when the practice team is available to answer telephone calls by checking practice leaflets, observing the office and asking reception and clinical staff.

The receptionists should be able to respond positively to a request by a patient to speak to a clinician on the telephone. The assessors should confirm with reception staff the information they give patients who require to speak to a GP or practice-employed nurse. Patients do not require to speak to a clinician immediately unless it is an emergency, but

at least one clinician in the practice should be available every working day. The assessors should confirm with staff how patients are informed of the policy and check the stated sources, e.g. practice leaflet, notices at the reception desk or in the waiting area, etc.

Information indicator 4

If a patient is removed from the practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient

Information 4.1 Practice guidance

It is good practice to explain to a patient the reasons for being removed from the list. This is the recommendation of both the BMA and the RCGP. Normally, this will be based on a perceived breakdown in the doctor/patient relationship but it will often be useful to give a fuller explanation than simply stating this. The letter should not normally be a standard letter of removal but tailored to the individual situation. The reason for removal should not be solely that a patient has made a complaint against the practice (see *Good medical practice for general practitioners*, 2002).

Many patients will not be aware of the procedure for registration with another practice and will not be aware that the primary care organisation can assist them. They should be given relevant guidance and contact details.

In exceptional circumstances, it will be felt that a written explanation of the reasons for removal from the list will further inflame a difficult situation, potentially endangering the safety of practice team members. In these circumstances, the omission of a written explanation will be justified. It may be useful to discuss this issue and include guidance in the practice's policy.

Information 4.2 Written evidence

There should be a written policy on removing patients from the list. (Grade B)

Information 4.3 Assessment visit

The written policy statement should be inspected or the practice team should be questioned on the policy.

Information 4.4 Assessors' guidance

The practice should submit a written policy. It may also be useful to check with team members that the policy is consistently used. Patients should normally be given a written reason for their removal and the letter should contain both the elements in the criterion.

Information indicator 5

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

Information 5.1 Practice guidance

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

Information 5.2 Written evidence

There should be a practice protocol concerning smoking cessation. (Grade A)

Information 5.3 Assessment visit

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

Information 5.4 Assessors' guidance

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

Information indicator 7

Patients are able to access a receptionist via telephone and face-to-face in the practice, for at least 45 hours over five days, Monday to Friday, except where agreed with the PCO

Information 7.1 Practice guidance

Good medical practice for general practitioners (2002) states "patients appreciate being able to contact the surgery throughout the working day." To satisfy this indicator, reception staff will have to be available face to face and on the telephone for the stated hours, spread through Monday to Friday. This indicator may be difficult and inappropriate to satisfy in some single-handed and remote and rural practices. In these circumstances, the level of receptionist cover should be agreed with the PCO. The practice should have written confirmation that this level of cover has been agreed.

There should be a written summary of the times when telephone/face-to-face access to receptionists is available. (Grade A)

Information 7.3 Assessment visit

Reception staff should be questioned concerning the arrangements for access to receptionists.

Information 7.4 Assessors' guidance

Assessors should confirm with reception staff that their hours of work as a team cover the hours of telephone and face-to-face availability as stated in the summary. In single-handed or remote and rural practices where it is not appropriate or possible to provide this amount of cover, the practice should have available written confirmation from the PCO of the agreed level of coverage.

Education and training

	Indicator
Education 1 4 points	There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months
Education 4 3 points	All new staff receive induction training
Education 5 3 points	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
Education 6 3 points	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
Education 7 4 points	<p>The practice has undertaken a minimum of 12 significant event reviews in the past three years which could include:</p> <ul style="list-style-type: none"> • any death occurring in the practice premises • new cancer diagnoses • deaths where terminal care has taken place at home • any suicides • admissions under the Mental Health Act • child protection cases • medication errors. <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different</p>
Education 8 5 points	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal
Education 9 3 points	All practice-employed non-clinical team members have an annual appraisal
Education 10 6 points	The practice has undertaken a minimum of three significant event reviews within the last year

Education indicator 1

There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months

Education 1.1 Practice guidance

The primary care team members deal with cardio-pulmonary collapse relatively rarely, but require up-to-date skills to deal with an emergency. This is best undertaken at

regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local accident and emergency department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Further information:

Cardiopulmonary resuscitation guidance for clinical practice and training in primary care (2001)

www.resus.org.uk/pages/cpatpc.htm#contents

Education 1.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 1.3 Assessment visit

Staff should be questioned on the date of their last BLS training.

Education 1.4 Assessors' guidance

Assessors should confirm by checking the BLS attendance list that practice-employed clinical staff have attended.

Education indicator 4

All new staff receive induction training

Education 4.1 Practice guidance

The use of a structured induction programme will help new staff fit more quickly into the practice and support them in becoming effective team members. It is useful to establish a programme of induction for a post, but to remember that it may need to be used flexibly, for example when an employee:

- is returning to work after a long absence
- has not worked before
- has a disability
- is from an ethnic minority group.

A programme could include:

- going through terms and conditions of employment
- meeting other members of the practice team, possibly including shadowing
- clarifying areas of responsibility and accountability
- practice codes and/or standards and regulations including health and safety/special hazards, uniforms, arrangements for working overtime, time in lieu etc
- familiarisation with protocols and procedures including employment procedures e.g. sickness absence policy

- training in the responsibilities of the post.

This list is not exhaustive.

Clear recording of the areas covered in the programme and regular reviews of progress will help establish the standard of performance which is expected and help the manager and new member of staff to identify any areas for future development.

Education 4.2 Written evidence

If a new member of staff has commenced after 1 April 2003, a copy of the induction programme which has been implemented should be available. (Grade B)

Education 4.3 Assessment visit

The induction programme should be inspected.

Education 4.4 Assessors' guidance

It may be useful to speak to the newest member of staff as well as inspecting the induction programme itself if he or she has commenced in post after 1 April 2003.

Education indicator 5

There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months

Education 5.1 Practice guidance

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

Education 5.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 5.3 Assessment visit

Staff should be questioned on the date of their last BLS training.

Education 5.4 Assessors' guidance

Confirmation that practice non-clinical staff have attended training should be obtained by checking the BLS attendance list.

Education indicator 6

The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team

Education 6.1 Practice guidance

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (Education 7 and Education 10).

Education 6.2 Written evidence

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

Education 6.3 Assessment visit

The issue of learning from complaints should be discussed with staff and doctors.

Education 6.4 Assessors' guidance

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

Education indicator 7

The practice has undertaken a minimum of 12 significant event reviews in the past three years which could include:

- any death occurring in the practice premises
- new cancer diagnoses
- deaths where terminal care has taken place at home
- any suicides
- any patient admitted under the Mental Health Act
- child protection cases
- medication errors
- a significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)

Education 7.1 Practice guidance

Detail of methodology on significant event analysis is given in Education 10.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, e.g. patient suicide, then this should be stated in the evidence.

Education 7.2 Written evidence

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 7.3 Assessment visit

The reviews should be discussed.

Education 7.4 Assessors' guidance

The practice should report on its analyses in a form consistent with either of the two methods described in Education 2.

Education indicator 8

All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal

Education 8.1 Practice guidance

The production of a personal learning plan should be one of the outcomes of the appraisal system and the points allocated to this indicator have been increased to reflect this. The plan should record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

Education 8.2 Written evidence

The staff appraisal system should be described. (Grade C)

Education 8.3 Assessment visit

A discussion should be held with practice-employed nursing staff about their personal learning plans and the appraisal system.

Education 8.4 Assessors' guidance

Personal learning plans and the appraisal system should be discussed with practice-employed nursing staff and the person responsible for managing the appraisal system.

Education indicator 9

All practice-employed non-clinical team members have an annual appraisal

Education 9.1 Practice guidance

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

Education 9.2 Written evidence

The staff appraisal system should be described. (Grade C)

Education 9.3 Assessment visit

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

Education 9.4 Assessors' guidance

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

Education indicator 10

The practice has undertaken a minimum of three significant event reviews within the last year

Education 10.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

- 1 A multidisciplinary meeting to explain the concept.
- 2 Consideration of events which should be important to the practice but need not imply criticism of the practice or of individuals. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper (see reference at end of this section). Some of the examples from this are below.

Preventative care: Measles
 Unplanned pregnancy
 Non-accidental injury
 Squint diagnosed by an ophthalmologist

Acute care: Sudden unexpected death
 Death occurring on the practice premises
 Suicide or suicide attempt
 All new cancer diagnoses
 Myocardial infarction
 Terminal care death at home
 Section under Mental Health Act

Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma – hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

- 3 Mechanism for identification of events.
A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.
- 4 Significant events meetings.
These are generally multidisciplinary but need not be so and need to be sensitively chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This could be:

- celebration of excellent care
- no change
- audit required
- immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- **Description of event.** This should be brief and can be in note form.
- **Learning outcome.** This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- **Action plan.** The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?

- Was insight demonstrated?
- Was change implemented?

Reference: Royal College of General Practitioners. *Significant event auditing: Occasional Paper 70*. London: RCGP, 1995.

A description of significant event audit is also available in: Robinson et al. *How to do it: Use facilitated case discussions for significant event auditing*. BMJ 1995; 311: 315-318.

Education 10.2 Written evidence

Each case report should consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 10.3 Assessment visit

The reviews should be discussed.

Education 10.4 Assessors guidance

The practice should report their analyses in a form consistent with either of the two following methods:

- A. Statement of the problem or event, learning outcome and action plan OR
- B. What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, if possible, all team members who were stakeholders in the event in the case discussion.

Practice management

	Indicator
Management 1 1 point	Individual healthcare professionals have access to information on local procedures relating to child protection
Management 2 1 point	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
Management 3 0.5 points	The hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
Management 4 1 point	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
Management 5 3 points	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
Management 6 2 points	Person specifications and job descriptions are produced for all advertised vacancies
Management 7 3 points	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> • a defined responsible person • clear recording • systematic pre-planned schedules • reporting of faults.
Management 8 1 point	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
Management 9 3 points	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
Management 10 2 points	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Management indicator 1

Individual healthcare professionals have access to information on local procedures relating to child protection

Management 1.1 Practice guidance

Awareness of the existence of local child protection procedures is mandatory and all healthcare professionals should be able to access a copy.

Management 1.2 Written evidence

There should be a description of how local procedures are accessed. (Grade C)

Management 1.3 Assessment visit

Access to local procedures should be demonstrated.

Management 1.4 Assessors' guidance

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

Management indicator 2

There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used

Management 2.1 Practice guidance

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

Management 2.2 Written evidence

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site
- authorisation to load programmes. (Grade A)

Management 2.3 Assessment visit

The back-up and loading arrangements should be demonstrated.

Management 2.4 Assessors' guidance

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

Management indicator 3

The hepatitis B status of all doctors and relevant practice employed staff is recorded and immunisation recommended if required in accordance with national guidance

Management 3.1 Practice guidance

Useful guidance on hepatitis B risks and immunisation is contained in the UK Health Departments' publication *Guidance for clinical health care workers: protection against infection with blood borne viruses – recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis* (www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf)

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 1994 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The DH guidance *Protecting health care workers and patients from hepatitis B* and the 1996 and 2004 addenda (see above reference to the website, Annex 1) states that all healthcare workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90% of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen hepatitis B immunisation policy in the general practice staff (non medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in *Immunisation against infectious disease* (see annex 1 in the above website).

In relation to confidentiality, the BMA website offers the following guidance:

"It is extremely important that hepatitis B infected healthcare workers have the same right of confidentiality as any patient seeking or receiving medical care. Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a

change of duties should take place, but hepatitis B status itself will not normally be disclosed without the healthcare worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information."

Management 3.2 Written evidence

There should be evidence that the hepatitis B status of all staff is known. (Grade C)

Management 3.3 Assessment visit

Questioning should take place on the system to check hepatitis B status.

Management 3.4 Assessors' guidance

It should be confirmed that evidence is available that the hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

Management indicator 4

The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care

Management 4.1 Practice guidance

The health departments in each country will issue guidance relating to instrument sterilisation on which the General Practitioners Committee will be consulted.

Management 4.2 Written evidence

There must be a policy for instrument sterilisation.

Management 4.3 Assessment visit

The sterilisation arrangements should be inspected.

Management 4.4 Assessors' guidance

Sterilisation arrangements should be in line with national guidance.

Management indicator 5

The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO

Management 5.1 Practice guidance

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the

range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

Management 5.2 Written evidence

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

Management 5.3 Assessment visit

The practice leaflet and appointment book should be checked.

Management 5.4 Assessors' guidance

The assessor should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

Management indicator 6

Person specifications and job descriptions are produced for all advertised vacancies

Management 6.1 Practice guidance

Production of a person specification and job description at the time of identifying a vacancy not only ensures that the practice maximises its chances of employing the right person for the job, but protects the practice against the risk of being in breach of the following acts: the Sex Discrimination Act, Equal Pay Act, Disability Discrimination Act and Race Relations Act. The Government is currently working on draft legislation covering discrimination on the grounds of sexual orientation, religion and age. It is also good practice not to discriminate on these grounds during the recruitment process.

Useful guidance on how to recruit without discrimination can be found on the following websites:

- The Equal Opportunities Commission Code of Practice – Sex Discrimination at www.eoc.org.uk. If unsuccessful candidates for a post were to claim that they had been discriminated against on the grounds of sex, then they could take their complaint to an employment tribunal. The tribunal would take into account whether the Code of Practice was relevant to the circumstances of the case and, if so, failure by the practice to follow the code would be taken into consideration in its determination. The ACAS website also gives guidance on equal opportunities (www.acas.org.uk).
- The Disability Discrimination Act: Code of Practice for the elimination of discrimination in the field of employment against disabled persons or persons who have had a disability. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the

selection process, terms and conditions of service and 'reasonable adjustments'. See www.disability.gov.uk/ and www.drc-gb.org/. Practice applies to employers with 15 or more employees. This threshold excluding small firms will be reviewed. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the selection process, terms and conditions of service and "reasonable adjustments."

- The Commission for Race Equality: Employment Code of Practice at: www.cre.gov.uk/. The Code of Practice covers advertising, selection/short listing, uniforms, language and other areas.

Practices in Northern Ireland should also be aware of their responsibilities under Section 75 of the Equality Legislation. For further information, see www.dhsspsni.gov.uk/equality/index.asp

Management 6.2 Written evidence

The person specification and job description of the last person employed after 1 April 2003 should be available. (Grade B)

Management 6.3 Assessment visit

The assessment should involve questioning on the person specification and job description of the last person employed after 1 April 2003.

Management 6.4 Assessors' guidance

The assessors should check that the practice's approach to recruitment has included production of a person specification and job description relevant to the actual vacancy. Discussion could include the process used for drawing up the person specification e.g. who was involved and the opportunity for reviewing the job description. The practice could demonstrate understanding of how the production of the specification and job description demonstrates good employment practice.

Management indicator 7

The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment, including:

- a defined responsible person
- clear recording
- systematic pre-planned schedules
- reporting of faults.

Management 7.1 Practice guidance

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website at www.hse.gov.uk. The website provides a free booklet, *Five steps to risk assessment*.

This website also contains a free leaflet, *Maintaining portable electrical equipment in offices and other low risk environments*. This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website, others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

Management 7.2 Written evidence

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

Management 7.3 Assessment visit

Assessors should undertake a review of equipment requiring maintenance, and the log of inspection and maintenance.

Management 7.4 Assessors' guidance

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule.

The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (e.g. printer) up to larger items such as a steriliser or defibrillator.

Management indicator 8

The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation, etc.)

Management 8.1 Practice guidance

The practice should have a policy which clearly defines the levels of financial responsibility in the practice. This will include a description of the activities which are

carried out by the practice manager (e.g. payroll), other staff (e.g. petty cash) and partners (e.g. calculation of drawings) and will make clear the extent of responsibility. For example, the senior receptionist may be responsible for managing the petty cash on a day-to-day basis and may produce a monthly statement for the practice manager along with handing over cash for banking. The practice manager may then be responsible for checking this and for recording and banking the cash. The practice manager may have overall responsibility for ensuring the management of the petty cash.

The line of accountability for finance in the practice should also be clearly defined. For example, a particular partner may be identified as being responsible on behalf of the partnership for financial management. This responsibility may be delegated to the practice manager, who may have responsibility for day to day bookkeeping, banking and other record-keeping, reconciling the bank statements and preparing regular financial statements for the finance partner. The finance partner will then be responsible to the partnership as a whole.

A fraud prevention policy may cover the following areas:

- a defined partner is responsible with the practice manager for business and finance affairs
- bank accounts are only operable with at least two signatories. The number of non-partners who are signatories should be restricted
- the same individual should where ever possible not be both payee and authorising signatory
- the practice should avoid undue reliance on one member of staff for financial and business controls
- staff are never paid in cash for work undertaken
- there is a written procedure for the removal of cash from petty cash
- all income and expenditure are recorded and reconciled with the bank statement
- purchases of equipment etc are only made with the prior approval of a partner – a level of expenditure may be agreed and set above which approval should be sought
- all transfers between accounts are properly authorised and can be substantiated
- all cheques signed should be accompanied by appropriate documentation e.g. invoice
- the practice should ensure where possible that one individual does not place an order, authorise the invoice and sign the cheque.

Management 8.2 Written evidence

The policy is provided. (Grade A)

Management 8.3 Assessment visit

Questioning is carried out on the steps taken to prevent fraud.

Management 8.4 Assessors' guidance

The practice's fraud prevention policy is discussed with the practice manager and the partner(s) with financial responsibility.

Management indicator 9

The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment

Management 9.1 Practice guidance

The practice should produce a procedure for how carers are identified and a referral protocol to social services for assessment of carers with specific needs.

A carer is defined as 'someone who, without payment, provides help and support to a relative, friend or neighbour, who could not manage to stay at home without their help due to age, sickness, addiction or disability.'

The practice should remember to include any young carers who are particularly vulnerable.

Further information:

Focus on carers and the NHS – identifying and supporting hidden carers. Good Practice Guide www.carers.org/data/files/carersnhs-11.pdf

BMA guidance on working with carers www.bma.org.uk/ap.nsf/Content/Carers

Management 9.2 Written evidence

The protocol is available. (Grade A)

Management 9.3 Assessment visit

The policy is discussed.

Management 9.4 Assessors' guidance

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

Management indicator 10

There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

Management 10.1 Practice guidance

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the disciplinary and grievance procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers at www.eoc.org.uk. Guidance can also be found on the ACAS website at www.acas.org.uk. The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers, giving practical advice on implementing equal opportunities policies.

- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at www.ihm.org.uk
- IHM Diversity Group recommendations for recruitment and selection.
- Sickness absence: ACAS as above, including their booklet entitled *Absence and labour turnover*.
- BMA guidance on managing absence at www.bma.org.uk

Management 10.2 Written evidence

Employment policies should be recorded (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

Management 10.3 Assessment visit

The procedures manual should be inspected.

Management 10.4 Assessors' guidance

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

Medicines management

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

Medicines indicator 2

The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis

Medicines 2.1 Practice guidance

Good medical practice for general practitioners (2002) states that the excellent doctor “has up-to-date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

Medicines 2.2 Written evidence

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

Medicines 2.3 Assessment visit

The appropriate equipment and drugs are inspected.

Medicines 2.4 Assessors' guidance

The dates of emergency drugs should be checked.

Medicines indicator 3

There is a system for checking the expiry dates of emergency drugs on at least an annual basis

Medicines 3.1 Practice guidance

Good medical practice for general practitioners (2002) states that the unacceptable GP "has drugs which are out of date" and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors' bags.

Medicines 3.2 Written evidence

The system is described. (Grade C)

Medicines 3.3 Assessment visit

A random sample of doctors' bags and other emergency drugs is checked.

Medicines 3.4 Assessors' guidance

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

Medicines indicator 4

The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)

Medicines 4.1 Practice guidance

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (Medicines indicator 8).

Medicines 4.2 Written evidence

The practice leaflet or policy is available. (Grade A). The receptionists are questioned on the policy.

Medicines 4.4 Assessors' guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines indicator 6

The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing

Medicines 6.1 Practice guidance

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

Medicines 6.3 Assessment visit

The actions should be discussed.

Medicines 6.4 Assessors' guidance

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

Medicines indicator 7

Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend

Medicines 7.1 Practice guidance

The consequences of patient default from this system are serious. It is therefore important that the practice's follow-up system is efficient and reliable. However, because of the relatively low number of patients in this group, a simple manual system will often be effective. If the practice has the opportunity for involving a CPN in the patient follow-up system, this can contribute significantly.

Medicines 7.2 Written evidence

The system should be described. (Grade C)

Medicines 7.3 Assessment visit

The assessors should question the practice team on whether they have patients on injectable neuroleptic medication and ask them to demonstrate the system for identifying and following up those who do not attend. Additionally the practice should be able to demonstrate that they are delivering this service to at least one patient during the QOF year in order to be eligible for the points.

Medicines 7.4 Assessors' guidance

If the patient receives his or her injections from a hospital team that is responsible for this care, then the practice does not need to include those patients who receive their

injection in this way in their system. This for example would apply in relation to a CPN who reports to the mental health team rather than to the practice.

Medicines indicator 8

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)

Medicines 8.1 Practice guidance

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (Medicines indicator 4).

Medicines 8.2 Written evidence

The practice leaflet or policy is available (Grade A). The receptionists are questioned on the policy.

Medicines 8.4 Assessors' guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines indicator 10

The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change

Medicines 10.1 Practice guidance

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

If the PCO prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Medicines 10.2 Written evidence

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Medicines 10.3 Assessment visit

Actions and improvements should be discussed.

Medicines 10.4 Assessors' guidance

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

Medicines indicator 11

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines

Standard 80%

Medicines 11.1 Practice guidance

Medication is by far the most common form of medical intervention. Four out of five people over 75 take a prescription medicine and 36% are taking four or more (*Medicines and older people – supplement to the National Service Framework for older people, 2001*). However, we also know that up to 50% of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5–17 per cent of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the Briefing Paper www.medicines-partnership.org/medication-review/room-for-review/downloads.

The underlying principles of any medication review, whether using the patient's full notes or face to face are:

1. all patients should have the chance to raise questions and highlight problems about their medicines
2. medication review seeks to improve or optimise impact of treatment for an individual patient
3. the review is undertaken in a systematic way by a competent person
4. any changes resulting from the review are agreed with the patient
5. the review is documented in the patient's notes
6. the impact of any change is monitored.

Medicines DO NOT include dressings and emollients but would include topical preparations with an active ingredient such as steroid creams and ointments and hormone preparations.

Medicines 11.2 Written information

A survey of medication review should be undertaken (Grade A). This could be a computerised search and print out or a survey of 50 records of patients on four or more medications.

Medicines 11.3 Assessment visit

Inspection of records should be carried out.

Medicines 11.4 Assessors' guidance

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

Medicines indicator 12

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines

Standard 80%

Medicines 12.1 Practice guidance

See Medicines 11.1

Medicines 12.2 Written information

See Medicines 11.2

Medicines 12.3 Assessment visit

See Medicines 11.3

Medicines 12.4 Assessors' guidance

See Medicines 11.4

Section 4. Patient experience domain

Patient experience
<p>PE 1 Length of consultations 33 points</p> <p>The length of routine booked appointments with the doctors in the practice is not less than ten minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment).</p> <p>For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least eight minutes.</p> <p>Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p>
<p>PE 2 Patient surveys (1) 25 points</p> <p>The practice will have undertaken an approved patient survey each year.</p>
<p>PE 5 Patient surveys (2) 20 points</p> <p>The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:</p> <ol style="list-style-type: none"> 1. summarises the findings of the survey 2. summarises the findings of the previous year's survey 3. reports on the activities undertaken in the past year to address patient experience issues.
<p>PE 6 Patient surveys (3) 30 points</p> <p>The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that:</p> <ol style="list-style-type: none"> 1. sets priorities for the next two years 2. describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative) 3. describes the plans for achieving the priorities, including indicating the lead person in the practice 4. considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

PE1 Length of consultations

The length of routine booked appointments with the doctors in the practice is not less than ten minutes. If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment

For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least eight minutes

Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria

PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things that are crucial parts of general practice, yet cannot easily be measured – e.g. listening to patients, taking time, involving patients in decisions, explaining treatments, in addition to providing high-quality care for the many conditions not specifically included in the QOF.

Practices can claim this payment if their normal booking interval is ten minutes or more. 'Normal' means that three quarters or more of their appointments should be ten minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

Practices with appointment systems

For practices where three quarters of patients are seen in booked appointments of ten minutes or more, and surgery sessions are not normally interrupted by 'extras', the contract requirement is met. Extras seen at the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at ten minute intervals, but six extras are routinely added in, then the average time for patients will be $120/18 = 6.7$ minutes, and these slots would not meet the ten-minute requirement. Practices will generally find it easier to decide whether they meet the 'three quarters' requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are ten minutes or more in length should be three quarters of the total.

Practices without appointment systems or with mixed systems

Some practices do not run an appointment system. In this case, or where some surgeries are regularly 'open', practices should measure the actual time of consultations in two separate sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of ten minutes or more, as the 'three quarters' requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face-to-face time has been eight minutes in three quarters of consultations (equivalent to the face-to-face time in a ten minute booked slot), and five minutes in the remainder.

Unusual systems

Practices organise consulting in a wide variety of different ways. This Guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

PE 1.2 Written evidence

If submitting on length of consultation, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

PE 1.3 Assessment visit

If the practice operates an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year.

If the practice has submitted a survey of consultation length, this should be reviewed.

PE 1.4 Assessors' guidance

The assessors may need to look at a number of sample days to confirm that 75% of consultations have been booked at least at ten-minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the doctors and reception staff on how and when this was carried out.

PE2 Patient surveys (1)

The practice will have undertaken an approved patient survey each year

PE 2.1 Practice guidance

A practice will meet the contract requirement if it has carried out a survey of patient views in the previous year, using one of two currently approved instruments (GPAQ – the General Practice Assessment Questionnaire, and IPQ – the Improving Practice Questionnaire). It is possible that other instruments will be added to the approved list following submission to and approval by the National Panel.

GPAQ is a shortened version of GPAS which has been developed for the new contract. GPAQ is available with full instructions at www.gpaq.info/s.co.uk

IPQ is available at www.cfep.co.uk/products_ipq_desc.html

Practices have a choice of how to administer their survey. IPQ and GPAQ can both be administered by giving them to patients attending the surgery, and filled in after

consultations with the GP. In addition, GPAQ is available in a version designed to be administered by post. In some cases, if practices consent, a PCO may take responsibility for carrying out a postal survey of all practices in its area.

One advantage of administering questionnaires in the surgery is that they can relate to an individual GP, who will then also be able to use the results in his or her revalidation folder. Surveys carried out by post do not generally relate to a named doctor, except in single-handed practices.

If surveys are carried out in the surgery, these should be conducted on consecutive patients. If carried out by post, adult patients should be randomly sampled.

The number of points allocated to this indicator has been decreased in recognition of the need to move towards the practice team actively addressing issues raised from a patient perspective.

A minimum of 25 completed questionnaires per 1,000 Contractor Registered Population should be obtained in the survey. In order to obtain this return, practices may need to administer a considerably higher number.

PE 2.2 Written evidence

Practices should provide evidence that the survey has been undertaken including the date and methodology. (Grade A)

PE5 Patient surveys (2)

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

- i. summarises the findings of the survey
- ii. summarises the findings of the previous year's survey
- iii. reports on the activities undertaken in the past year to address patient experience issues.

PE 5.1 Practice guidance

The practice will undertake one of the surveys detailed in PE2.

The practice should examine and summarise the results of the survey from the current and previous year and consider the areas where changes could be made to improve the services and quality of care for patients. This should include a comparison of numerical scores in the relevant survey areas and a review of patient comments. They should then report on the activities they have chosen to undertake to address these issues in their action plan.

The practice need not provide the results of the surveys but should provide an overview of their analysis of the surveys and any subsequent proposals for change. Some proposals for change may have resource consequences which need to be discussed with the PCO. This could take the form of a report from a team meeting.

PE 5.2 Written evidence

A report of the action plan from the practice should be available. (Grade A)

PE6 Patient surveys (3)

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

- i. sets priorities for the next two years
- ii. describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative)
- iii. describes the plans for achieving the priorities, including indicating the lead person in the practice
- iv. considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group

PE 6.1 Practice guidance

Practices should have undertaken a recommended patient survey and have discussed it as a team (see PE2 and PE5) and produced an action with priorities as described above. A lead person for patient experience should be identified in each practice.

Subsequently, the team should share the contents of the action plan with the most appropriate person or persons which may be a PCO approved patient representative. If the practice has a patient participation group then this group may be used.

If no patient group exists, one could be convened using one or more of the following methods:

- an advertisement placed in the waiting room at least two weeks before the meeting
- a random sample of patients who are written to and invited by the practice at least three weeks in advance of the meeting
- an advertisement in the practice newsletter if the practice has one
- a leaflet handed out by reception staff or a notice on the side of prescriptions.

Practices may wish to convene a focus group with particular service needs e.g. mothers with young children, the elderly, patients whose first language is not English, patients with mental health problems etc, with which to share the results of the surveys and action plan.

PE 6.2 Written evidence

Practices should submit a copy of their action plan, with evidence that some change has been achieved e.g. through patient report or by demonstrating a positive change in the patient survey. (Grade A)

Section 5. Additional services

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

Cervical screening

	Indicator
CS 1 11 points	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 40 – 80%
CS 5 2 points	The practice has a system for informing all women of the results of cervical smears
CS 6 2 points	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every two years
CS 7 7 points	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/ recall, exception reporting and the regular monitoring of inadequate smear rates

Child health surveillance (CHS)

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

Maternity services (MAT)

	Indicator
MAT 1 6 points	Antenatal care and screening are offered according to current local guidelines

Contraceptive services (CON)

	Indicator
CON 1 1 point	The team has a written policy for responding to requests for emergency contraception
CON 2 1 point	The team has a policy for providing pre-conceptual advice

Cervical screening (CS)

CS indicator 1

The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years

Standard 40–80%

CS 1.1 Practice guidance

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged from 25 to 64 (from 21 to 60 in Scotland, from 20 to 64 in Wales and from 20 to 65 in Northern Ireland) who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 40 and 80%, in a similar fashion to the clinical indicators.

Exception reporting (as detailed in the clinical section) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

CS 1.2 Written evidence

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had an a cervical smear performed in the last five years (Grade A). In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

CS 1.3 Assessment visit

The print-out should be inspected.

CS 1.4 Assessors' guidance

The assessors should enquire on how patients who are exception-reported are identified and recorded.

CS indicator 5

The practice has a system for informing all women of the results of cervical smears

CS 5.1 Practice guidance

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outwith the practice.

CS 5.2 Written evidence

There should be a description of system and example of letters sent to patients. (Grade C)

CS 5.3 Assessment visit

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

CS 5.4 Assessors' guidance

A letter sent to the patient containing and explaining the result is ideal.

CS indicator 6

The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every two years

CS 6.1 Practice guidance

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear-takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

CS 6.2 Written evidence

An audit of inadequate smears should be recorded. (Grade A)

CS 6.3 Assessment visit

A discussion with smear-takers should take place, dealing with the audit and any educational needs which arose and how these were met.

CS 6.4 Assessors' guidance

All the elements for an audit stated in the practice guidance need to be present.

CS indicator 7

The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates

CS 7.1 Practice guidance

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outwith the practice and should be in line with national guidance.

CS 7.2 Written evidence

There should be a written policy covering the issues outlined above. (Grade A)

CS 7.3 Assessment visit

The policy should be discussed with relevant staff and the practice should demonstrate how the systems operate.

CS 7.4 Assessors guidance

It may be necessary to ask the practice to demonstrate how its policy operates.

Child health surveillance (CHS)

CHS indicator 1

Child development checks are offered at intervals that are consistent with national guidelines and policy

CHS 1.1 Practice guidance

The child health surveillance programme should be based on national guidelines. It is important that the practice has a system to ensure follow-up of any identified problem and that referrals are made as appropriate.

CHS 1.2 Written evidence

There should be a description of the child health surveillance programme and how problems are followed up. (Grade C)

CHS 1.3 Assessment visit

The practice team is asked for details of child health surveillance in the practice and how problems are followed up.

CHS 1.4 Assessors' guidance

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure problems are followed up.

Maternity services

MAT Indicator 1

Antenatal care and screening are offered according to current local guidelines

MAT 1.1 Practice guidance

Most local areas have produced guidelines, which should be adopted within the practice.

MAT 1.2 Written evidence

There should be written guidelines on antenatal care and screening. (Grade A)

MAT 1.3 Assessment visit

The assessment should involve a description of antenatal care, using the illustration of one case.

MAT 1.4 Assessors' guidance

The case should show that the guidance is known and is being used.

Contraception (CON)

CON indicator 1

The team has a written policy for responding to requests for emergency contraception

CON 1.1 Practice guidance

The purpose of the policy is to ensure requests for emergency contraception are appropriately handled so that it can be offered within the effective time. Receptionists as well as clinicians will need to be aware of and act on the policy.

CON 1.2 Written evidence

There should be a written policy on responding to requests for emergency contraception. (Grade A)

CON 1.3 Assessment visit

The policy should be discussed.

CON 1.4 Assessors' guidance

The policy must allow emergency contraception to be given within the effective time.

CON indicator 2

The team has a policy for providing pre-conceptual advice

CON 2.1 Practice guidance

The policy should cover such areas as smoking, alcohol, diet, prophylactic folic acid, rubella status, any genetically inherited condition, substance abuse and any pre-existing medical condition.

CON 2.2 Written evidence

There should be a written policy for providing pre-conceptual advice. (Grade A)

CON 2.3 Assessment visit

The policy should be discussed.

CON 2.4 Assessors' guidance

All the elements contained in the practice guidance (2.1) should be present in the policy.

Annex 2: Summary of changes to QOF indicators for 2006/07 by domain and indicator set

Clinical domain

Indicator set	Prior to 31 March 2006	From 1 April 2006
Coronary heart disease	CHD 3	Smoking 1
	CHD 4	Smoking 2
Sub-set – Left ventricular dysfunction	LVD 1, 2 and 3	Replaced by Heart Failure indicator set
Stroke and TIA	STROKE 2	STROKE 11
	STROKE 3	Smoking 1
	STROKE 4	Smoking 2
	STROKE 9	STROKE 12
Hypertension	BP 2	Smoking 1
	BP 3	Smoking 2
Diabetes mellitus	DM 1	DM 19
	DM 3	Smoking 1
	DM 4	Smoking 2
	DM 6	DM 20
	DM 8	DM 21
	DM 14	DM 22
Chronic obstructive pulmonary disease	COPD 2	COPD 9
	COPD 3	COPD 9
	COPD 4	Smoking 1
	COPD 5	Smoking 2
	COPD 6	COPD 10
	COPD 7	COPD 11
	Epilepsy	EPILEPSY 1
EPILEPSY 2		EPILEPSY 6
EPILEPSY 3		EPILEPSY 7
EPILEPSY 4		EPILEPSY 8
Cancer	CANCER 2	CANCER 3

Indicator set	Prior to 31 March 2006	From 1 April 2006
Mental health	MH 1	MH 8
	MH 2	MH 19
	MH 3	withdrawn
		MH 6 (new indicator)
		MH 7 (new indicator)
Asthma	ASTHMA 2	ASTHMA 8
	ASTHMA 4	Smoking 1
	ASTHMA 5	Smoking 2
	ASTHMA 7	withdrawn
Dementia		DEM 1(new indicator)
		DEM 2 (new indicator)
Depression		DEP 1 (new indicator)
		DEP 2 (new indicator)
Chronic kidney disease		CKD 1 (new indicator)
		CKD 2 (new indicator)
		CKD 3 (new indicator)
		CKD 4 (new indicator)
Atrial fibrillation		AF 1 (new indicator)
		AF 2 (new indicator)
		AF 3 (new indicator)
Obesity		OBESITY 1 (new indicator)
Learning disabilities		LD 1 (new indicator)
Smoking		Smoking 1 (new indicator)
		Smoking 2 (new indicator)

Organisational domain

Indicator set	Prior to 31 March 2006	From 1 April 2006
Records and information	Records 1	withdrawn
	Records 2	withdrawn
	Records 4	withdrawn
	Records 5	withdrawn
	Records 6	withdrawn
	Records 7	withdrawn
	Records 10	withdrawn
	Records 12	withdrawn
	Records 14	withdrawn
	Records 16	withdrawn
		Records 20 (new indicator)
		Records 21 (new indicator)
		Records 22 (new indicator)
Information for patients	Information 1	withdrawn
	Information 2	withdrawn
	Information 6	withdrawn
	Information 8	withdrawn
Education and training	Education 2	Education 10
	Education 3	withdrawn
Medicines management	Medicines 1	withdrawn
	Medicines 5	Medicines 11
	Medicines 9	Medicines 12

Patient experience domain

Indicator set	Prior to 31 March 2006	From 1 April 2006
Patient experience	PE3	PE5
	PE4	PE6

Additional services

Indicator set	Prior to 31 March 2006	From 1 April 2006
Cervical screening	CS2	withdrawn
	CS3	withdrawn
	CS4	withdrawn
		CS7 (new indicator)

Annex 3: 2006/07 DES payments

2006/07 DES payments

	Payments per patient		
	Aspiration/ up front £	Reward/ year end £	Total £
Access			
Commitment and plan to deliver four elements	0.35		0.35
Commitment to PCAS	0.34		0.34
Survey results:			
Two working days		0.41	0.41
Advance booking		0.41	0.41
Telephone access		0.41	0.41
Practitioner of choice		0.14	0.14
Total	0.69	1.37	2.06
Practice based commissioning			
Agreement of practice plan	0.95		0.95
Delivery of plan		0.95	0.95
Total	0.95	0.95	1.90
Choice and booking			
Component 1: Agree to offer choice	0.24		0.24
Component 1: 60% survey satisfaction		0.24	0.24
Component 2: Agree to use of booking system	0.24		0.24
Component 2: CfH 90% referrals converted UBRN		0.24	0.24
Total	0.48	0.48	0.96
IT adoption			
Component 1: Agreement of plan	0.40		0.40
Component 2: Data accreditation		0.44	0.44
Component 3: Remaining practice requirements		0.27	0.27
Component 4: Migration to CfH accredited system		0.22	0.22
Total	0.40	0.93	1.33

Annex 4 – Specification for a directed enhanced service in England: access to primary care

Introduction

1. It is the Government's continuing priority to improve patient access to primary medical care in England.
2. PCTs will have a duty in 2006/07 to work with local practices (and other providers) to develop and implement plans to secure improvements in access. This directed enhanced service (DES) focuses on four key dimensions of access to general practice for patients:
 - (i) opportunity to consult a GP within two working days
 - (ii) opportunity to book appointments more than 48 hours in advance
 - (iii) ease of telephone access to the practice
 - (iv) opportunity to be seen by a practitioner of preference.
3. This specification is for 2006/07 and will be reviewed for 2007/08. The maximum investment for 2006/07 will be the value of 50 QOF points associated with access and the value of the 2005/06 access DES. This equates to £108 million for England.
4. Payments to participating general practices will comprise two components:
 - Component one: This will represent one third of the total investment available equivalent to £0.69 per registered patient. Half of this will be awarded to practices upon agreement of a written practice plan demonstrating how the practice will work towards delivery of access areas in respect of the first three dimensions – i.e. within two working days, advance booking and ease of telephone access. The other half will be awarded for upon receipt by the PCT of the practice's written commitment to continue participation in the monthly Primary Care Access Survey (PCAS). For 2006/07 the PCAS survey will be developed to include a number of improvements, including randomised survey date and third available appointment. If the practice does not subsequently participate in PCAS then the appropriate amount of the component one payment will be repayable by the practice.
 - Component two: This will be paid at the end of the year based on the results of a national patient experience survey which will be conducted in quarter four seeking feedback from patients on all four access dimensions. This will represent two thirds of the total investment available as shown below.
5. From 2007 onwards the focus will continue on improving access to general practice. However, this current DES will be reviewed in the light of experience, developing policies and the appropriateness of the award thresholds.

The survey

6. The Department of Health is developing a new national patient experience survey to help understand how well Government priorities in primary care are being implemented across England. Initially, this survey will focus on access to general practice and the offer of choice of secondary care provider (the subject of a separate enhanced service).
7. Currently, the QOF provides for a practice survey to be carried out that has a focus on patient access. The ultimate intention is to incorporate this survey into the national patient experience survey. However, given the timescale for 2006/07, the QOF patient questionnaire will remain in place for a further year.

Validation and payment

8. The budget for component two will be weighted as follows:

Target area	Weighting	Budget	£ per head
Two working days	30%	£21.6m	£0.41
Advance booking	30%	£21.6m	£0.41
Telephone access	30%	£21.6m	£0.41
Preferred GP	10%	£7.2m	£0.14

(N.B. £ per head based on total population of 52.5m)

9. The proposed threshold targets and associated rewards as a percentage of the above are attached in appendix A. These are based on a number of principles, including:
 - The financial reward for achieving the minimum satisfaction levels for each target recognises the up-front work which practices may need to undertake to start providing these levels of service.
 - The maximum reward of 100% for each target is payable at a satisfaction level below 100% to allow for the principle of continuous improvement in future years.

10. The minimum and higher satisfaction levels for reward payments are as follows:

	Minimum satisfaction level at which reward becomes payable	% of maximum possible reward payable for minimum satisfaction level	Satisfaction level at which 100% of reward becomes payable
Within two working days	50%	50	90%
Advance booking	40%	40	90%
Telephone access	30%	50	80%
Practitioner of choice	20%	40	80%

11. Appendix A (attached) provides details of the % financial reward payable to practices for patient satisfaction levels between the minimum and maximum.
12. Payments to practices will be based on practice list size in line with the £ per head figures shown above.
13. In line with the principle of continuous improvement agreed across other areas of the GMS contract, the above performance thresholds will be realigned annually to incentivise continued improvement year-on-year.
14. Payments will be made manually by PCOs based on the survey results as soon as they are received. For planning purposes, PCTs should note that this may be during the first quarter of the following financial year.

Annex 4, appendix A. Percentage of financial reward payable to practices

Satisfaction rate %	16	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	50	52	54	56	58	60
Two working days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	52.5	55.0	57.5	60.0	62.5
Advance booking	0	0	0	0	0	0	0	0	0	0	0	0	40	42.4	44.8	47.2	49.6	52.0	54.4	56.8	59.2	61.6	64.0
Telephone access	0	0	0	0	0	0	0	50	52	54	56	58	60	62	64	66	68	70	72	74	76	78	80
Preferred GP	0	0	40	42	44	46	48	50	52	54	56	58	60	62	64	66	68	70	72	74	76	78	80

Satisfaction rate %	62	64	66	68	70	72	74	76	78	80	82	84	86	88	90	92	94	96	98	100	
Two working days	65.0	67.5	70.0	72.5	75.0	77.5	80.0	82.5	85.0	87.5	90.0	92.5	95.0	97.5	100	100	100	100	100	100	100
Advance booking	66.4	68.8	71.2	73.6	76.0	78.4	80.8	83.2	85.6	88.0	90.4	92.8	95.2	97.6	100	100	100	100	100	100	100
Telephone access	82	84	86	88	90	92	94	96	98	100	100	100	100	100	100	100	100	100	100	100	100
Preferred GP	82	84	86	88	90	92	94	96	98	100	100	100	100	100	100	100	100	100	100	100	100

Annex 5 – Specification for a directed enhanced service in England: choice and booking

Introduction

1. It is the Government's priority for England to:
 - provide patients with an offer of **choice** when it has been decided they need a first consultant outpatient appointment; and
 - offer patients booked appointments in secondary care by delivering **booking** arrangements through the national Choose and Book system.
2. This one-year directed enhanced service (DES) for 2006/07 supports the drive to deliver this priority to patients. It is designed to provide an incentive to general practice to offer choices to patients who are referred for a first consultant outpatient appointment by a GP and also utilise the Choose and Book system available to practices. This DES will be reviewed for 2007/08.
3. The total investment available for this DES in 2006/07 is £50 million.

PCT duty

4. PCTs will have a duty in 2006/07 to make payments to practices at the end of the year in respect of this DES, providing that the results of a new patient experience questionnaire and/or the booking validation are sufficient to trigger an award. Payment for delivering booking arrangements will be triggered by the system at supra PCT level. Aspiration payments will be made as set out in paragraph 12.
5. For practices that close down, split, merge or start up in-year, it will be for the PCT to decide with that practice what awards will be made to them in respect of this DES.

Patient experience survey

6. The Department of Health is developing a new, national, patient experience survey to help understand how well Government priorities in the NHS are being implemented across England. Initially, this practice-level survey will focus on access to primary care and offer of choice of secondary care provider. The focus on access is set out in a separate DES for 2006/07. The plan is to develop questions that require yes/no answers. The GPC will be working with the Department of Health and NHS Employers on those questions.
7. Detailed information about the survey will be provided to practices and PCTs later. However, the plan is that existing systems will be deployed to facilitate

administration (including identification of the cohort of patients) and thus will be managed remotely from the practice. For those practices without access to the appropriate software or information technology, separate arrangements will be made. The cohort will include a statistically viable sample of all patients that are referred for an outpatient consultant-led appointment to assess and trigger payment for the offer of choice.

The award

8. The award will comprise two components for payment to practices: component one for delivering choice and component two for implementing and utilising the Choose and Book system. An award of component one is not dependent upon an award of component two and vice versa.

Component one

9. Component one is an award for offering choice to patients through an initial discussion between GP and patient about the range of clinically appropriate choice of providers available, and some clinical information to help patients make an informed decision. The scheme is underpinned by providing patients with information confirming the offer of choice e.g. providing patient booklet and where they can access further help such as through patient choice advisers employed by PCTs.
10. Practice responsibility to support choice – practices will be required to provide the following support for patients to make an informed choice of hospital/provider and utilise the Choose and Book system.
 - The patient’s referrer, normally their GP, should generate a shortlist of clinically appropriate provider choices.
 - The patient’s referrer, normally their GP, should initiate the choice offer and discuss the relevant clinical aspects of choice with the patient.
 - Practices should work with PCTs to support patients in discussing other aspects of choice.
 - Patients should have access to meaningful information in the practice to support their choice decision, including:
 - the patient information booklet tailored to PCT commissioned choices
 - the ‘At A Glance’ poster of commissioned choices for the top 15 referrer specialties (this is for GPs rather than patients)
 - where patients can access further information and local support, including advice from patient choice advisers, and an explanation of process
 - outpatient waiting time information for each commissioned specialty (PCTs have been instructed to provide practices with monthly outpatient waiting time information).
 - Practices should work with PCTs to quality assure the choice process from the patient perspective.

Component two

11. Component 2 of this DES is an award made in response to the practice's utilisation of the Choose and Book system for first consultant outpatient appointments. This will include bookings ie. converted unique booking reference numbers (UBRN) made in the GP surgery, by the appointments line, the internet, local booking services or via Indirectly Bookable Services (IBS). In the event of national system(s) failure, the commitment to award practices will still hold on a pro-rata basis.
12. Practice responsibility to support utilisation of the Choose and Book system:
 - The patient should leave the practice with a Choose and Book-generated appointment request (UBRN) and a patient password.
 - The patient should leave the practice with an appointment with their chosen provider or written information about what they do next to complete their choice and make a booking.
 - The practice should generate and attach a referral letter to an appointment request or auto generate a referral letter via a GP integrated system, e.g. EMIS, within agreed time limits. For cancer referrals (maximum two-week wait) or urgent referrals, this must be within one working day and for routine referrals normally three working days unless there are exceptional circumstances, e.g. delays for inclusion of any test/diagnostic results, or when information cannot be forwarded subsequently.

Validation and payment

13. Of the total investment available for this DES, 50% will be allocated to each of components one and two. Within each component, half of the funds will be available as an aspirational payment and half will be triggered through validated data.
14. **Component one.** 50% of the value of this DES will be paid to the practice if at least 60% of the patients, via the patient experience questionnaire, agree they were offered a choice of provider. Note that the requirement is for the patient to recall a choice conversation.
15. **Component two.** Data to indicate GP use of the Choose and Book system will be obtained from the system itself at supra practice level by Connecting for Health reports throughout the year for PCTs. Practices' utilisation will trigger payment on a sliding scale based on percentage of first consultant outpatient referrals made using the Choose and Book system by the practice in the period 1 September 2006 to 28 February 2007, i.e. UBRNs converted. This will be paid regardless of how the actual booking is made, e.g. via the internet etc.

% referrals (converted UBRN) as % of total	Proportions payment of component 2
%	%
50	60
60	70
70	80
80	90
90	100

Aspirational payments

16. For both components of this DES there will be a 50% aspirational payment available with the remainder to be paid on confirmation of successful achievement of the standard. At the end of the DES period, if practices fail to achieve the minimum level, PCOs should initiate arrangements for the managed repayment of the aspirational funding or, for a balancing mechanism, which offsets this repayment against other income due to practice.
17. For Choose and Book utilisation the aspirational payment will be provided on the basis that practices agree to implement and actually utilise the Choose and Book system for at least 25% of referrals to consultant outpatient appointments in June 2006.

System fall down

18. PCTs will make prompt payments to practices upon completion of each component, and the expectation is that by the end of this DES, practices will have received relevant funding for both components. If, by the end of 2006/07, a practice has not been able to implement a particular programme due to circumstances beyond its control (e.g. due to national or regional difficulties) the commitment to award payment to practices will still hold and the practice should receive a pro-rata payment for the work that they have completed. This payment is to be decided by the PCT.

Annex 6 – Specification for a directed enhanced service in England: towards practice based commissioning

1. In June 2004 the NHS Improvement Plan indicated, “from April 2005, GP practices that wish to do so will be given indicative commissioning budgets.” Guidance issued by the Department of Health in December 2004 set out the initial steps to deliver practice based commissioning, and reiterated the drivers for change resulting from system reform across the NHS, including:
 - **Choice** – the importance of patient choice as a driver for empowerment.
 - **Resources** – changes to the financial regime through Payment By Results offer opportunities for the development of alternative services. Where practices are able to provide or commission services locally, the funds will follow.
 - **Care of people with long-term conditions** – practices or localities will be able to direct funding into packages of care that best support patients with long-term conditions.
2. Practice based commissioning supports and enables primary care teams to assess health needs, plan services and secure delivery of care for patients within the practice. Through greater clinical freedom in primary care, it presents an opportunity to innovate and redesign care pathways and services in primary and community care settings as well as improve management of finite resources.
3. Many PCTs and practices have already been working together to develop practice based commissioning. PCTs are supporting this development by providing practices with referral information, activity and expenditure analysis to encourage stronger demand management and robust patient referral arrangements. In some parts of the country indicative budgets have been devolved to practices.
4. This specification outlines a scheme for engagement in practice based commissioning to encourage those practices that have either yet to engage in developing the initiative, or yet to finalise their plans to do so ahead of the Department of Health national target for universal coverage of 31 December 2006. The DES provides a set of incentives around the key areas that will be important to focus on initially. Where PCTs and practices agree additional workload for practices, additional resource to this DES should be made available. It complements guidance issued by the Department of Health in January 2006. It also encourages practice engagement through guaranteed resources where deficits in local health economy budgets make the prospect of savings even against reduced activity unavailable.
5. The incentive payments to participating general practices are for 2006/07 and will comprise two components:

- Component one: An early payment in response to the practice and the PCT agreeing a plan for the implementation of the practice based commissioning DES and specific objectives. For 2006/07 the total available for component one is 95p per patient. This payment is to cover the time needed by the practice to implement the plan.
- Component two: This will be paid at the end of the financial year providing the practice successfully meets the agreed objectives in the plan. This will be a minimum of 95p per patient.

PCT responsibility

6. This one-year DES directs PCTs to offer this enhanced service to all their general practices from April 2006. There are two components to the scheme. This specification sets out how PCTs will validate practices' activity in order to make the payments. Practices will only be eligible to earn component two of this scheme if component one is payable.
7. It is accepted that there will be similar or alternative schemes already in place and agreed between PCTs and practices that include funding to practices. Where this is the case, the level of funding outlined in this specification must be the minimum made available to all practices. Where the aims and preparatory funding criteria are met through an earlier scheme this DES will fund its provisions. Where such locally agreed funding exceeds that of this DES, then the higher level of funding should be honoured. In essence:
 - Practices will be entitled to the equivalent of component one of this DES when an acceptable plan has been agreed with the PCT. The payment in part one reflects the practice time involved in developing and implementing the DES practice plan.
 - Practices who deliver the agreed plan and its objectives will be entitled to either component two of this DES or other freed resource made against an agreed budget. Component two will not be available in addition to other freed resource that already exceeds the value of component two.
8. For support and guidance, appendix 1 includes a template for a practice plan.

Component one: planning and redesigning patient flows

9. Payment of this component is in recognition of the preparatory time and effort that the practice will need to invest to engage in and develop the practice's DES plan. It also includes funding to implement and monitor the DES plan throughout the year. For any activity above and beyond this DES plan, which the PCT and practice agrees, additional resources should be provided. The emphasis will be on the need for clinical time to be invested alongside non-clinical support time in managing this change. The plan will set out the practice's aims and how they link to the PCT's strategic plan, as well as details of the activity proposed and the practice time to effect change. Once agreed with the PCT, the practice will receive component one of this DES. The plan will provide the basis on which the PCT will monitor the practice's activity and delivery.

10. Practices can take up this DES at any time during 2006/07. Ideally this should be before the end of April 2006. The expectation is that practices' DES plans will be agreed and therefore component one payments awarded by the end of the first quarter 2006/07. Where this is not possible, for example because a new practice is set up mid-year or there is a delay by the PCT in providing relevant data to the practice, PCTs and practices will agree a date to finalise the DES plan as soon as possible.
11. PCTs should ensure that any new practices established mid-year are invited to take up this DES. Those practices will be entitled to a payment in respect of component one if they develop a plan within a timescale agreed with the PCT, as will they be entitled to component two (or freed-up resources) upon achievement of the agreed objectives. Where practices split, merge or close within the year, it will be for the PCT to decide whether and how a payment should be made.
12. The expectation is that PCTs will support their practices to develop their approach and plan in the following way:
 - The PCT will provide relevant information to practices about their use of health services and national/local priorities and commitments. Information to be provided is for local discussion and should include as a minimum:

Benchmarking data

- referral rates
- admission rates
- first outpatient appointment attendances
- follow-up rates

Activity and financial information for NHS and non-NHS activity

- elective data – inpatient and day case
- non-elective admissions, including length of stay
- first outpatient appointments and follow-up appointments
- use of diagnostic tests and procedures
- consultant to consultant referrals
- A&E attendances
- prescribing
- community and mental health services
- primary care, particularly essential and enhanced, GMS, PMS, APMS and PCTMS services
- attendances at other services such as walk-in centres.

Practices will also benefit from receiving information about the needs, demands and demographics of the local population.

Where practices believe these data to be inaccurate the PCT should work together with the practice to ensure an accurate data set is agreed.

- Clearly, there are aspects of care which are not suited to being included in the scheme. These include areas of low volume, high-cost treatments, which are usually commissioned through specialist regional groups and are not suitable for pathway redesign at practice level.
 - PCTs will need to make available a summary of strategic and local priorities which have been included in planning assumptions and which practices should be aware of in developing their plans. Some of the targets at PCT level may be sensibly quantified at practice level (for example, plans to reduce emergency admissions to hospital). PCTs may already be engaging practices in activities that can be reflected in the plans such as local service redesign priorities (e.g. orthopaedics bottle necks and practices' role in patch-wide solutions.) Other plans may include longer-term commissioning agreements, for example through the Independent Sector Treatment Programme.
 - Other locally agreed and financed arrangements, for activities such as data verification by practices, are not precluded by this DES.
13. Working with the information provided by their PCTs, practices will be able to produce a plan which should demonstrate a strong commitment to improving the quality of care for patients, including managing patients in primary care through improved or extended services, ensuring the most appropriate use of secondary care.
 14. The practice's plan will include information about how the practice based commissioning DES is to be implemented, including:
 - details of practice clinical engagement, including identifying a clinical lead, and proposed activity including clinical areas that will provide a focus for activity in the practice
 - proposed improvements to be made relating to reasonable and achievable objectives that are relevant to the practice's existing circumstances; achievement of these objectives will result in payment of component two (in the absence of an equivalent level of freed-up resources). The objectives might relate to, for example, redesigning care pathways, reducing the level of referrals made into secondary care, or a reduction in unplanned admissions. It will be for the practice and the PCT to agree the specific targets.
 15. Managing the level of acute referrals and admissions is dependent on redesign and/or development of services to support patients in the community. A key expectation within practice plans will therefore be the plan to manage care differently for patients with long-term conditions, in particular, in line with national and PCT commitments. For practices, this is likely to involve investment in primary and community services and engagement with the PCT, providers, and locality arrangements in planning and redesigning care pathways. Clinical engagement and participation in these discussions should therefore be reflected in plans.
 16. Practices will be expected to work with other relevant local stakeholders, especially community staff and social services in the development and implementation of their plans.

17. The practice may choose to work alone or with other practices and with support from the PCT in developing commissioning and service redesign arrangements and in producing a plan. However, commissioning and redesign plans must fit with the overall strategy and be approved by the PCT. Where there is a composite plan drawn up by more than one practice, each practice will still remain eligible for component one of this DES, as will they for component two (or freed-up resources).
18. The practice should expect PCT support on:
 - clinical reviews of appropriateness of provider activity, as well as emergency admissions, for example, to help identify where inappropriate activity takes place in relation to the national tariff, such as unnecessary A&E admissions
 - the delivery of national priorities such as patient choice, access and clinical targets, and reducing health inequalities as set out in *Choosing health*.

Component two: demonstrating success

19. GP practices, through practice based commissioning, will be able to improve the range of services delivered in the community and ensure that the right care is delivered to patients at the right time and in the right place.
20. For practices to be eligible for component two, they will need to have met the objectives agreed with the PCT, as identified in the practice plan.
21. Practices will be expected to invest component two in practice activity designed to ensure continued or improved achievement against the objectives agreed in the DES plan.
22. Payments for component two will not be available in addition to resources freed up from the practice based commissioning budget. Where these resources do not meet the minimum level set out in component two of this DES, the difference should be met by the PCT if agreed activity targets have been met. Component two is the minimum that the practice will receive.
23. In reaching agreement on objectives, the PCT and practice will need to ensure account is taken of local circumstances which may include, for example:
 - i. significant changes to practice populations
 - ii. changes which are reflected at national level (e.g. flu outbreaks)
 - iii. changes to coding or counting practice
 - iv. taking into account patient and public views
 - v. additional activity required to achieve improved waiting times as per national targets (e.g. 18-week target).

Annex 6, appendix A: Practice plan template

Practice plan template

1. Practice name and details and if joint plan with other practices.
2. Agreed scope of services covered by indicative budget. Description of specialties and nature of service (acute/elective) which practice is to redesign in order to improve services to patients and/or the nature of activity/planning to be undertaken by practice to achieve more appropriate hospital usage.
3. Method by which quality of the redesigned services will be assured/ demonstrated.
4. Agreed baseline of referrals and/or admissions by speciality for 2005/06.
5. Agreed threshold for meeting the objectives in this DES plan to trigger the award of component 2.
6. Agreed information and monitoring requirements by PCT and practice.

Annex 7 – Specification for a directed enhanced service in England: information management and technology

Introduction

1. This directed enhanced service (DES) is designed to facilitate information management and technology (IM&T) adoption to support the delivery of the National Programme for IT. It requires PCTs to pay practices specified, non-recurring payments following successful preparation for and adoption of information technology (IT) systems and processes. There will be variations in the timing of roll-out of these systems across the country. Therefore, timing of payments in respect of this DES will also vary across the country. In some cases, the implementation of an area of work might not take place until 2007 or later and PCTs will need to ensure, for budgetary purposes, that they plan for the likely local timescales of implementation.

Background

2. NHS Connecting for Health (CfH) is the agency delivering key Department of Health priorities in the National Programme for IT. It is tasked with providing new IT facilities for the NHS to improve patient care in all parts of the health service, by reducing risks, increasing efficiency and enabling more effective ways of working.
3. Among these new IT facilities are a number which will initially have significant impact, on the delivery of high-quality patient services by GPs and their practice teams, including:
 - i. Electronic Prescription Service (EPS)
 - ii. electronic transfer of GP records (GP2GP)
 - iii. Choose and Book
 - iv. the NHS Care Record Service.
4. Introducing these systems and services to GP practices will result in benefits and increased efficiencies within practice workflows and business processes. New processes and procedures will support the requirements of data quality, data protection and patient confidentiality, system failure recovery, and systems management. With time, as practices move to paper-light status¹, these processes and procedures will become increasingly vital to the security, stability and safety of clinical care. These changes will result in improved patient care and improved

¹ 'Paper-light' infers a practice that uses its computer system as the main place it records its patient records. Practices will not be dually recording that information on paper. They will be using the computer system contemporaneously in the consultation and recording their findings according to the standards set out in the Good Practice Guidelines and will be coding their data systematically against standards to be published.

practice efficiency and will enable practices to communicate electronic patient information with other parts of the NHS for the direct benefit of their patients and their practice organisation.

Aims

5. This DES will support practices to become properly equipped for the innovative new IT approaches to patient service delivery. This will include:
 - i. active implementation of the key national initiatives outlined above
 - ii. ensuring that all practice staff, clinical and non-clinical, receive adequate training to equip them to adopt new methods and systems; and that staff receive sufficient skills development to ensure that the practice can function effectively in the new IT-intensive environment that will prevail in primary care
 - iii. recognition of and resources for the successful installation and implementation of new technologies. Practices will benefit from increased efficiency once these programmes are embedded in the practice, but it is recognised that the initial installation and training has workload implications
 - iv. provision of adequate support to ensure smooth service delivery during installation of new systems and the practice's adaptation to new ways of working
 - v. accreditation of the quality of the electronic record keeping of practices which record their consultations in the surgery setting contemporaneously through their computer systems, otherwise termed paper-light.

Requirements

6. The timing of deployments of programmes across the country will vary depending on the state of readiness of practices and the development of the programmes in those localities. DES payments will reflect these variations and be made available when the deployment takes place.
7. The elements below are key to successful implementation of the overall programme and the DES provides practices with a contribution to supporting the costs of them:
 - i. protected time for team members to attend training tailored to their needs and ensure that the practice meets information governance, data quality and system operation standards. This does not include the direct costs of the facilitator staff provided by the PCT whose training is provided free by the NHS CfH contract Primis+
 - ii. protected time for new team members, especially clinical, to be inducted to meet the practice's information standards
 - iii. time for practice staff to undertake necessary additional work in order to ensure safe and effective implementation
 - iv. provision of additional clinical and non-clinical support to ensure efficient service when practices are learning how to use each new technology to best effect

- v. recognition of any adjustments to skill mix that may be required due to the higher technology environment.

Component one

8. Practices will be required to prepare a plan that demonstrates their commitment to the DES which should include:
 - i. nomination of a practice lead who will liaise with CfH
 - ii. nomination of a Caldicott Guardian
 - iii. a training needs assessment and linked training plan for each member of the practice team involved with the operation of IT systems
 - iv. evidence of compliance with good information governance practice, including clauses on confidentiality in contracts of employment, training, compliance with the Data Protection Act, Computer Misuse Act and Caldicott guardianship.
9. In addition, practices should:
 - i. maintain a log of training undertaken by each member of the practice team linked to his or her training needs assessment and personal development plan
 - ii. maintain a log of in-house training events undertaken, including induction of new staff, including locums and relief staff, and a signing-off process
 - iii. undertake appropriate training and demonstrate proficiency in information governance standards.
10. All practices are expected to be connected to the N3 network by the end of this DES. Practices are expected to enable the upgrade of the hardware estate to a nationally specified standard as set by CfH in consultation with the Joint GPC/RCGP IT Committee.
11. Every staff member who is to have access to the computer system must be authenticated and registered with a smart card and know how to use it. The practice must have a process in place for staff changeover with regard to the smart cards. This process will be supported by the PCT.

Component two – preparation of data for accreditation

12. Practices will be expected to work towards data accreditation in readiness to upload electronic patient summaries to the spine when appropriate. This includes electronic note summarisation. This accreditation will be for paper-light practices and will require a process of reviewable accreditation. The data standards required for this accreditation can be found in annex A. It is not envisaged that practices will be finally uploading data to the spine in 2006/7 other than in pilot practices. It is not intended that detailed discussions with patients about their spine data would occur under this DES.

Component three

13. Maintenance of patients' addresses with opportunistic regular validation with patients – the practice is the sensible location within the health service for

the patients' addresses to be maintained and validated for accuracy. This will require administrative effort and new workflows to ensure that address changes are processed accurately. It would be expected that practices will validate a patient's address and other relevant details at the point of referral and/or when a practice has received information about a patient that contains a conflicting address.

14. Electronic Prescription Service (EPS) – practices will prepare for the EPS programme, including accessing training, and identify changes in working practice and amend standard operating procedures. Practices will be required to utilise EPS Release 1 software. Patient information (via practice leaflets etc) on any local changes for prescription collection arrangements should be available. When available and permissible, EPS Release 2 software should be utilised.

Payment schedule

15. Component one: In order to receive an upfront, first component payment, practices will need to agree a practice plan with the PCT. This payment acknowledges the commitment and planning the practice will need to invest ahead of programme deployments, and the work required to fulfil all the elements in paragraphs 8 to 11 above. This component is worth 40p per registered patient.
16. Component two: Practices will receive a further payment following data accreditation, as set out in the standards in annex A. This component is worth 44p per registered patient.
17. Component three: Practices will receive a further payment for successful completion of the requirements set out in paragraphs 13 and 14 above. This component is worth 27p per registered patient.
18. Component four: Practices will receive a further payment following migration to a CfH accredited hosted system. This component is worth 22p per registered patient.
19. PCTs will make prompt payments to practices upon completion of each component. If a practice has not made reasonable efforts to complete the elements of a component it agreed with the PCT to do, the PCT may seek repayment of a proportion of the specific component payment relative to the amount of work done by the practice. If a practice has not been able to fully implement a component of this DES due to circumstances beyond its control (e.g. due to national or regional difficulties), the practice should receive a pro rata payment for the work that they have completed.

Validation

20. Connecting for Health will provide PCTs on a regular basis with electronic evidence of those practices that have successfully deployed each of the programmes. This will enable PCTs to make the specified payments to practices upon receipt of individual claims and supporting evidence from practices.

Annex 7, appendix A: Data standards for accreditation process

Data standards for accreditation process

The accreditation of practices is required by NHS Connecting for Health before patients' electronic summaries are uploaded to the spine.²

The demonstration of a workable and regularly updated summary of patients' records is required in order that another clinician can rapidly comprehend the clinical issues that are pertinent to the patient's clinical care. The summary should include repeat medications that are linked to the significant diagnoses/problems that are identified. Allergies and adverse reactions should be included.

Uploads will be taking place during the year 2007/08 of patients who are registered with accredited practices. This document outlines the accreditation standards and process.

The standards that are expected of practices are those already signed up to by the profession and outlined in detail within the Good Practice Guidelines.³

Practices will be expected to be part of the PRIMIS+ facilitated network or equivalent. PRIMIS+ facilitators will support practices with their education and training on data quality issues and information governance. This will help them in providing the evidence of audits required for the accreditation process.

Practices will be expected to demonstrate compliance with Good Practice Guidelines and the process that has been designed is to enable practices to demonstrate their abilities in the ways outlined overleaf.

² www.connectingforhealth.nhs.uk/crdb/docs/a_step_on_the_journey.doc

³ www.connectingforhealth.nhs.uk/publications/

Organisational

#	Standard	e-audit	submis- sion	visit
1	Practice is using the computer contemporaneously in consultation for all clinicians consulting regularly at the practice; or entries are made expeditiously – partial note-keeping on the computer is not an acceptable standard		✓	✓
2	There is a process in place to update patients' addresses opportunistically (in line with the DES) on the computer system		✓	✓
3	Locums and people who are unused to the system have a system to support their consultation and data entry		✓	✓
4	Evidence of recording of telephone consultations in the electronic record at an appropriate rate	✓		
5	Evidence of recording of visits in the electronic record at an appropriate rate	✓		
6	Referrals are coded and recorded at an appropriate rate, including to secondary care and to other agencies who are not part of the extended practice team, such as counsellors, physiotherapists, community psychiatric nurses	✓		

Information governance

#	Standard	e-audit	submis- sion	visit
7	The practice is registered under the Data Protection Act		✓	✓
8	The practice complies with laws on data access, including role-based access for all terminals, ensuring that no terminals are used by a staff member on another staff member's card		✓	✓
9	The practice has effective, validated data recovery processes		✓	✓
10	The practice has a nominated and trained Caldicott Guardian who performs the role appropriately		✓	✓
11	Alleged breaches of data security are investigated promptly and efficiently		✓	✓

Clinical data entry

#	Standard	e-audit	submis- sion	visit
12	Prevalence of specified significant, common disease diagnoses, relevant to the practice demographics, within two standard deviations of the mean or evidence to explain the variation	✓		
13	Prescriptions indicative of a major chronic diagnosis not present without an appropriate diagnostic code in the summary record	✓		
14	Problems/diagnoses classified as “significant” or “important” so that an accurate and complete summary can be created	✓		
15	The rate of recording of drug and other important allergies and adverse reactions, is within two standard deviations or a valid explanation given	✓		
16	Major diagnoses made by secondary care and other healthcare professional are recorded and prioritised if appropriate in the summary	✓		

Measurement of standards

There will be a three-part process of accreditation:

1. When a practice applies for accreditation it will submit a plan that includes the suggested letter in appendix 5 of good practice guidelines. It will submit evidence of protocols and audits in support of the standards described above.
2. A quantitative analysis of practice data will look at the following suggested areas⁴ to help identify practices whose recording is substandard.
3. A visit will be arranged by a team from the PCT to accredit the practice. The visit will do qualitative checks of a cross-section of notes from every clinician who consults on a regular basis. The team will also explore areas it has identified in the evidence submitted by the practice in its application.

Accreditation will normally last for three years but the team will be able to give a shorter time of approval if they feel that it is more appropriate due to the special circumstances within the practice.

⁴ Searches to be defined with PRIMIS+

Annex 8 – Excessive or inappropriate prescribing: guidance for health professionals on prescribing NHS medicines

Improving the quality, cost-effectiveness and affordability of prescribing in the context of the overall use of NHS resources is of benefit to patients.

The guidance provided here is designed to support those objectives and to guide all health professionals who prescribe and/or dispense NHS medicines, or who have responsibilities in practices, services, clinics etc. and in primary care organisations (PCOs) for promoting appropriate, effective and efficient prescribing.

Comments on this guidance and suggestions for amendment should be addressed to NHS Employers or the General Practitioners Committee (GPC) of the British Medical Association.

1. Introduction

- 1.1 The aim of this guidance is to outline and provide examples of what might be considered to be excessive or inappropriate prescribing.
- 1.2 It has been developed by NHS Employers and the GPC. It will be subject to subsequent discussion with the bodies representing the other professions who have or are being given prescribing rights through changes in legislation.
- 1.3 “Excessive prescribing” is defined within contractual regulations for GPs. GP practices can be in breach of their contract by “prescribing drugs, medicine or appliance whose cost or quantity, in relation to any patient, is, by reason of the character of the drug, medicine or appliance in question in excess of that which is reasonably necessary for the proper treatment of that patient (NHS General Medical Services Contracts Regulations 2004, Schedule 6, Part 6, Paragraph 46).
- 1.4 Any health professional believed to be prescribing excessively may be subject to challenge by their PCO and required to justify their prescribing behaviour. PCOs are authorised to manage excessive prescribing under paragraph 46 of Schedule 6 to The NHS (General Medical Services Contracts) Regulations 2004, Paragraph 44 of Schedule 5 to The NHS (Personal Medical Services Agreements) Regulations 2004 and Schedule 1, Part 4 of the Terms of Service of Pharmacists in the NHS (Pharmaceutical Services Regulations) 2005.
- 1.5 It is possible that potentially excessive prescribing will be identified in the first instance by the local PCO prescribing adviser. In the interests of developing good prescribing practice it is recommended that the initial approach to health professionals who are perceived to prescribe excessively should be by

way of education. Appropriate remedial action should be instituted if the practice agrees that such action is warranted.

- 1.6 In the absence of an agreed course of action, the PCO will need to consider whether there is sufficient evidence to demonstrate that the contractor's prescribing practice constitutes a breach of their contractual requirement (see paragraph 1.3 above). If there has been a breach of contract then the PCO will need to consider what action it wishes to take against the contractor. This might involve issuing a breach or remedial notice or invoking a contract sanction. If the contractor does not accept that they have breached their contract or that the PCO's action is appropriate it can challenge the PCO action by invoking the dispute resolution mechanism. The LMC may be involved as appropriate and must be involved where this is a requirement of the contract.

2. Principles

- 2.1 NHS cash for prescribing is part of the wider resource available for the care of patients.
- 2.2 Professional guidance on standards of practice states that it is the responsibility of every prescriber to make efficient uses of the resources available (e.g. GMC Good Medical Practice). The GMC advises doctors that they have a responsibility to consider the impact of their actions, such as prescribing, on resources available to other patients; it also states that doctors must not deliberately withhold appropriate treatment. Judgement of excessive or inappropriate prescribing by any health professional will need to reflect the balance between these duties.
- 2.3 As a guiding principle it is appropriate to prescribe the most cost effective medication for a patient. It follows that switching patients to less expensive drugs usually within a therapeutic class is generally appropriate where there is no contra-indication and where there is evidence of equal or greater efficacy. This may release cash within the system that can be invested in additional and different care for patients. Patients should be informed of the rationale for these changes, for example via patient information handouts.
- 2.4 Switching significant numbers of patients' drugs within a therapeutic class (e.g. either by changing to brand or by changing the drug) should only be undertaken where the predicted NHS savings is expected to be sustained and provided there is no clinical disadvantage for the patient.
- 2.5 There may be occasions where switching patients may be clinically inappropriate e.g. in line with BNF or MHRA guidance certain drugs should be prescribed by brand to ensure continuity with regard to bio-availability.
- 2.6 It is appropriate that doctors and health professionals have the clinical freedom to switch individual patients to higher priced drugs (branded or otherwise), or to alternative drugs, for clinical reasons.

3. Due process

- 3.1 PCOs are recommended to demonstrate due process e.g. that the development of prescribing incentive or improvement schemes are supported by appropriate processes involving local clinicians, and that the process of developing and implementing such schemes is evidence-based and appropriately documented. Where practices are expected by PCOs to change prescribing practice to improve the quality and/or cost-effectiveness of prescribing, or to make prescribing budget savings, PCOs are recommended that information about the rationale behind such prescribing changes should usually be available for patients, e.g. from the PCO prescribing advisory group.
- 3.2 Similarly, prescribers and dispensers should also demonstrate due process e.g. it is reasonable and appropriate for health professionals to exercise wise buying in the purchase of drugs from wholesalers and manufacturers. This acts as a driver for manufacturers and suppliers to reduce prices which in turn reduces the NHS drugs bill via the discount claw-back systems that apply to dispensing doctors and community pharmacy.
- 3.3 However, other than as outlined in 3.2, substantial sponsorship or financial deals that could reasonably be perceived to affect the choice of treatment in a way that is financially beneficial to the prescriber but significantly increases NHS costs, other than where there is clear evidence of clinical benefit to patients, should be recorded in a register of “Gifts and Hospitality”.

4. Examples that may be judged to indicate excessive prescribing

- 4.1 The following examples illustrate behaviours that may be judged to indicate excessive or inappropriate prescribing, particularly where this has been done for a significant proportion of patients and/or in a systematic manner by health professionals or their staff:
 - prescriptions where the drug is initiated or switched, e.g. within a therapeutic class/indication, with the effect that reimbursement is based on a product that provides a larger purchase margin for the prescriber(s) and the product(s) selected cost the NHS more, unless there is good clinical evidence to support the switch or the exceptions noted in paragraphs 2.5 or 2.6 apply
 - prescribing that is varied according to the impact on reimbursement to the practice, e.g. differences between patients to whom the practice directly supplies medicines (including personally administered drugs and through NHS dispensing) and those to whom they supply prescriptions for dispensing elsewhere, and where the prescriber(s) is/are unable to provide a reasonable explanation
 - profligate prescribing may be considered to exist where the prescriber(s) consistently prescribes excessive amounts of high-cost products or inappropriate, high quantities of medicines that are significantly at

- variance with comparable clinical scenarios and where the prescriber(s) is/are unable to provide a reasonable explanation
- it may also be appropriate for a PCO to investigate a prescriber that consistently significantly under-prescribes where there is evidence to suggest that there is a failure to adhere to good clinical prescribing practice.

Annex 9: Managed lists

It is recognised that in certain circumstances there are difficulties in managing practice lists. In an attempt to offer a practical and transparent solution to patients, practices and PCOs the following advice is offered. This advice is provided in the context of promoting constructive working relationships between practices and their PCOs.

In the situation that a practice is unable routinely to accept new patients (beyond immediate family members of existing patients) a discussion between the practice and the PCO should take place to allow the situation to be explored. The PCO is expected to work constructively with the practice to try to jointly achieve resolution. This could take the form of, for example, additional support given by the PCO to the practice. In some situations, practices may wish to use the closed list procedure.

It is recognised that GMS contractors retain their freedom within the contract not to register new patients, provided they have reasonable, non-discriminatory grounds for doing so in each case.

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