

2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF)

Guidance for GMS contract 2019/20 in England

April 2019



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Publishing Approval Reference:

000339

Document Purpose	Resources
Document Name	2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2019/20 in England
Author	NHS England
Publication Date	29 March 2019
Target Audience	NHS England Regional Directors, NHS England Directors of Commissioning Operations, GPs
Additional Circulation List	CCG Clinical Leaders, CCG Accountable Officers, Communications Leads
Description	The aim of this document is to provide additional guidance on the interpretation and verification of the QOF indicators for 2019/20 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE) . It is effective from 1 April 2019 and replaces versions issued in previous years.
Cross Reference	NA
Superseded Docs (if applicable)	NA
Action Required	NA
Timing / Deadlines (if applicable)	NA
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Document Status

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Section 1: Introduction

Background

The Quality and Outcomes Framework (QOF) is a voluntary scheme within the General Medical Services (GMS) contract. It aims to support contractors to deliver good quality care. Changes to QOF are agreed as part of wider changes to the GMS contract which are negotiated by NHS England and the British Medical Association's (BMA) General Practitioners Committee (GPC) England.

In January 2019, NHS England agreed a new five-year framework for GP contract reform to implement *The NHS Long Term Plan*¹. This included a number of improvements to QOF in line with the recommendations of the QOF Review (published in July 2018)².

Summary of changes for 2019/20

A number of changes have been agreed for 2019/20 in order to begin to implement the recommendations of the Report of the QOF Review². These include:

- The **retirement of 28 indicators** (worth 175 points) which are either no longer in line with NICE guidance, have known measurement issues (usually because of low numbers at a practice level) or where the care described is now viewed as a core professional responsibility.
- The **introduction of 15 new indicators** (worth 101 points) to bring QOF into closer alignment with NICE guidance and Screening Committee recommendations, mainly on diabetes, blood pressure control and cervical screening. The rationale and changes to requirements are detailed in the appropriate clinical domain in Sections 3 and 4 of this document.
- Exception reporting has been replaced with a **Personalised Care Adjustment**. This will better reflect individual clinical situations and patients' wishes. There is a detailed explanation of the criteria for this and the associated recording requirements in Section 6.
- The introduction of a new **QOF Quality Improvement (QI) domain** (worth 74 points). The first two modules will be prescribing safety and end-of-life care. These topics are anticipated to change on annual basis. The changes are explained in Section 5.

The size of QOF remains unchanged at 559 points. The value of a QOF point in 2019/20 will be £187.74 and the national average practice population figure will be 8,479. There are no changes to payment thresholds for indicators carried forward from 2018/19.

¹ <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2018/07/05-a-i-pb-04-07-2018-qof-report.pdf>

Purpose of this document

The aim of this document is to provide additional guidance on the interpretation and verification of the QOF indicators for 2019/20 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE)³. It is effective from 1 April 2019 and replaces versions issued in previous years.

This document covers:

- Section 2: the list of QOF indicators as detailed in Annex D of the SFE Directions
- Section 3: specific information about each clinical indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement.
- Section 4: specific information about each public health indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement
- Section 5: detailed information about the requirements of contracts in relation to the quality improvement domain
- Section 6: detailed information about the new Personalised Care Adjustment
- Section 7: a full list of indicators which are no longer in QOF but are subject to ongoing data collection
- Section 8: the process for raising queries in relation to QOF indicators and their interpretation
- Section 9: glossary of acronyms
- Section 10: summary of clinical and public health indicator changes for 2019/20

It should be read in conjunction with the SFE Directions and Business Rules.

Definition of ‘commissioner’

The NHS Commissioning Board (NHS CB) is the organisation legally responsible for the commissioning of primary care in England, which operates under the name NHS England. NHS England is used throughout this guidance, except where it is necessary to use NHS CB to reflect the SFE Directions. Following the implementation of co-commissioning arrangements references to ‘commissioners’ in this document could refer to NHS England or a clinical commissioning group (CCG).

³ <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Additional Indicator information

Full descriptions of each indicator, its rationale for inclusion and any specific criteria for reporting and verification are detailed in Sections 3, 4 and 5.

Clinical and public health indicators

Clinical and public health indicators are organised by disease or intervention categories. These indicators have been selected as they represent care where:

- The responsibility for ongoing management rests principally with the contractor and the primary care team
- There is good evidence of the health benefits likely to result from improved primary care

A summary of the indicators for each disease/ intervention category is provided at the beginning of each disease/ intervention section. The rationale section for each indicator may link to relevant guidelines for further information. This will be to the guideline which was used to underpin indicator development.

Indicator numbering

Indicators are prefixed with an abbreviation of the category to which they belong. For example, coronary heart disease indicator one is identified as CHD001. Indicator IDs are unique to each indicator and are not reused. New indicators will be given the next available unused number. Therefore, this may not flow sequentially from the existing indicator IDs. Similarly, where there has been a change to indicator wording, activity timescales or significant changes to coding or the data extraction logic these indicators will be given a new unique ID. This is to ensure that indicators are not inappropriately compared to those in previous years and to avoid any confusion which could arise from re-using ID numbers.

Where an indicator has been developed through the NICE led process⁴ they will also be annotated with their NICE menu ID number (NICE [year] menu ID: NMXX). If a NICE developed indicator has been amended during negotiations this will be annotated with 'based on NICE [year] menu ID: NMXX'.

Identifying the target population or disease register

Clinical indicators all have a defined target population. This may be defined within a register indicator or as part of the business rules. This target population will be identified either by the presence of predetermined clinical diagnosis codes in the patient record or by using other attributes of the patient such as age and sex. For example, the target population for cervical screening is constructed using age and sex to determine inclusion in the denominator for each indicator. Where the target population is identified using clinical codes the contractor is responsible for demonstrating that it has systems in place to maintain a high quality, accurate register. This may be verified by the commissioner and contractors may be asked to explain reasons for variation from expected prevalence levels. Contractors are reminded that QOF registers must not be used as the sole input for the purposes of

⁴ <https://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/QOF-Advisory-Committee/QOF-indicators-process-guide.pdf>

patient care and clinical audit. There may be patients for whom a treatment or activity is clinically appropriate but they may not meet the criteria as defined by the QOF register. Contractors are reminded of this when developing their call/recall systems.

Patients with co-morbidities will be included in all relevant target populations and registers where they meet the defined criteria. Where a patient is in more than one target population then they are eligible for the interventions outlined in all the relevant disease areas.

Some indicators refer to a sub-set of patients in the target population or register. Patients who are not included in an indicator denominator for definitional reasons are classified as 'exclusions' and are automatically identified through the business rules and removed from the denominator.

Patients are eligible for the interventions outlined in QOF indicators as soon as they are fully registered with the contractor or a relevant diagnosis is recorded.

Quality improvement indicators

Section 5 provides detailed guidance on the interpretation of the quality improvement indicators and the aims and objectives which their quality improvement plans should be seeking to address.

Reporting, payment calculation and verification

Reporting

Reporting requirements and the rules for the calculation of QOF points and their payment are set out in the SFE. For most indicators anonymised data will be collected automatically from GP clinical systems by the General Practice Extraction Service (GPES) and reported to Calculating Quality Reporting Service (CQRS).

The clinical codes and logical extraction sequence used in this data collection is defined in a series of technical documents – the Business Rules. These are based entirely on SNOMED codes (Read version 2 and Clinical Terms Version 3 (CTV3) were used in QOF up to and including 2017/18) and associated dates. SNOMED codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting.

The Business Rules are updated twice yearly around April and October and are available on the NHS Digital website⁵.

For indicators where achievement is not automatically collected this should be self-declared through the CQRS web-based server. Commissioners may request the evidence underpinning this self-declaration as part of their verification processes.

⁵ NHS Digital. <http://content.digital.nhs.uk/qofesextractspecs>

Payment calculation and achievement

CQRS will calculate achievement and payments for QOF as set out in the SFE and report to commissioners and practices. Whilst full details of the achievement calculations are detailed in the SFE, the following key points are useful to note:

- Achievement is measured on the last day of the financial year i.e. 31 March in respect of patients registered with the practice on that date. Whilst estimates of achievement may be made through the year these may not accurately predict final performance.
- The time-period referred to in an indicator is calculated by counting back from the last day of the financial year. Time periods vary between indicators
- The phrase 'currently treated' should be interpreted as a prescription for the specified medication being given in the six months preceding the last day of the financial year i.e. between 1 October and 31 March
- Some indicators require the intervention to be offered to patients when they reach a defined age or within a specified time before and/or after diagnosis. Care recorded outside of these time periods will not be recognised in the QOF achievement calculation.

There are specific provisions within the SFE which describe the calculations to be made where a contract comes to an end before the last day of the financial year.

Verification

The contractor must ensure that it is able to provide any information that the NHS CB or commissioner may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled. The contractor must make that information available to the commissioner on request. In verifying that an indicator has been achieved and information correctly recorded, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.

Commissioners and practices will be aware of the requirements of access to patient identifiable data. Where patients have expressed a desire that their information is not shared for this purpose, practices will need to advise the commissioner and make an appropriate note in the record.

Commissioners and practices will be aware of the need to:

- obtain the minimum necessary information for the specific purpose
- anonymise data where possible

It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trail is in place to fulfil the obligations of the practice towards their patients and that of commissioners to practices.

The terms 'notes' and 'patient record' are used to indicate either electronic or paper patient records.

Disputes

When a QOF related contractual dispute arises, the commissioner and the contractor, would be expected to make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute without the need to refer it for formal determination by NHS Resolution (Primary Care Appeals) (or in certain cases, the courts). Further information is available in the SFE.

Section 2: Summary of all indicators⁶

Section 2.1: Clinical domain (379 points)

Section 2.1. applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA ₂ DS ₂ -VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS ₂ or CHA ₂ DS ₂ -VASc score of 2 or more) <i>NICE 2014 menu ID: NM81</i>	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA ₂ DS ₂ -VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy <i>NICE 2014 menu ID: NM82</i>	12	40-70%

For AF007, patients with a previous score of 2 or above using CHADS₂, recorded prior to 1 April 2015 will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	

⁶ The 'summary of indicators' section is an extract from Annex D of the SFE.

Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken <i>NICE 2015 menu ID: NM88</i>	7	56–96%
CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM87</i>	7	56–96%
CHD008. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2013 menu ID: NM68</i>	12	40–77%
CHD009. The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>Based on NICE 2015 menu ID: NM86</i>	5	46–86%

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register <i>NICE 2015 menu ID: NM116</i>	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB <i>NICE 2015 menu ID: NM89</i>	10	60–100%
HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure <i>NICE 2015 menu ID: NM90</i>	9	40–65%

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

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

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

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP003. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2012 menu ID: NM53</i>	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>NICE 2012 menu ID: NM54</i>	5	40-80%

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease <i>NICE 2011 menu ID: NM32</i>	2	

Stroke and transient ischaemic attack (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	
Ongoing management		

STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken <i>NICE 2015 menu ID: NM94</i>	4	57–97%
STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM140</i>	2	55–95%
STIA010. The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2013 menu ID: NM69</i>	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>Based on NICE 2015 menu ID: NM93</i>	2	46-86%

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed <i>NICE 2011 menu ID: NM41</i>	6	
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) <i>NICE 2015 menu ID: NM95</i>	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months <i>NICE 2010 menu ID: NM13</i>	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register <i>NICE 2011 menu ID: NM27</i>	11	40–90%

DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM139</i>	3	55–95%
DM019. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less <i>NICE 2018 menu ID: NM159</i>	10	38-78%
DM020. The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months <i>NICE 2018 menu ID: NM157</i>	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months <i>NICE 2018 menu ID: NM158</i>	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) <i>NICE 2018 menu ID: NM162</i>	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin <i>NICE 2018 menu ID: NM163</i>	2	50-90%

Asthma (AST)

Indicator	Points	Achievement thresholds
Records		
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
Initial diagnosis		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis <i>NICE 2015 menu ID: NM101</i>	15	45–80%
Ongoing management		

AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions <i>NICE 2011 menu ID: NM23</i>	20	45–70%
AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months <i>NICE 2015 menu ID: NM102</i>	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD001. The contractor establishes and maintains a register of patients with COPD	3	
Initial diagnosis		
COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register <i>NICE 2015 menu ID: NM103</i>	5	45–80%
Ongoing management		
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months <i>NICE 2015 menu ID: NM104</i>	9	50–90%
COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM106</i>	6	57-97%
COPD008. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) <i>NICE 2012 menu ID: NM47</i>	2	40-90%

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months <i>NICE 2015 menu ID: NM107</i>	39	35–70%

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial management		
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis <i>Based on NICE 2012 menu ID: NM50</i>	10	45–80%

Disease register for depression

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

Mental health (MH)

Indicator	Points	Achievement thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate <i>NICE 2015 menu ID: NM108</i>	6	40–90%

MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months <i>NICE 2010 menu ID: NM17</i>	4	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months <i>NICE 2010 menu ID: NM16</i>	4	50-90%

Disease register for mental health

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

Remission from serious mental illness

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

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

Where a patient is recorded as being ‘in remission’ they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for indicators MH002, MH003, and MH006.

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

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

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

Cancer (CAN)

Indicator	Points	Achievement thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	
Ongoing management		
CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis <i>Based on NICE 2012 menu ID: NM62</i>	6	50–90%

Chronic kidney disease (CKD)

Indicator	Points	Achievement thresholds
Records		
CKD005. The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5) <i>NICE 2014 menu ID: NM83</i>	6	

Epilepsy (EP)

Indicator	Points	Achievement thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	

Learning disability (LD)

Indicator	Points	Achievement thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities <i>NICE 2013 menu ID: NM73</i>	4	

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis <i>NICE 2011 menu ID: NM29</i>	3	

Disease register for osteoporosis

Although the register indicator OST004 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis <i>NICE 2012 menu ID: NM55</i>	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months <i>NICE 2012 menu ID: NM58</i>	5	40–90%

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	

Disease register for palliative care

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

Section 2.2: Public health domain

Section 2.2.1: Public health domain (106 points)

Section 2.2.1. applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins	10	40–90%

Disease register for CVD-PP

The disease register for the purpose of calculating the APDF for the CVD-PP indicator is defined as "patients diagnosed in the preceding 12 months with a first episode of hypertension, excluding patients with the following conditions:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes
- CKD with classification of categories G3a to G5.

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years <i>NICE 2012 menu ID: NM61</i>	15	50–90%

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months	8	

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months <i>NICE 2011 menu ID: NM38</i>	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months <i>Based on NICE 2011 menu ID: NM40</i>	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months <i>NICE 2011 menu ID: NM39</i>	25	56–96%

Disease register for smoking

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

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

Smokers

For patients who smoke this recording should be made in the preceding 12 months for SMOK002.

Non-smokers

It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 12 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

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

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

Ex-smokers

Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

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

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

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS005. The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months <i>NICE 2017 menu ID: NM154</i>	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

Section 2.3: Quality improvement domain (74 points)

Section 2.3 applies to all contractors participating in QOF.

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

End of Life Care

Indicator	Points	Achievement thresholds
QI003. The contractor can demonstrate continuous quality improvement activity focused upon end of life care as specified in the QOF guidance	27	NA
QI004. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

Section 3: Clinical domain

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA ₂ DS ₂ -VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS ₂ or CHA ₂ DS ₂ -VASc score of 2 or more) <i>NICE 2014 menu ID: NM81</i>	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA ₂ DS ₂ -VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy <i>NICE 2014 menu ID: NM82</i>	12	40-70%

AF – rationale for inclusion of indicator set

AF is the most common sustained cardiac arrhythmia. Men are more commonly affected than women and the prevalence increases with age with prevalence in those over 65 years 7.2 per cent and over 75 years ten per cent⁷.

In people who have had a stroke, concurrent AF is associated with a higher rate of mortality, greater disability, a longer stay in hospital and a lower rate of discharge home⁸.

AF indicator 001

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

AF001.1 Rationale

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

AF 001.2 Reporting and verification

See indicator wording for requirement criteria.

⁷ NICE CG180. AF: management. 2014. <http://www.nice.org.uk/Guidance/CG180>

⁸ Lin HJ, Wolf PA, Helly-Hayes M et al 1996. Stroke severity in atrial fibrillation. The Framingham Study.

Where a patient has been diagnosed with AF and been subsequently successfully treated, if there is an 'AF resolved code' present in their record after the latest AF recording, they will be removed from the register.

AF may resolve in some specific and limited situations. Contractors should also note that patients who have been recorded with AF resolved, continue to be at an increased risk of stroke compared to patients who have never had an episode of AF⁹. Contractors should consider the implications of this for individual patients before using the AF resolved code.

AF indicator 006 (NICE 2014 menu ID: NM81)

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA₂DS₂-VAS_c score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS₂ or CHA₂DS₂-VAS_c score of 2 or more)

AF 006.1 Rationale

The NICE guideline on atrial fibrillation¹⁰ recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter and/or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA₂DS₂-VAS_c risk assessment tool.

The CHA₂DS₂-VAS_c is a refinement of CHADS₂. The revised CHA₂DS₂-VAS_c system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or TIA, or age ≥75 which scores double, hence the '2'):

- C: congestive HF (one point)
- H: hypertension (one point)
- A₂: age 75 or over (two points)
- D: diabetes mellitus (one point)
- S₂: previous stroke or TIA or thromboembolism (two points)
- V: vascular disease (e.g. PAD, MI, aortic plaque) (one point)
- A: age 65-74 years (one point)
- Sc: sex category (i.e. female sex) (one point)

AF 006.2 Reporting and verification

⁹ Adderley et al. risk of stroke and transient ischaemic attack in patients with a diagnosis of resolved atrial fibrillation: retrospective cohort studies. BMJ 2018;360:k1717
<http://dx.doi.org/10.1136/bmj.k1717>

¹⁰ NICE CG180 Atrial fibrillation (2014) <https://www.nice.org.uk/guidance/cg180>

See indicator wording for requirement criteria.

Stroke risk assessment should be repeated on an annual basis unless the patient has previously scored 2 or more using either CHA₂DS₂-VAS_c at any time, or CHADS₂ prior to 1 April 2015.

AF indicator 007 (NICE 2015 menu ID: NM82)

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

AF 007.1 Rationale

This indicator aims to support the identification of people with AF who are at increased risk of stroke so that they may be offered anti-coagulation drug therapy.

Around 980,000 people in England are known to be at risk of stroke from AF¹¹, though it is estimated an additional 440,000 may be at-risk¹². Of these, around three-quarters are taking anti-coagulants in primary care.

However, around 60 per cent of people admitted to a hospital with a stroke with preceding AF are not taking the recommended anti-coagulant medication¹³. NICE estimates that with effective detection and protection with anti-coagulant drugs, 7,000 strokes and 2,000 premature deaths could be avoided each year¹⁴.

All patients with AF and a CHA₂DS₂-VAS_c score of two or above should be offered anti-coagulation therapy taking their bleeding risk into account. A CHA₂DS₂-VAS_c score of one in women (women under age 65 with no other risk factors) should be regarded as low risk and should not receive anti-coagulation. Men with a CHA₂DS₂-VAS_c score of one should be regarded as at intermediate risk and a group in whom anti-coagulation should be considered.

Anti-coagulation may be with apixaban, dabigatran etexilate, rivaroxaban, edoxaban or a vitamin K antagonist. Practices should not offer aspirin monotherapy solely for stroke prevention to people with AF. Aspirin is not as effective as anti-coagulants at preventing stroke in people with AF who are at increased risk of stroke and is also not as safe in terms of causing bleeding. Although the risks of anti-coagulation also increase with age, the evidence also shows that its benefits outweigh the risks in the vast majority of people with AF.

NICE provide a patient decision aid¹⁵ to support discussions with patients as to the risks and benefits of taking anticoagulants.

¹¹ NHS Digital. QOF 2015/16. <http://digital.nhs.uk/catalogue/PUB22266>

¹² National Cardiovascular Intelligence Network. 2015. AF prevalence estimates for local populations. <https://www.gov.uk/government/publications/atrial-fibrillation-prevalence-estimates-for-local-populations>

¹³ Royal College of Physicians. Sentinel Stroke National Audit Programme (SSNAP). 2016. <https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx>

¹⁴ Total avoidable strokes/deaths if NICE CG implemented in full. Statement by Prof Mark Baker. June 2014. <http://www.nice.org.uk/News/Article/thousands-of-strokes-and-deaths-preventable-from-silent-killer>

¹⁵ NICE. Patient decision aid. June 2014. <https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797>

AF 007.2 Reporting and verification

See indicator wording for requirement criteria.

The Business Rules will look for the latest CHA₂DS₂-VAS_c score in the patient record and if the score is equal to, or greater than two, the patient will be included in the denominator. If the patient does not have a CHA₂DS₂-VAS_c score, but does have a CHADS₂ score of greater than, or equal to two recorded before 1 April 2015, they will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken <i>NICE 2015 menu ID: NM88</i>	7	56–96%
CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM87</i>	7	56–96%
CHD008. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2013 menu ID: NM68</i>	12	40-77%
CHD009. The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>Based on NICE 2009 menu ID: NM86</i>	5	46-86%

CHD – rationale for inclusion of indicator set

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

CHD indicator 001 (NICE 2015 menu ID: NM86)

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

CHD 001.1 Rationale

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

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

CHD 001.2 Reporting and verification

See indicator wording for requirement criteria.

CHD indicator 005 (NICE 2015 menu ID: NM88)

The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken

CHD 005.1 Rationale

NICE guidelines^{16, 17} recommend aspirin (75–150 mg per day) is given routinely and continued for life in all patients with CHD unless there is a contra-indication. Clopidogrel (75 mg/day) is an effective alternative in patients with contra-indications to aspirin, or who are intolerant of aspirin.

CHD 005.2 Reporting and verification

See indicator wording for requirement criteria.

CHD indicator 007 (NICE 2015 menu ID: NM87)

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

CHD 007.1 Rationale

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

Further information - PHE. Influenza.

<https://www.gov.uk/government/collections/annual-flu-programme>

CHD 007.2 Reporting and verification

See indicator wording for requirement criteria.

CHD indicator 008 (NICE 2013 menu ID: NM68)

The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less

CHD 008.1 Rationale

¹⁶ NICE CG172 MI: cardiac rehabilitation and prevention of further MI (2013)

<http://guidance.nice.org.uk/CG172>

¹⁷ NICE CG126 Stable angina (2011) <http://www.nice.org.uk/guidance/CG126>

This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with CHD. The aim is to promote secondary prevention of cardiovascular disease through satisfactory blood pressure control. This may be achieved through lifestyle advice or drug therapy.

CHD008.2 Reporting and verification

See indicator wording for requirement criteria

CHD indicator 009 (based on NICE 2015 menu ID: NM86)

The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

CHD 009.1 Rationale

This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with coronary heart disease as recommended by the NICE clinical guideline for hypertension (NICE clinical guideline 127).

CHD009.2 Reporting and verification

See indicator wording for requirement criteria.

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register <i>NICE 2015 menu ID: NM116</i>	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB <i>NICE 2015 menu ID: NM89</i>	10	60–100%
HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic	9	40–65%

dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure <i>NICE 2015 menu ID: NM90</i>		
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HF – rationale for inclusion of indicator set

HF represents the only major cardiovascular disease with increasing prevalence and carries a poor prognosis for patients. This indicator set refers to all patients with HF unless specified otherwise.

HF indicator 001

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

HF 001.1 Rationale

All patients with a diagnosis of HF, are included on the register.

HF 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

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

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

HF indicator 002 (NICE 2015 menu ID: NM116)

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

HF 002.1 Rationale

This indicator requires that all patients with suspected HF have further specialist investigation (such as echocardiography) or specialist assessment. Specialists may include GPs identified by NHS England as having a special interest in HF. Many HF patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintigraphy or angiography rather than echocardiography.

NICE guidance^{18, 19} recommends using N-terminal pro-B-type natriuretic peptide (NT-proBNP) measurement to guide the urgency of referral for echocardiogram and specialist assessment. Patients with suspected HF who have very high levels of NT-

¹⁸ NICE NG106. Chronic heart failure in adults. 2018. <https://www.nice.org.uk/guidance/ng106>

¹⁹ NICE QS9. Chronic heart failure in adults. 2011, updated 2018. <http://www.nice.org.uk/guidance/qs9>

pro-BNP require urgent referral for specialist assessment and transthoracic echocardiography (within 2 weeks) due to their poor prognosis.

HF 002.2 Reporting and verification

See indicator wording for requirement criteria. For measurement purposes, three months before the date of diagnosis is defined as 93 days.

HF indicator 003 (NICE 2015 menu ID: NM89)

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

HF 003.1 Rationale

There is strong clinical and cost-effectiveness evidence to support the use of ACE-I in all patients with HF with LVSD. ACE-I improve symptoms, reduce the hospitalisation rate and improve the survival rate. This is applicable in all age groups.

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

NICE NG106 recommends ACE-I is used as first-line therapy in all patients with HF due to LVSD and that ARBs are used only in patients who are intolerant of ACE-I.

HF 003.2 Reporting and verification

See indicator wording for requirement criteria.

HF indicator 004 (NICE 2015 menu ID: NM90)

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

HF 004.1 Rationale

The NICE guideline for chronic heart failure²⁰ recommends that beta-blockers licensed for HF are used as first-line therapy in all patients with HF due to LVSD. It also recommends that treatment with beta-blockers is not withheld solely because of age or the presence of peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

The British National Formulary (BNF) states that “the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should

²⁰ NICE NG106. Chronic heart failure.2018. <https://www.nice.org.uk/guidance/ng106>

be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy”²¹.

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

HF 004.2 Reporting and verification

See indicator wording for requirement criteria.

Patients prescribed a beta-blocker unlicensed for heart failure before being given a diagnosis of heart failure will be excluded from this indicator.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP003. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2012 menu ID: NM53</i>	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>NICE 2012 menu ID: NM54</i>	5	40-80%

HYP – rationale for inclusion of indicator set

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

HYP indicator 001

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

HYP 001.1 Rationale

²¹ BNF. <http://www.evidence.nhs.uk/formulary/bnf/current>

Effective treatment of hypertension aims to reduce the risk of cardiovascular problems such as heart attacks and strokes.

Patients who have had one-off high blood pressure readings and women who have been hypertensive in pregnancy should not be included in the register.

NICE CG127²² uses the following definitions:

Stage 1 hypertension

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

Stage 2 hypertension

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

Severe hypertension

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

The NICE guideline for hypertension²³ recommends the use of ABPM to confirm a diagnosis of hypertension, particularly if a clinic blood pressure reading is 140/90 mmHg or higher. If a person is unable to tolerate ABPM, HBPM is a suitable alternative to confirm a diagnosis of hypertension.

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

HYP 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

HYP indicator 003 (NICE 2012 menu ID: NM53)

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less

HYP003.1 Rationale

²² NICE CG127. Hypertension in adults: diagnosis and management. 2016. <https://www.nice.org.uk/guidance/CG127>

²³ NICE CG127. Hypertension. 2016. <https://www.nice.org.uk/guidance/cg127>

This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with hypertension. Its intent is to promote the primary and secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or the use of drug therapy.

HYP003.2 Reporting and verification

See indicator wording for requirement criteria.

HYP indicator 007 (NICE 2012 menu ID: NM54)

The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

HYP007.1 Rationale

The NICE guideline for hypertension²⁴ recommends that patients aged 80 years and over with hypertension should be treated to a target blood pressure of 150/90 mmHg or less. It also recommends that this group of patients should be offered the same antihypertensive drug treatment as people aged 55-80 years, taking into account any co-morbidities.

Where people have had a lower treatment target before the age of 80 years their treatment should continue and not be adjusted or back titrated. There is an important distinction between continuing long term and well tolerated treatment in people aged 80 years and older, and starting blood pressure lowering therapy at this age.

HYP007.2 Reporting and verification

See indicator wording for requirement criteria.

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease <i>NICE 2011 menu ID: NM32</i>	2	

PAD – rationale for inclusion of indicator set

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

²⁴ NICE CG127. Hypertension. 2016. <https://www.nice.org.uk/guidance/cg127>

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

Further information

NICE CG147. PAD: diagnosis and management. 2012.

<https://www.nice.org.uk/guidance/cg147>

PAD indicator 001 (NICE 2011 menu ID: NM32)

The contractor establishes and maintains a register of patients with peripheral arterial disease

PAD 001.1 Rationale

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

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

PAD 001.2 Reporting and verification

See indicator wording for requirement criteria.

Stroke and TIA (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken <i>NICE 2015 menu ID: NM94</i>	4	57–97%
STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM140</i>	2	55–95%
STIA010. The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured	3	40-73%

in the preceding 12 months) is 140/90 mmHg or less <i>NICE 2013 menu ID: NM69</i>		
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less <i>Based on NICE 2015 menu ID: NM93</i>	2	46-86%

STIA – rationale for inclusion of indicator set

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

STIA indicator 001

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

STIA 001.1 Rationale

For patients diagnosed prior to 1 April 2003 it is accepted that various diagnostic criteria may have been used. For this reason, the presence of the diagnosis of stroke or TIA in the record will be acceptable. Generally, patients with a diagnosis of transient global amnesia or vertebra-basilar insufficiency are not included in the retrospective register. However, contractors may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.

It is up to the contractor to decide, on clinical grounds, when to include a patient on the register eg when a 'dizzy spell' becomes a TIA. Patient records coded with 'Amaurosis fugax', but without a code for TIA are excluded from the register.

STIA 001.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 007 (NICE 2015 menu ID: NM94)

The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken

STIA 007.1 Rationale

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

The BNF²⁵ makes the following recommendations:

²⁵ BNF stroke treatment summary. <https://bnf.nice.org.uk/treatment-summary/stroke.html>

“Patients should receive long-term treatment following a transient ischaemic attack or an ischaemic stroke to reduce the risk of further cardiovascular events.

Following a transient ischaemic attack or an ischaemic stroke (not associated with AF), long-term treatment with clopidogrel [unlicensed in transient ischaemic attack] is recommended. If clopidogrel is contra-indicated or not tolerated, patients can receive modified-release dipyridamole in combination with aspirin; if both aspirin and clopidogrel are contra-indicated or not tolerated, then modified-release dipyridamole alone is recommended; if both modified-release dipyridamole and clopidogrel are contra-indicated or not tolerated, then aspirin alone is recommended.

Patients with stroke associated with AF should be reviewed for long-term treatment with warfarin sodium or an alternative anti-coagulant (see initial management under ischaemic stroke).”

Further information - NICE technology appraisal (TA) TA210. Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events. 2010. <http://www.nice.org.uk/guidance/TA210>

STIA 007.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 009 (NICE 2015 menu ID: NM140)

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

STIA 009.1 Rationale

There is evidence to suggest that flu vaccination reduces risk of stroke by 24 per cent²⁶.

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

Further information - PHE. Influenza.

<https://www.gov.uk/government/collections/annual-flu-programme>

STIA 009.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 010 (NICE 2013 menu ID: NM69)

The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less

STIA 010.1 Rationale

This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years and under who have experienced a stroke or TIA. It aims to promote the secondary prevention of cardiovascular disease through

²⁶ Siriwardena et al. Vaccine 2014; 32, 12, 1354–1361

satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or drug therapy subject to the caveat below.

The NICE guideline on hypertension²⁷ recommends drug therapy in people aged 79 years and under with stage 1 hypertension and cardiovascular disease.

Antihypertensive drug treatment is recommended for people of any age with stage 2 hypertension.

STIA 010.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 011 (based on NICE 2015 menu ID: NM93)

The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

STIA011.1 Rationale

This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people age 80 years and over with a history of stroke or TIA. The aim of treating people to this target is to promote secondary prevention of vascular events through satisfactory blood pressure control.

STIA011.2 Reporting and verification

See indicator wording for requirement criteria.

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed <i>NICE 2011 menu ID: NM41</i>	6	
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) <i>NICE 2015 menu ID: NM95</i>	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin	4	50–90%

²⁷ NICE CG127. Hypertension. 2016. <https://www.nice.org.uk/guidance/cg127>

changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months <i>NICE 2010 menu ID: NM13</i>		
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register <i>NICE 2011 menu ID: NM27</i>	11	40–90%
DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM139</i>	3	55–95%
DM019. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less <i>NICE 2018 menu ID: NM159</i>	10	38-78%
DM020. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months <i>NICE 2018 menu ID: NM157</i>	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months <i>NICE 2018 menu ID: NM158</i>	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) <i>NICE 2018 menu ID: NM162</i>	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin <i>NICE 2018 menu ID: NM163</i>	2	50-90%

DM – rationale for inclusion of indicator set

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

Further information:

NICE NG28. Type 2 diabetes in adults: management. 2015.

<http://www.nice.org.uk/guidance/NG28>

NICE NG19. Diabetic foot problems: prevention and management. 2015.

<http://www.nice.org.uk/guidance/NG19/>

NICE NG18. Diabetes (type 1 and type 2) in children and young people: diagnosis and management. 2015. <http://www.nice.org.uk/guidance/NG18>

NICE NG17. Type 1 diabetes in adults: diagnosis and management. 2015.

<http://www.nice.org.uk/guidance/NG17>

The English National Service Framework (NSF) for Diabetes website²⁸ also includes details of the evidence behind a range of recommendations.

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

DM indicator 017 (NICE 2011 menu ID: NM41)

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

DM 017.1 Rationale

A greater understanding and knowledge of the complexities of diabetes has led to increasing difficulty in accurately diagnosing or classifying the type of diabetes. In March 2011, a report by the Royal College of General Practitioners (RCGP) and NHS Diabetes was published which examined the issue of coding, classification and diagnosis of diabetes in primary care in England²⁹. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes. In line with this report, the diabetes register indicator includes all types of diabetes within the proposed algorithm. Women with gestational diabetes are excluded from this indicator set.

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

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

²⁸ DH. <https://www.gov.uk/government/publications/national-service-framework-diabetes>

²⁹ RCGP and NHS Diabetes. Coding, classification and diagnosis of diabetes. 2011. <http://webarchive.nationalarchives.gov.uk/20130402234253/http://gp.dh.gov.uk/2011/03/28/coding-classification-and-diagnosis-of-diabetes/>

incorrect diagnosis of diabetes. Contractors are therefore encouraged to adopt a systematic approach to the diagnosis of diabetes.

The World Health Organisation (WHO) 2006³⁰ states that fasting plasma glucose ≥ 7.0 mmol/l (126 mg/dl) or 2-h plasma glucose ≥ 11.1 mmol/l (200 mg/dl) is used as criteria for diagnosing diabetes.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM³¹. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5 per cent) is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/mol (6.5 per cent).

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

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

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

Practices may wish to review their patient records and re-code patients previously coded as “diabetes resolved” as “diabetes in remission” if they still require monitoring for the reasons outlined above.

DM 017.2 Reporting and verification

See indicator wording for requirement criteria.

³⁰ WHO. Definition and diagnosis of DM and intermediate hyperglycaemia. 2006.

www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf

³¹ WHO. Use of HbA1c in the diagnosis of DM. Abbreviated report of a WHO consultation. 2011. www.who.int/diabetes/publications/report-hba1c_2011.pdf

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

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

DM indicator 006 (NICE 2015 menu ID: NM95)

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

DM 006.1 Rationale

NICE guidelines^{32, 33} recommend the use of ACE-I (or ARBs) to slow the progression of renal disease in patients with diabetes and trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. Although trial evidence is based largely on ACE-I, it is believed that similar benefits occur from treatment with ARBs in patients who are intolerant of ACE-I.

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

DM 006.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 012 (NICE 2010 menu ID: NM13)

The percentage of patients with diabetes, on the register, with a record of foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months

DM 012.1 Rationale

Patients with diabetes are at high risk of foot complications that could lead to ulcer, amputation or death. Evaluation and risk classification on an annual basis is important for the detection of feet at most risk.

The NICE guideline on diabetic foot problems³⁴ outlines foot risk classification.

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

DM 012.2 Reporting and verification

³² NICE NG17. Type 1 diabetes in adults. 2015. <https://www.nice.org.uk/guidance/ng17>

³³ NICE NG28. Type 2 diabetes in adults: management. 2015. <https://www.nice.org.uk/guidance/ng28>

³⁴ NICE NG19 Diabetic foot problems: prevention and management (2015)
<http://www.nice.org.uk/guidance/NG19/>

See indicator wording for requirement criteria.

DM indicator 014 (NICE 2011 menu ID: NM27)

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

DM 014.1 Rationale

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

The NICE guideline for type 2 diabetes in adults³⁵ considered SE models for diabetes to be both clinically and cost-effective. There are a number of SE programmes available for diabetes. Some programmes will be more suitable for type 1 diabetes and others for type 2 diabetes.

The NICE quality standard for diabetes in adults³⁶ is based on NICE guidelines. The NICE quality statement on SE states that 'People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education'.

The NICE quality standard states that a patient educational programme meets five key criteria laid down by the Department of Health and Social Care (DHSC) and the Diabetes UK Patient Education Working Group:

1. Any programme should be evidence-based and suit the needs of the individual. The programme should have specific aims and learning objectives. It should support the learner plus his or her family and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes.
2. The programme should have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials and is written down.
3. The programme should be delivered by trained educators who have an understanding of educational theory appropriate to the age and needs of the learners and who are trained and competent to deliver the principles and content of the programme.

³⁵ NICE NG28 Type 2 diabetes in adults: management (2017) www.nice.org.uk/guidance/NG28

³⁶ NICE quality standard QS6 Diabetes in adults (2016) www.nice.org.uk/guidance/qs6

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

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

From February 2020 onwards, there is expected to be a phased roll-out of the Healthy Living in Diabetes Programme (HeLP). Referral to this programme will also meet the criteria for this indicator.

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

DM 014.2 Reporting and verification

See indicator wording for requirement criteria. For measurement purposes, nine months is defined as 279 days.

Where services are not available locally, practices would be expected to discuss this with the CCG and encourage the commissioning of the relevant services. This may take some time so practices may wish to consider whether it would be appropriate to offer the service in-house, or to services available in different CCGs or neighbouring practices etc.

DM indicator 018 (NICE 2015 menu ID: NM139)

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

DM 018.1 Rationale

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

Further information - PHE. Influenza.

<https://www.gov.uk/government/collections/annual-flu-programme>

DM 018.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 019 (NICE 2018 menu ID: NM159)

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less

DM019.1 Rationale

Lowering blood pressure in people with diabetes reduces the risk of developing micro and macrovascular complications.

Applying universal BP targets to all people with diabetes may inadvertently lead to the potential for undertreatment in those with less complex need and overtreatment in those with complex needs and co-morbidity³⁷. This indicator focuses upon blood pressure management in people with diabetes without moderate or severe frailty and thus aims to reduce potential undertreatment and support better control of biomedical targets in people with the greatest capacity to benefit.

Contractors should note that the BP target in this indicator is higher than that recommended for patients with Type 1 diabetes in NG17, where they should be aiming for 135/85mmHg or 130/80mmHg if the person has albuminuria or two or more features of metabolic syndrome.

The NICE guideline for type 2 diabetes³⁸ recommends that people with type 2 diabetes should aim for a BP target of less than 140/80 mmHg unless they have kidney, eye or cerebrovascular damage in which case they should aim for less than 130/80 mmHg.

DM019.2 reporting and verification

See indicator wording for requirement criteria.

DM indicator 020 (NICE 2018 menu ID: NM157)

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months

DM020.1 Rationale

Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of average plasma glucose over the preceding 8-12 weeks. Rising levels of HbA1c increase the risk of mortality and developing macrovascular and microvascular complications. However, applying universal target levels regardless of comorbidities may inadvertently lead to over-treatment, especially in older people with type 2 diabetes.³⁹ This indicator allows for an individualised management approach that adjusts care according to an individual's frailty status. It aims to enable patients without moderate or severe frailty to benefit from tighter glycaemic control. Whilst the target in this indicator is higher than those presented in NICE guidelines^{40, 41}, this has been pragmatically selected as it represents the point at which people with type 2 diabetes should be considered for treatment intensification.

DM020.2 Reporting and verification

See indicator wording for requirement criteria.

³⁷ Kearney et al. Overtreatment and undertreatment: time to challenge our thinking. BJGP. 2019;67(633):442-443.

³⁸ NICE NG28. Type 2 diabetes in adults: management (2017) www.nice.org.uk/guidance/NG28

³⁹ Strain et al. Type 2 diabetes mellitus in older people: a brief statement of key principles of modern day management including the assessment of frailty. Diabetic medicine. 2018;35(7): 838-845.

⁴⁰ NICE NG17 Type 1 diabetes in adults: diagnosis and management (2015) <http://www.nice.org.uk/guidance/NG17>

⁴¹ NICE NG28 Type 2 diabetes in adults: management (2017) www.nice.org.uk/guidance/NG28

DM indicator 021 (NICE 2018 menu ID: NM158)

The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months

DM021.1 Rationale

This indicator allows for an individualised management approach that adjusts care according to an individual's frailty status. It aims to reduce complications and improve quality of life for people with moderate or severe frailty. NICE guidelines recommend that individualised HbA1c targets should be agreed with people with both type 1 and type 2 diabetes which consider factors such as their daily activities, aspirations, likelihood of complications, comorbidities and occupation. Individual targets, even for people with moderate or severe frailty, should be lower than the level specified in this indicator. The target in this indicator has been pragmatically selected as a level that HbA1c should not go beyond in order to avoid people becoming symptomatic of hyperglycaemia.

DM021.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 022 (NICE 2018 menu ID: NM162)

The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)

DM022.1 Rationale

Cardiovascular risk is elevated in people with type 1 and type 2 diabetes, and statin therapy can be used for the primary prevention of CVD. The NICE guideline for cardiovascular disease risk assessment and lipid modification⁴² recommends that people with type 1 diabetes are offered statin treatment for primary prevention when they are older than 40 years, or they have had diabetes for more than 10 years, or they have established nephropathy or other CVD risk factors. People with type 2 diabetes should be offered statin therapy if they have a 10% or greater 10-year risk of developing CVD, estimated using the QRISK2 assessment tool.

The NICE quality standard for cardiovascular risk assessment and lipid modification⁴³ notes that people choosing statin therapy for primary prevention should be offered atorvastatin 20mg.

DM022.2 Reporting and verification

See indicator wording for requirement criteria.

⁴² NICE CG181 Cardiovascular disease: risk assessment and reduction, including lipid modification (2016) <https://www.nice.org.uk/guidance/cg181>

⁴³ NICE QS100 Cardiovascular risk assessment and lipid modification (2015) <https://www.nice.org.uk/guidance/qs100>

People with type 2 diabetes who have a less than 10% 10-year risk of developing CVD recorded in the preceding 3 years will be excluded from the denominator for this indicator.

DM indicator 023 (NICE 2018 menu ID: NM163)

The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin.

DM023.1 Rationale

The NICE guideline for cardiovascular disease risk assessment and lipid modification⁴⁴ recommends that statin therapy be considered for the secondary prevention of CVD. Statin therapy helps to lower levels of low-density lipoprotein (LDL) cholesterol and is associated with a reduction in MI, coronary heart disease and stroke. Treatment should start with atorvastatin 80mg, however there are situations in which a lower dose should be used. This indicator wording allows for the selection of an appropriate and individualised dosage.

DM023.2 Reporting and verification

See indicator wording for requirement criteria.

Asthma (AST)

Indicator	Points	Achievement thresholds
Records		
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
Initial diagnosis		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis <i>NICE 2015 menu ID: NM101</i>	15	45–80%
Ongoing management		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions <i>NICE 2011 menu ID: NM23</i>	20	45–70%

⁴⁴ NICE CG181 Cardiovascular disease: risk assessment and reduction, including lipid modification (2016) <https://www.nice.org.uk/guidance/cg181>

AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months <i>NICE 2015 menu ID: NM102</i>	6	45–80%
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AST – rationale for inclusion of indicator set

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

This indicator set is currently under review for 2020/21. The indicators and guidance will be updated once this review is complete to reflect the latest NICE guidance.

AST indicator 001

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

AST 001.1 Rationale

Proactive structured review as opposed to opportunistic or unscheduled review is associated with reduced exacerbation rates and days lost from normal activity.

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

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

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

Children

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

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

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

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

Further information

SIGN guideline 153. SIGN and BTS. British guideline on the management of asthma. 2016. <http://www.sign.ac.uk/assets/sign153.pdf>

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

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

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

AST 001.2 Reporting and verification

See indicator wording for requirement criteria.

Part of the register criteria for asthma is based on appropriate prescribing of therapies. From October 2014, the Business Rules were updated to exclude drug therapies licensed only for use in patients with a diagnosis of COPD as they are not licensed as a treatment for asthma.

Patients with asthma whose sole asthma medication is one of the inhalers listed above then they will no longer appear on the QOF asthma register. Patients receiving additional, appropriate asthma treatment such as short-acting bronchodilators or steroid inhalers will remain on the register. Practices may wish to review the records of any patients affected by this change to review their asthma treatment however, a change in prescribing should only be done where clinically appropriate.

AST indicator 002

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

AST 002.1 Rationale

There is no single infallible test to confirm a diagnosis of asthma. On the basis of the clinical history and examination it will be possible to decide if the probability of asthma is high, intermediate or low and the aim of investigations is to demonstrate objectively the presence of variability in order to support or reject the diagnosis.

There are Read codes for 'suspected asthma' and 'suspected respiratory condition' which may be used whilst investigations are undertaken and the diagnosis confirmed.

Further information about the diagnosis of asthma is provided in the BTS-SIGN asthma guideline⁴⁵. It is crucial that diagnostic spirometry is performed to published quality standards⁴⁶.

Further information – Association for respiratory technology and physiology. A guide to performing quality assured diagnostic spirometry. <http://www.artp.org.uk/>

Asthma history

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

Practices may wish to confirm a diagnosis of asthma for those patients who were diagnosed with asthma in previous QOF years before they were eight years of age. Once the patient turns eight it is acceptable to re-examine the diagnosis using tests of variability or reversibility. In those patients who are not receiving long-term anti-inflammatory therapy they should be treated as a new presenting case and the diagnosis re-evaluated.

If asthma is probable

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

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

- Spirometry may be used to demonstrate reversibility in symptomatic patients with demonstrated airflow obstruction. A bronchodilator reversibility test can be performed with inhaled or nebulised short acting beta agonist and if the obstruction reverses then asthma is confirmed. Significant reversibility is a change in FEV₁ >12 per cent and 200 ml (the absolute change is scaled down according to predicted FEV₁ in children). Increases of >400 mls are strongly suggestive of asthma. Lower levels of bronchodilator reversibility may be demonstrated in some patients with COPD⁴⁷. Normal spirometry, however,

⁴⁵ BTS/SIGN clinical guideline 153. Management of Asthma
<http://www.sign.ac.uk/guidelines/fulltext/153/index.html>

⁴⁶ Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes S, Small I. Diagnostic spirometry in primary care: Proposed standards for general practice compliant with ATS and Euro Respiratory Society recommendations: a General Practice Airways Group document in association with the Association for Respiratory Technology & Physiology and Education for Health. PCRJ. 2009; 18:130-47.
<http://dx.doi.org/10.4104/pcrj.2009.00054>

⁴⁷ NICE NG115. COPD in over 16s: diagnosis and management. 2018.
<http://guidance.nice.org.uk/NG115>

does not exclude asthma; indeed the variable nature of asthma means that many of the milder patients seen in primary care will be asymptomatic at the time of the lung function test and will have completely normal lung function with no reversibility at the time of testing.

- Variability of PEF. This may be demonstrated by monitoring diurnal, or day to day variation (recorded twice a day for two weeks using the same peak flow meter) and/or demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks of inhaled steroids, or up to two weeks after oral steroid treatment) and/or after exposure to triggers (such as exercise, laughter, or allergens). Significant variability is a change of 20 per cent and >60 l/min (the absolute change is scaled down in children to 20 per cent of predicted PEF). PEF are effort dependent and patients need to be taught the correct technique.
- Variability in objective measures of asthma symptom scores (eg RCP questions⁴⁸, ACQ⁴⁹, ACT questionnaire⁵⁰, or GINA Control Tool⁵¹). Symptom scores may be particularly useful in patients unable to undertake accurate serial measures of lung function and to aid clinical interpretation of lung function (eg normal lung function in a symptomatic patient might suggest an alternative cause for the symptoms).

A trial of treatment, with repeated lung function measurements and/or symptoms scores over time will demonstrate objective improvement of symptoms and lung function in people with asthma, thereby confirming the diagnosis. In children it is particularly important to reduce and stop treatment to exclude spontaneous improvement⁵².

If the probability of asthma is intermediate

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations⁵³. More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

If another diagnosis is more likely

⁴⁸ Pearson MG, Bucknall CE, editors. Measuring clinical outcome in asthma: a patient-focused approach. RCP. 1999.

⁴⁹ Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. *Euro Respiratory Journal*. 1999;14:902-7

⁵⁰ Nathan RA, Sorkness CA, Kosinski M, et al. Development of the asthma control test: a survey for assessing asthma control. *Journal of Allergy Clinical Immunology* 2004;113:59-65

⁵¹ GINA. Global Strategy for Asthma Management and Prevention. 2011. <http://www.ginasthma.org>

⁵² Brand P. New guidelines on recurrent wheeze in preschool children: implications for primary care. *PCRJ* 2008; 17:243-245

⁵³ BTS/SIGN clinical guideline 153. Management of Asthma
<http://www.sign.ac.uk/guidelines/fulltext/153/index.html>

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

Co-morbidity: asthma and COPD

A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility⁵⁴.

AST 002.2 reporting and verification

See indicator wording for requirement criteria. For measurement purposes, three months prior to diagnosis is defined as 93 days.

AST indicator 003 (NICE 2011 menu ID: NM23)

The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions

AST 003.1 Rationale

Structured care has been shown to produce benefits for patients with asthma. The reckoning of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. The BTS/SIGN clinical guideline⁵⁵ proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

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

QOF explicitly requires the following RCP questions⁵⁶ are used as an effective way of assessing symptoms:

In the last month:

- have you had difficulty sleeping because of your asthma symptoms (including cough)?
- have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
- has your asthma interfered with your usual activities (for example, housework, work/school, etc.)?

The questions are to be asked at the same time and as part of the review. A

⁵⁴ NICE NG115. COPD in over 16s: diagnosis and management. 2018.

<http://guidance.nice.org.uk/NG115>.

⁵⁵ BTS/SIGN clinical guideline 153. Management of asthma. 2016.

<http://www.sign.ac.uk/guidelines/fulltext/141/index.html>

⁵⁶ RCP. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: patient focused approach.

response of 'no' to all questions is consistent with well-controlled asthma⁵⁷.

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

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

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

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

During an asthma review the following takes place:

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

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

AST 003.2 Reporting and verification

See indicator wording for requirement criteria.

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

AST indicator 004

⁵⁷ Thomas M, Gruffydd-Jones K, Stonham C et al. Assessing asthma control in routine clinical practice: use of the RCP '3 Questions'. 2009. PCRJ 18: 83-8

The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months

AST 004.1 Rationale

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

Studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control⁵⁸.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity⁵⁹.

AST 004.2 Reporting and verification

See indicator wording for requirement criteria.

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD001. The contractor establishes and maintains a register of patients with COPD	3	
Initial diagnosis		
COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register <i>NICE 2015 menu ID: NM103</i>	5	45–80%
Ongoing management		
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months <i>NICE 2015 menu ID: NM104</i>	9	50–90%

⁵⁸ Price et al. ClinExp Allergy 2005; 35: 282-287

⁵⁹ Thomson et al. Euro Respiratory Journal. 2004; 24: 822-833

COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March <i>NICE 2015 menu ID: NM106</i>	6	57–97%
COPD008. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) <i>NICE 2012 menu ID: NM47</i>	2	40-90%

COPD – rationale for inclusion of indicator set

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

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

COPD indicator 001

The contractor establishes and maintains a register of patients with COPD

COPD 001.1 Rationale

A diagnosis of COPD is considered in any patient who has a history of exposure to risk factors for the disease (generally smoking) and symptoms of breathlessness, chronic persistent cough, sputum production, winter bronchitis or wheeze. The diagnosis is confirmed by post bronchodilator spirometry.

See COPD002.1

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

NICE guidance⁶⁰ recommended a change to the diagnostic threshold for COPD in 2010

COPD 001.2 Reporting and verification

⁶⁰ NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018.
<https://www.nice.org.uk/guidance/ng115>

See indicator wording for requirement criteria.

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

COPD indicator 002 (NICE 2015 menu ID: NM103)

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

COPD 002.1 Rationale

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

NICE NG115⁶¹ provides the following definition of COPD:

- Airflow obstruction is defined as a reduced FEV₁/FVC ratio (where FEV₁ is forced expired volume in one second and FVC is forced vital capacity), such that FEV₁/FVC is < 0.7.
- If FEV₁ is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

The NICE guideline recommends performing post bronchodilator spirometry to confirm a clinical diagnosis of COPD. Failure to use post bronchodilator readings has been shown to overestimate the prevalence of COPD by 25 per cent. Spirometry is to be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400 mcg salbutamol).

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

The guideline on COPD recommends that all health professionals involved in the care of patients with COPD have access to spirometry and be competent in the interpretation of the results. The NICE quality standard for COPD in adults⁶², states that people aged over 35 years who present with a risk factor and one or more symptoms of chronic obstructive pulmonary disease (COPD) have post-bronchodilator spirometry. It should be performed by a healthcare professional who has had appropriate training and who has up-to-date skills.

COPD 002.2 Reporting and verification

See indicator wording for requirement criteria. For measurement purposes, three months before diagnosis is defined as 93 days.

COPD indicator 003 (NICE 2015 menu ID: NM104)

⁶¹ NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018.

<https://www.nice.org.uk/guidance/ng115>

⁶² NICE QS10. COPD. 2011, updated 2016. <http://www.nice.org.uk/guidance/qs10>

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months

COPD 003.1 Rationale

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management is based on NICE NG115 and international GOLD guidelines in terms of both drug and non-drug therapy.

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

- current lung function
- exacerbation history
- the degree of breathlessness (Medical Research Council [MRC] dyspnoea scale).

A tool such as the COPD Assessment Test (CAT) could be used to assess current health status.

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

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

COPD 003.2 Reporting and verification

See indicator wording for requirement criteria.

COPD indicator 007 (NICE 2015 menu ID: NM106)

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

COPD 007.1 Rationale

The NICE guideline for COPD⁶³ recommends annual flu vaccination and it is a current recommendation from the Chief Medical Officer and the Joint Committee on Vaccination and Immunisation.

Further information

PHE. Influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

COPD 007.2 Reporting and verification

⁶³ NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018. <https://www.nice.org.uk/guidance/ng115>

See indicator wording for requirement criteria.

COPD indicator 008 (NICE 2012 menu ID: NM47)

The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme).

COPD 008.1 Rationale

Pulmonary rehabilitation is a multidisciplinary programme of care which aims to reduce disability and improve quality of life in patients with a chronic respiratory impairment. It is individually tailored and designed to optimise each patient's physical and social performance and independence.

The NICE guideline for COPD⁶⁴ recommends that pulmonary rehabilitation should be offered to all patients who consider themselves to be functionally disabled due to their COPD (usually MRC dyspnoea scale score of ≥ 3). Whilst most patients are likely to benefit, a rehabilitation programme is not suitable for patients who are unable to walk, have unstable angina or who have recently had a myocardial infarction.

Medical management should be optimised before referral.

COPD 008.2 reporting and verification

See indicator wording for requirement criteria.

Patients who have previously attended a pulmonary rehabilitation programme will be excluded from the denominator for this indicator.

Where practices do not have locally commissioned pulmonary rehabilitation programmes they may exclude patients from the denominator using the specific service unavailable codes.

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months <i>NICE 2015 menu ID: NM107</i>	39	35–70%

⁶⁴ NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018.
<https://www.nice.org.uk/guidance/ng115>

DEM – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately seven per cent in those over 65. Alzheimer's disease accounts for around 62 per cent of cases of dementia with vascular dementia accounting for around 17 per cent^{65,66}.

The annual incidence of dementia of the Alzheimers type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing.

DEM indicator 001

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

DEM 001.1 Rationale

It is expected that the diagnosis will largely be recorded following patients being referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However, it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.

DEM 001.2 Reporting and verification

See indicator wording for requirement criteria.

DEM indicator 004 (NICE 2015 menu ID: NM107)

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months

DEM 004.1 Rationale

Where a patient does not already have a care plan or an advanced care plan in place, it is expected that the practice will develop a care plan.

The face-to-face care plan or advanced care plan review focuses on support needs of the patient and their carer. Regular review can help ensure that any changes in need can be addressed. In particular the review should address the following key issues:

⁶⁵ Alzheimer's Society. Dementia UK: update 2014.

⁶⁶ NICE NG97 Dementia: assessment, management and support for people living with dementia and their carers (2018) <https://www.nice.org.uk/guidance/ng97>

- an appropriate physical, mental health and social review for the patient,
 - a record of the patients' wishes for the future,
 - communication and co-ordination arrangements with secondary care (if applicable),
 - identification of the patients' carer(s); and
1. obtain appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family, 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,
 2. as appropriate, the carer should be included in the care plan or advanced care plan discussions,
 3. if applicable, the impact of caring on the care-giver,
 4. offer the carer a health check⁶⁷ to address any physical and mental health impacts, including signposting to any other relevant services to support their health and wellbeing.

The practice will agree with the patient and their carer, what is to be covered in the review and the duration of the consultation - where appropriate, extended consultations may take up to 30 minutes⁶⁸. Ideally the first such appointment would be within six months of diagnosis.

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

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

Depression could also be considered as it is more common in patients with dementia than those without⁶⁹.

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia⁷⁰. As the illness progresses, needs may change and the review may focus more on issues such as respite care.

⁶⁷ Where the carer is registered at a different practice, the patients practice should inform the patient's carer that they can seek advice from their own practice.

⁶⁸ The practice should agree with the patient the most suitable length of this for this appointment, this could be provided as two 15 minute appointments if this is more appropriate for the patient.

⁶⁹ Alzheimers society: Apathy, anxiety and depression. 2017

⁷⁰ Eccles et al. BMJ 1998; 317: 802-808

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

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

Further information

NICE NG97. Dementia: assessment. Management and support for people living with dementia and their carers. 2018 <https://www.nice.org.uk/guidance/ng97>

NICE QS1: Dementia. 2010. <https://www.nice.org.uk/guidance/qs1>

NICE QS30: supporting people to live well with dementia. 2013. <https://www.nice.org.uk/guidance/QS30>

Forget me not dementia training. <http://www.forgetmenotdementia.co.uk/>

NSF for Older People. 2001. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066

NICE public health guidance 16. Mental wellbeing in older people. 2008. <https://www.nice.org.uk/guidance/ph16>

NHS Choices. Looking after someone with dementia. 2015. <https://www.nhs.uk/conditions/dementia/carers/>

DEM 004.2 Reporting and verification

See indicator wording for requirement criteria.

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

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial management		
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis <i>Based on NICE 2012 menu ID: NM50</i>	10	45–80%

DEP – rationale for inclusion of the indicator set

Depression is common and disabling.

In 2012, the estimated prevalence for a depressive episode among people aged 16 or over and under the age of 74 in England was 2.5 per cent. If the broader and less specific category of 'mixed depression and anxiety' is included, these figures increase dramatically to 8.9 per cent^{71, 72}. It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world's disabling diseases⁷³. 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 2007, the total cost of depression in England was reported to be £7.5 billion of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. When the cost of informal care, lower productivity and other public sector costs are included this figures is estimated at between £20.2-23.8 billion a year⁷⁴.

DEP indicator 003 (based on NICE 2012 menu ID: NM50)

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

DEP 003.1 Rationale

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

CG90 recommends that patients with mild or moderate depression who start

⁷¹ NICE CG90. Depression in adults: recognition and management. 2009.

<https://www.nice.org.uk/guidance/CG90>

⁷² PHE. Fingertips data. Common mental health disorders. 2012. <http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/0/gid/8000026/pat/6/par/E12000004/ati/102/are/E06000015/iid/90419/age/240/sx/4>

⁷³ Murray CJ. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the global burden of disease study 2010. *Lancet*. 2012;380(9859):2197–223.

⁷⁴ DH. No health without mental health – supporting document. 2011.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide.

This indicator promotes a single depression review between ten and 56 days inclusive after the date of diagnosis. For some patients this may not be their first review as they will have been reviewed initially within a week of the diagnosis. Unless a patient's symptoms have resolved, further reviews may be required.

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

DEP 003.2 Reporting and verification

See indicator wording for requirement criteria.

Those patients whose on-going care is being provided by specialist mental health services may have a personalised care adjustment applied.

It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should find out the diagnosis date in order to record this and invite the patient for a review within the timeframe specified.

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

The register for DEP003 for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Verification – Commissioners may ask contractors about the percentage of telephone reviews conducted and who they were delivered by.

Mental health (MH)

Indicator	Points	Achievement thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate <i>NICE 2015 menu ID: NM108</i>	6	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months <i>NICE 2010 menu ID: NM17</i>	4	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months <i>NICE 2010 menu ID: NM16</i>	4	50-90%

MH – rationale for inclusion of indicator set

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

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

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

NICE CG178⁷⁵ recommends primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia.

NICE CG185⁷⁶ recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including the following health checks:

- weight or BMI, diet, nutritional status and level of physical activity

⁷⁵ NICE CG178. Psychosis and schizophrenia in adults: prevention and management. 2014.
<http://www.nice.org.uk/guidance/CG178>

⁷⁶ NICE CG185. Bipolar disorder: assessment and management. 2014.
<http://www.nice.org.uk/guidance/CG185>

- cardiovascular status, including pulse and blood pressure
- metabolic status, including glycosylated haemoglobin (HbA1c) and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long-term lithium.

QOF continues to incentivise annual monitoring of blood pressure, BMI and smoking status for patients with schizophrenia, bipolar affective disorder and other psychoses. Clinicians should use their professional judgement to decide when and how frequently checks of lipid levels, glucose levels and discussing alcohol consumption should be carried out, in accordance with the needs of each patient. Guidelines suggest that these are normally performed annually.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD⁷⁷.

MH indicator 001

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

MH 001.1 Rationale

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

Remission from serious mental illness

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

Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the 'remission code' is largely based on clinical judgement. A longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery⁷⁸ is used.

In the absence of strong evidence of what constitutes 'remission' from serious mental illness, it is advised that clinicians should only consider using the remission

⁷⁷ Mackin P, Bishop D, Watkinson H et al. Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. 2007. BJP 191: 23-9.

⁷⁸ Harrison G, Hopper K, Craig T, Laska E, Siegel C, Wanderling J et al. Recovery from psychotic illness: A 15 and 25 year international follow-up study. 2001. BJP, 178: 506-517.

codes if the patient has been in remission for at least five years, that is where there is:

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

Where a patient is recorded as being 'in remission' they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for subsequent indicators.

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

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

MH 001.2 Reporting and verification

See indicator wording for requirement criteria.

Verification – Commissioners may require randomly selecting a number of patient records in which a 'remission code' has been recorded and request evidence as to why it was appropriate for that patient to be considered 'in remission' and to confirm the ongoing accuracy of this coding.

Contractors may be expected to demonstrate they have a protocol to guide their clinicians as to how this would work and who would be suitable to make the decision. It would not be appropriate for non-clinical members of the practice to make the decision as to when to enter this code.

MH indicator 002 (NICE 2015 menu ID: NM108)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the records, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate

MH 002.1 Rationale

This indicator reflects good professional practice and is supported by NICE CG178⁷⁹.

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

Up to half of patients who have a serious mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes

⁷⁹ NICE CG178. Psychosis and schizophrenia in adults: prevention and management. 2014.
<http://www.nice.org.uk/guidance/CG178>

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:

- patient's current health status and social care needs including how needs are to be met, by whom and the patient's expectations
- how socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement. People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services⁸⁰
- co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received
- occupational status - in England just over 30 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of working aged people⁸¹. Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work⁸².
- 'Early warning signs' from the patient's perspective that may indicate a possible relapse⁸³. Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.
- 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.

If a patient is treated under the care programme approach (CPA), then they have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of QOF provided the practice has evidence of a review having taken place with the community key worker and the patient treated under the CPA.

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

⁸⁰ See Ford et al. Psychiatric Bulletin. 1993. 17(7): 409-411 and office of the Deputy Prime Minister, Mental health and social exclusion report. 2004. ODPm.

⁸¹ ONS. Labour force survey. 2012/13. <http://www.ons.gov.uk/ons/guide-method/method-quality/specific/labour-market/labour-market-statistics/index.html>

⁸² See Grove and Drurie. Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK. 1999.

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

MH 002.2 Reporting and verification

See indicator wording for requirement criteria.

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

MH indicator 003 (NICE 2010 menu ID: NM17)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months

MH 003.1 Rationale

Patients with schizophrenia have mortality between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. A prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population⁸⁴. The NICE guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population⁸⁵. A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hypertension of 35 per cent⁸⁶.

There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of patients with asthma, patients with schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups⁸⁷.

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

MH 003.2 Reporting and verification

See indicator wording for requirement criteria.

MH indicator 006 (NICE 2010 menu ID: NM16)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months

⁸⁴ Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. *BJP*. 2010. 196: 116-21.

⁸⁵ Hennekens C, Hennekens A, Hollar D. Schizophrenia and increased risks of CVD. 2005. *Am Heart Journal* 150: 1115-21

⁸⁶ Kilbourne AM, Cornelius JR, Han X et al. Burden of general medical conditions among individuals with bipolar disorder. 2004. *Bipolar Disorder* 6: 368-73

⁸⁷ Roberts L, Roalfe A, Wilson S et al. Physical health care of patients with schizophrenia in primary care: a comparative study. 2007. *FamPract* 24: 34-40

MH006.1 Rationale

As noted above, people with serious mental illness are at increased risk of premature and preventable cardiovascular mortality and morbidity when compared to the general population. Obesity is a key risk factor linked to this. When compared to the general population people with psychosis lead more sedentary lives, eat less fruit and vegetables, are more likely to be obese and to smoke. In addition to these lifestyle factors, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance and dyslipidaemia), which is a predictor of type 2 diabetes and coronary heart disease.

About 40% of people with schizophrenia are obese and obesity is also common in people with bipolar disorders. NICE Guidelines CG178 and CG185 recommend annual weight monitoring in this patient group.

MH006.2 Reporting and verification

See indicator wording for requirement criteria.

Cancer (CAN)

Indicator	Points	Achievement thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	
Ongoing management		
CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis <i>Based on NICE 2012 menu ID: NM62</i>	6	50–90%

CAN – rationale for inclusion of indicator set

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

CAN indicator 001

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

CAN 001.1 Rationale

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

CAN 001.2 Reporting and verification

See indicator wording for requirement criteria.

CAN indicator 003 (based on NICE 2012 menu ID: NM62)

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

CAN 003.1 Rationale

A GP will have an average of eight or nine new cancer diagnoses per year and will be looking after 20 to 30 patients with cancer⁸⁸. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management.

Contractors are required to record that a patient review has occurred within six months of diagnosis to achieve this indicator. However, given the importance of primary care practitioners making early contact with patients who have been diagnosed with cancer, good practice would suggest that a review should occur between three to six months of diagnosis.

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

A cancer review in primary care includes:

- the patient's individual health and support needs, which will vary with, for example, the diagnosis, staging, age and pre-morbid health of the patient and their social support networks. In collaboration with the National Cancer Survivorship Initiative (NCSI)⁸⁹, Macmillan primary care community has produced a template⁹⁰ which recommends that this could cover a discussion of

⁸⁸ MacMillan.

<http://www.macmillan.org.uk/aboutus/healthandsocialcareprofessionals/newsandupdates/macvoice/winter2013/sharinggoodpracticewinter2013.aspx>

⁸⁹ NCSI. <http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/cancer-care-review/>

⁹⁰ Macmillan primary care community template. <http://www.ncsi.org.uk/wp-content/uploads/EMIS-guide-info.pdf>

- the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer's details
- the co-ordination of care between sectors.

Further information on survivorship and the potential role for primary care can be found on the NCSI website⁹¹.

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

CAN 003.2 Reporting and verification

See indicator wording for requirement criteria.

For the purposes of this indicator, the six-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care. For measurement purposes, six months is defined as 186 days.

Verification – Commissioners may wish to review records where a review is claimed to confirm that the review has been completed within six months of diagnosis.

Chronic kidney disease (CKD)

Indicator	Points	Achievement thresholds
Records		
CKD005. The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5) <i>NICE 2015 menu ID: NM83</i>	6	

CKD – rationale for inclusion of indicator set

The NICE guideline⁹² was published in July 2014 and reviewed the classification of CKD.

NICE CG182 recommends classifying CKD using a combination of GFR and Albumin Creatinine Ratio (ACR) categories as G1 to G5, see description in table 1.

In a cross-sectional point prevalence study⁹³ of over 130,000 adults in England the age standardised prevalence of people with an estimated GFR <60 ml/min/1.73 m² (CKD stages 3-5) was 8.5 per cent. Those with CKD were more likely to have hypertension, diabetes and CVD compared to people with GFR>60 ml/min/1.73 m², the prevalence of CKD rose with age and female gender. Limited data are available

⁹¹ NCSI website. <http://www.ncsi.org.uk/>

⁹² NICE CG182. CKD in adults: assessment and management. 2014.
<http://www.nice.org.uk/guidance/cg182>

⁹³ Stevens, P et al. CKD management in the UK: NEOERICA project results. *Kidney International*: 2007. 2 (1) 92-99

to provide an estimate of the overall population prevalence of CKD (diagnosed and undiagnosed). The available estimate suggests an overall prevalence of 13 per cent.

Further information - NSF for Renal Services. 2005.


<https://www.gov.uk/government/publications/national-service-framework-kidney-disease>

This disease area applies to patients with category G3a, G3b, G4 and G5 CKD (eGFR<60 mL/min/1.73 m² confirmed with at least two separate readings over a three month period).

Late presentation of patients with kidney failure increases morbidity, mortality and healthcare associated with costs. The total cost of CKD in England in 2009/10 was estimated as being circa £1.4 billion⁹⁴.

Early identification of CKD is therefore important to not only allow appropriate measures to be taken to slow or prevent the progression to more serious CKD, but also to highlight and manage the key associated risks related to patient safety and avoidable harm.

Table 1. Classification of CKD using GFR and ACR categories

GFR and ACR categories (including stages of CKD from previous guideline)			Albuminuria categories (mg/mmol)			Increased risk ↓
			<3 Normal to mildly increased	3-30 Moderately increased	>30 Severely increased	
			A1	A2	A3	
GFR categories (mL/min/1.73m ²)	290 Normal and high	G1 (stage 1)	No CKD*	G1 A2	G1 A3	
	60-89 Mild reduction related to normal range for a young adult	G2 (stage 2)		G2 A2	G2 A3	
	45-59 Mild-moderate reduction	G3a (stage 3a)	G3a A1^	G3a A2	G3a A3	
	30-44 Moderate-severe reduction	G3b (stage 3b)	G3b A1	G3b A2	G3b A3	
	15-29 Severe reduction	G4 (stage 4)	G4 A1	G4 A2	G4 A3	
	<15 Kidney failure	G5 (stage 5)	G5 A1	G5 A2	G5 A3	
						Increasing risk

⁹⁴ Kerr, M. et al. Estimating the financial cost of CKD to the NHS in England. Nephrology dialysis and transplantation. 2012. 27 (3) 73-80.

*By definition, in the absence of evidence of kidney damage, these categories are not CKD
 ^ Consider using eGFRcystatinC to confirm the diagnosis of CKD in people with eGFRcreatinine of 45-59 ml/min/1.73m², sustained for at least 90 days and no proteinuria (ACR less than 3 mg/mmol)

CKD indicator 005 (NICE 2015 menu ID: NM83)

The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)

CKD 005.1 Rationale

CKD is common, frequently unrecognised and often exists with other conditions such as CVD and diabetes. A GFR less than 60 ml/min/1.73m² is strongly associated with increased risk of adverse outcomes (acute kidney injury, end-stage kidney disease, all-cause mortality and cardiovascular mortality). Furthermore, a GFR less than 60 is also associated with increased frailty, impaired cognitive ability, increased risk of infection and an increase in prescribing errors.

This indicator aims to establish a register of people with CKD categories G3a to G5 to enable appropriate advice, treatment and support to be provided for people with moderate to severe CKD and so help preserve kidney function and reduce the risk of developing co-morbidity.

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

CKD 005.2 Reporting and verification

See indicator wording for requirement criteria.

Epilepsy (EP)

Indicator	Points	Achievement thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.	1	

EP – rationale for inclusion of indicator set

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

EP indicator 001

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

EP 001.1 Rationale

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

The phrase 'receiving treatment' has been included in order to exclude the large number of patients who may have had epilepsy in the past, may have not received treatment and been fit-free for many years. Some patients may still be coded as 'epilepsy' or 'history of epilepsy' and will be picked up on computer searches.

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

EP 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

Learning disabilities (LD)

Indicator	Points	Achievement thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities <i>NICE 2013 menu ID: NM73</i>	4	

LD – rationale for inclusion of indicator set

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

Further information

RCN learning disabilities guidance.

<http://www.rcn.org.uk/search?Scope=Local&Keyword=learning%20disabilities%20guidance%20&Relevance=True>

DH. 'Valuing People Now'. 2009.

<https://www.gov.uk/government/publications/valuing-people-now-summary-report-march-2009-september-2010>

Valuing People Now delivery plan 2010/2011 (published in 2010, this paper includes a section on further work needed following the 2009 paper. http://base-uk.org/sites/base-uk.org/files/fuser-raw/11-06/valuing_people_now_delivery_plan_2010-11.pdf

DHSC Review. 'Transforming care: A national response to Winterbourne View Hospital'. 2012. <http://www.dh.gov.uk/health/2012/12/final-winterbourne/>

Building the right support 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

LD indicator 004 (NICE 2015 menu ID: NM73)

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

LD 004.1 Rationale

This register indicator includes people of any age with a learning disability. This is because without a complete register of people with learning disabilities, practices may not be aware of the reasonable adjustments that may be needed for a child or young person with learning disabilities and their family, and of the help and support that may be useful to them. Evidence suggests there are an increasing number of children with learning disabilities now surviving childhood, some of whom will have profound and multiple disabilities as they grow up⁹⁵. It also suggests that health services are often unprepared for these children and young people and the complexity of their problems⁹⁶.

A full register of patients with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

Learning disabilities are heterogeneous conditions, but are defined by three core criteria:

- lower intellectual ability (usually defined as an Intelligence Quotient [IQ] of less than 70)
- significant impairment of social or adaptive functioning; and
- onset in childhood.

An IQ below 70 should not be used on its own to determine whether someone has a learning disability. 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 definition does not include all those people who have a “learning difficulty”, eg specific difficulties with learning, such as dyslexia.

Learning disability is defined in Valuing People as the presence of:

⁹⁵ Emerson, E. Estimating Future Numbers of Adults with Profound learning disabilities in England. 2009. <http://www.emeraldinsight.com/doi/abs/10.1108/13595474200900040?journalCode=tldr>

⁹⁶ Betz, C. Transition of Adolescents with Special Health Care Needs: review and analysis of the literature. 2004. Issues in Comprehensive Paediatric Nursing 27:179–241

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood (under the age of 18), with a lasting effect on development.

For many people, there is little difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about a diagnosis or the level of learning disability, referral to a multi-disciplinary specialist learning disability team (where available) may be necessary to assess the degree of disability and diagnose any underlying condition. In some areas, locality community learning disability teams, working with CCGs, provide expertise and data about and for people with learning disabilities. Contractors may wish to liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where available to assist in the construction of a primary care database⁹⁷.

It is a statutory requirement under the Equality Act 2010 that public sector agencies make 'reasonable adjustments' to their practice that will make them as accessible and effective as they would be for people without disabilities. Reasonable adjustments include removing physical barriers to accessing health services, but importantly also include making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for people with learning disabilities⁹⁸.

Further information

British Institute of Learning Disabilities. <http://www.bild.org.uk/>

Mencap. <https://www.mencap.org.uk/advice-and-support/health/dont-miss-out-annual-health-checks>

Hanlon P, MacDonald S, Wood K, Allan L, Cooper SA. Long-term condition management in adults with intellectual disability in primary care: a systematic review BJGP Open 2018; 2(1):bjgpopen18X101445

Carey I, Hosking F, DeWilde S, Harris T, Beighton C, Cook D. Learning disability registers in primary care. Br J Gen Pract 2016; 66 (648): 351-352 DOI: <https://doi.org/10.3399/bjgp16X685861>

LD 004.2 Reporting and verification

See indicator wording for requirement criteria.

A number of clinical codes were removed from the business rules in 2018 and practices were previously advised to review their recording of learning disability. A full list of acceptable clinical codes is detailed in the Business rules.

⁹⁷ See Martin and Martin. Journal of Learning Disabilities. 2000; 4(1): 37-48

⁹⁸ PHE. Making reasonable adjustments to eye care services for people with learning disabilities. 2013. <http://www.improvinghealthandlives.org.uk/publications.php5?rid=1167&edit>

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis <i>NICE 2011 menu ID: NM29</i>	3	

OST – rationale for inclusion of indicator set

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

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

OST indicator 004 (NICE 2011 menu ID: NM29)

The contractor establishes and maintains a register of patients:

- Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; and
- Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis

OST 004.1 Rationale

Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has described this as a force equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fractures^{99, 100}.

⁹⁹ WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis. 1998.

¹⁰⁰ NICE CG146. Osteoporosis: assessing the risk of fragility fracture. 2017.

<http://www.nice.org.uk/guidance/CG146>

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

NICE guidance on osteoporosis fragility fractures recommends that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible¹⁰¹. The SIGN guideline on the management of osteoporosis¹⁰² recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish that bone mass density (BMD) is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

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

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

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

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

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

¹⁰¹ NICE technology appraisal TA161. Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. 2017. <http://www.nice.org.uk/guidance/TA161>

¹⁰² SIGN guideline 142. Management of osteoporosis and the prevention of fragility fractures. 2015. <http://sign.ac.uk/pdf/SIGN142.pdf>

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

OST 004.2 Reporting and verification

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

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

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

In patients aged 75 or over:

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

Patients aged 50 or over and under the age of 75 in whom a diagnosis of osteoporosis has not been confirmed with DXA scanning will not be included in the register.

For patients aged 75 or over the diagnosis of osteoporosis can be either confirmed with DXA scanning or clinically assumed (if DXA scan is considered to be clinically inappropriate or unfeasible).

Patients with fragility fractures sustained in the last three months of the year will be excepted from this indicator.

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

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis <i>NICE 2012 menu ID: NM55</i>	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months <i>NICE 2012 menu ID: NM58</i>	5	40–90%

RA – rationale for inclusion of indicator set

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

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

RA indicator 001 (NICE 2012 menu ID: NM55)

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

RA 001.1 Rationale

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

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

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

- patients who are being treated and whose disease is in remission
- patients who are not receiving treatment for RA but have evidence of past disease, i.e. joint deformities. This type of RA is sometimes known as 'burnt

out' RA. These patients are on the register as they remain at risk of the systemic effects of RA

- patients who are not receiving treatment for RA who have no evidence of past disease but there is doubt about their diagnosis. The contractor may wish to request (ESR) or plasma viscosity, C-reactive protein (CRP), rheumatoid factor and hand X-ray to determine the accuracy of the diagnosis. Inaccurate diagnoses can be removed from the patient's patient record which would also remove them from the register.

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

Identifying recent-onset RA can be challenging in primary care because of the variety of ways in which synovitis can present itself and the small number of patients who have RA compared with the number of patients with musculoskeletal symptoms. NICE guideline NG100¹⁰³ recommends that patients with persistent synovitis are referred for specialist opinion. Urgent referral is needed when any of the following are present:

- the small joints of the hands or feet are affected
- more than one joint is affected
- there has been a delay of three months or longer between the onset of symptoms and seeking medical advice.

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

RA 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

RA indicator 002 (NICE 2012 menu ID: NM58)

The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months

RA 002.1 Rationale

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

¹⁰³ [NICE NG100](https://www.nice.org.uk/guidance/ng100). Rheumatoid arthritis in adults: management. 2018
<https://www.nice.org.uk/guidance/ng100>

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

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

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease upon the patient's life and whether they would benefit from any referrals to the MDT

RA 002.2 Reporting and verification

See indicator wording for requirement criteria.

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

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	

PC – rationale for inclusion of indicator set

Palliative or end of life care is the active total care of patients with life-limiting disease and their families by a multi-professional team. The first National End of Life Care (EoLC) Strategy¹⁰⁴ was published in July 2008 followed by:

- the National Palliative and EoLC Partnership. Ambitions for palliative and EoLC: A national framework for local action 2015-2020.
<http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>
- DH. Our commitment to you for EoLC: The Government response to the review of choice in EoLC. 2016.

¹⁰⁴ DH. National EoLC strategy. 2008. <https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life>

Supporting patients to make personalised end of life care plans is a key commitment in the NHS Long Term Plan.¹⁰⁵ There is also a commitment to improve access to palliative and end of life care for children. Timely identification of people in need of this support will be key to making these quality improvements.

PC indicator 001

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

PC 001.1 Rationale

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

Identifying patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator is focused on identifying these patients – a critical first step in addressing the key elements of good medical practice identified by the General Medical Council.¹⁰⁶

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

- their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask 'the 'surprise question' – 'Would I be surprised if this patient were still alive in 12 months?')
- they have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one or more core/general and one disease specific indicator in accordance with the gold standard framework (GSF) prognostic indicators guidance or the Supportive and Palliative Care Indicators Tool (SPICT)
- they are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

¹⁰⁵ NHS England. The NHS Long Term Plan. 2019. <https://www.longtermplan.nhs.uk>

¹⁰⁶ General Medical Council. 2010. Treatment and care towards the end of life: good practice in decision making. <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life>

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

PC 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

Section 4: Public health domain

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Initial diagnosis		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with NHS CB) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins	10	40–90%

CVD-PP – rationale for inclusion of indicator set

The latest Global Burden of Disease study shows that cardiovascular disease and specifically heart disease and stroke is one of the top five causes of early death in England¹⁰⁷. Whilst there have been significant improvements in the last 40 years the rate of improvement has slowed. The NHS Long Term Plan (2019) identifies cardiovascular disease and its prevention as the single biggest area where the NHS can save lives over the next 10 years¹⁰⁸.

CVD-PP indicator 001

In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with NHS

¹⁰⁷ Steel et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of disease Study 2016. The Lancet 2018;392(10158):1647-1661. [https://doi.org/10.1016/S0140-6736\(18\)32207-4](https://doi.org/10.1016/S0140-6736(18)32207-4)

¹⁰⁸ <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

England) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins

CVD-PP 001.1 Rationale

The risk of cardiovascular disease may be reduced through lifestyle changes, public health and NHS action on risk factors and the appropriate use of lipid modifying therapy. People with hypertension are at increased risk of cardiovascular disease and NICE Guidance CG127¹⁰⁹ recommends that they are offered an assessment of risk using a validated assessment tool.

NICE CG181 recommends QRISK2^{110, 111} as the risk assessment tool of choice in patients aged between 25-84 years. However, the Business rules for this indicator will also accept a risk assessment performed using the following additional tools:

- Framingham
- Joint British Society 2 (JBS2)
- QRISK
- QRISK3.

Clinical effectiveness of primary prevention

As noted above, actions to reduce the risk of cardiovascular disease include lifestyle changes and, where appropriate, lipid modification therapy using statins. NICE CG181 recommends offering atorvastatin 20 mg for the primary prevention of CVD to patients who have a 10% or greater 10-year risk of developing CVD however, the intervention threshold in this indicator has been pragmatically set at a 20% or greater 10-year risk. NICE CG181 also recommends that modifiable CVD risk factors such as smoking, diet and exercise should be optimised before statin therapy is offered for primary prevention.

NICE guidance recommends the decision whether to start statin therapy should be made after an informed discussion between the clinician and patient about the risks and benefits of statin treatment, considering additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy. A decision aid is available for patients:

<https://www.nice.org.uk/guidance/cg181/resources/cg181-lipid-modification-update-patient-decision-aid2>

The following recommendations are made in relation to the communication of risk and treatment:

- Set aside adequate time during the consultation to provide information on risk assessment and to allow any questions to be answered.
- Document the discussion relating to the consultation on risk assessment and the patient's decision.

¹⁰⁹ NICE CG127. Hypertension in adults. 2016. <https://www.nice.org.uk/guidance/cg127>

¹¹⁰ QRISK2. <https://qrisk.org/>

¹¹¹ QRISK3 is under development and will supersede QRISK2. Once QRISK3 is available, it will be added to the Business Rules at the first opportunity.

- Offer information about the person's absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. This information:
 1. presents individualised risk and benefit scenarios
 2. presents the absolute risk of events numerically
 3. uses appropriate diagrams and text.

Before starting statin treatment perform baseline blood tests and clinical assessment and treat comorbidities and secondary causes of dyslipidaemia. Include all of the following in the assessment:

- smoking status
- alcohol consumption
- blood pressure
- BMI or other measures of obesity (NICE CG189¹¹²)
- total cholesterol, non-HDL cholesterol, HDL cholesterol and triglycerides
- HbA1c
- renal function and eGFR
- transaminase level (alanine aminotransferase or aspartate aminotransferase)
- thyroid stimulating hormone (TSH).

Where a patient declines the offer of treatment, they should be advised that their CVD risk should be reconsidered in the future. The guideline also notes that CVD risk may be underestimated in people who are already taking anti-hypertensive or lipid modification therapy, or who have recently stopped smoking.

The guideline also states that a target for total or low density lipoprotein (LDL) cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD. The guideline (CG181) states that total cholesterol, HDL and non-HDL cholesterol should be measured in people started on high intensity statin (both primary and secondary prevention, including atorvastatin 20mg for primary prevention) at 3 months of treatment and target is for >40% reduction in non-HDL cholesterol. An annual non-fasting non-HDL measurement should be considered to inform an annual medication review.

CVD-PP 001.2 Reporting and verification

See indicator wording for requirement criteria.

Patients with the following conditions are excluded from this indicator:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes
- CKD with classification of categories G3a to G5.

¹¹² NICE CG189. Obesity prevention. 2014. <https://www.nice.org.uk/guidance/cg189>

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

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years. <i>NICE 2012 menu ID: NM61</i>	15	50–90%

BP indicator 002 (NICE 2012 menu ID: NM61)

The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years

BP 002.1 Rationale

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. Guideline recommendations for the diagnosis and treatment of hypertension¹¹³ are to be followed by practitioners when deciding on whether to treat raised blood pressure.

The age limit of aged 45 or over, has been chosen as the vast majority of patients develop hypertension after this age, this is also in line with the NHS Health Checks Scheme. It is also to align the indicator more closely with the vascular checks programme and the cost-effectiveness modelling undertaken to support that programme. The age range 45 or over, coupled with a five-year reference period, is designed to ensure that a blood pressure measurement takes place by the time someone reaches the age of 45.

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

BP 002.2 Reporting and verification

See indicator wording for requirement criteria.

Generally, personalised care adjustment criteria (see Section 6) do not apply to this indicator. However, practices are able to remove patients from the denominator where the patient declines to accept offered care.

¹¹³ NICE CG127. Hypertension in adults: diagnosis and management. 2016.
<http://www.nice.org.uk/guidance/cg127>

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months	8	

OB – rationale for inclusion of indicator set

The Global Burden of Disease study identifies obesity as one of the top five risk factors contributing to premature death in England along with smoking, poor diet, high blood pressure and drug and alcohol use¹¹⁴. Nearly two-thirds of adults in England are overweight or obese, some of the worst figures in Europe¹¹⁵. As noted in the NHS Long Term Plan obesity is linked with type 2 diabetes, high blood pressure, high cholesterol, increased rates of respiratory, musculoskeletal and liver disease and certain types of cancer.

The NHS Long Term Plan commits to a targeted offer of support and access to weight management services in primary care for people with a diagnosis of hypertension or type 2 diabetes with a BMI >30 , amongst other actions to reduce obesity.

Further information

NICE has produced multiple guidelines on clinical and public health approaches to tackling obesity, they can be accessed via the NICE Obesity Pathway <https://pathways.nice.org.uk/pathways/obesity>

OB indicator 002

The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months

OB 002.1 Rationale

The register includes all patients whose BMI has been recorded by the practice as part of routine care. It is expected that this data will inform public health planning and support onward referral to weight management services.

NICE guideline CG189¹¹⁶ recommends using BMI as a practical estimate of adiposity in adults. Identifying people with a BMI ≥ 25 includes a preventative aspect of care in

¹¹⁴ Steel et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of disease Study 2016. The Lancet 2018;392(10158):1647-1661. [https://doi.org/10.1016/S0140-6736\(18\)32207-4](https://doi.org/10.1016/S0140-6736(18)32207-4)

¹¹⁵ OECD. Obesity update 2017. Available from <http://www.oecd.org/health/obesity-update.htm>

¹¹⁶ NICE CG189. Obesity. 2014. <https://www.nice.org.uk/guidance/cg189>

managing obesity and supports interventions for people at risk of obesity ie those who are overweight but not yet obese.

OB 002.2 Reporting and verification

See indicator wording for requirement criteria.

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months <i>NICE 2011 menu ID: NM38</i>	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months <i>Based on NICE 2011 menu ID: NM40</i>	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months <i>NICE 2011 menu ID: NM39</i>	25	56–96%

SMOK – rationale for inclusion of indicator set

Smoking has been identified as one of the top five risk factors for premature death in England. About 6.1 million people in England smoke¹¹⁷ and an estimated quarter of women in the UK smoke during pregnancy¹¹⁸, Smoking is linked to a wide range of disease and conditions including cancers, respiratory disease, cardiovascular

¹¹⁷ ONS. Adult smoking habits in the UK: 2017. Available from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>

¹¹⁸ Royal college of Paediatrics and Child Health. Child health in England in 2030: comparisons with other wealthy countries. 2018. <https://www.rcpch.ac.uk/resources/child-health-england-2030-comparisons-other-wealthy-countries>

disease, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age related macular degeneration and periodontitis¹¹⁹. Smoking during pregnancy can cause serious pregnancy related health problems, these include: complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy¹²⁰. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40 per cent¹²¹.

The aim of this domain is to increase the proportion of successful smoking quit attempts by providing the best available support and treatment. There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone. For example, a Cochrane review that included 132 trials of nicotine replacement therapy (NRT), with over 40,000 people in the main analysis, found evidence that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70 per cent¹²². NHS Stop Smoking Services, combine psychological support and medication.

'An offer of support and treatment' means offering a referral or self-referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. Where such support is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

The NICE guidance on smoking cessation¹²³ states that healthcare professionals who advise on, or prescribe, NRT, varenicline or bupropion:

- offer NRT, varenicline or bupropion, as appropriate, to patients who are planning to stop smoking
- offer behavioural support including referral to the local Stop Smoking Service, to help patients in their attempt to quit
- when deciding which therapies to use and in which order, discuss the options with the client and take into account:
 1. whether a first offer of referral to the local Stop Smoking Service has been made
 2. contra-indications and the potential for adverse effects
 3. the client's personal preferences
 4. the availability of appropriate counselling or support
 5. their previous experience of smoking cessation aids.

¹¹⁹ US DH and Human Services 2004

¹²⁰ NICE public health guidance 26. Smoking: stopping in pregnancy and after childbirth. 2010. <http://www.nice.org.uk/guidance/ph26>

¹²¹ DH. Review of the health inequalities infant mortality PSA target. 2007. <http://www.perinatal.nhs.uk/smoking/Health%20Inequalities%20report%202007.pdf>

¹²² Stead LF, Perera R, Bullen C etc al. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews. 2008. John Wiley and Sons, Ltd no.1

¹²³ [NICE NG92](https://www.nice.org.uk/guidance/ng92). Stop smoking interventions and services. <https://www.nice.org.uk/guidance/ng92>

The guidance also states that managers and providers of local Stop Smoking Services:

- offer behavioural counselling, group therapy, pharmacotherapy, or a combination of treatments that have been proven to be effective
- ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments'¹²⁴ or its updates
- provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups
- provides services in the language chosen by clients, wherever possible.

NICE guidance also states that stop smoking advisers and other healthcare practitioners who advise on, supply, or prescribe, pharmacotherapies should encourage people who are already using an unlicensed nicotine-containing product (such as unlicensed electronic cigarettes) to switch to a licensed product¹²⁵.

Due to the potential for ex-smokers to resume smoking within three years of cessation, it is good clinical practice to ask patients with a history of smoking their current smoking status and offer treatment and advice where necessary. It is also good practice to ask and record the smoking status of newly registered patients and to offer support and treatment where necessary.

For further information

NICE public health guidance [45](https://www.nice.org.uk/guidance/ph45). Smoking: harm reduction. 2013.
<https://www.nice.org.uk/guidance/ph45>

NICE public health guidance 48. Smoking: acute, maternity and mental health services. 2013. <https://www.nice.org.uk/guidance/ph48>

SMOK indicator 002 (NICE 2011 menu ID: NM38)

The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months

SMOK 002.1 Rationale

See rationale above.

SMOK 002.2 Reporting and verification

See indicator wording for requirement criteria. The contractor should report smoking status using the following guidance:

Smokers

¹²⁴ NCSCT training standard http://www.ncsct.co.uk/usr/pub/NCSCT_Training_Standard.pdf

¹²⁵ NICE public health guidance 48. Smoking: acute, maternity and mental health services. 2013.
<http://www.nice.org.uk/guidance/PH48>

For patients who smoke, smoking status should be recorded in the preceding 12 months.

Non-smokers

It is recognised that life-long non-smokers are very unlikely to start smoking and repeatedly asking smoking status can be unnecessary. Smoking status for this group of patients should be recorded in the preceding 12 months for until the end of the financial year in which the patient reaches the age of 25.

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

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

Ex-smokers

Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

For the purposes of QOF users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.

The disease register for the purpose of calculating APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities e.g. diabetes and CHD are only counted once.

SMOK indicator 004 (based on NICE 2011 menu ID: NM40)

The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months

SMOK 004.1 Rationale

See rationale above.

SMOK 004.2 Reporting and verification

See indicator wording for requirement criteria.

There is no APDF calculation for SMOK004.

SMOK indicator 005 (NICE 2011 menu ID: NM39)

The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months

SMOK 005.1 Rationale

See rationale above for guidance on 'support and treatment' and smoking cessation.

This indicator relates to patients who are on the disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma and mental health who are recorded as current smokers.

SMOK 005.2 Reporting and verification

See indicator wording for requirement criteria.

The disease register for the purpose of calculating APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities e.g. diabetes and CHD are only counted once.

Public health domain – additional services

For contractors providing additional services the following indicators apply.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS005. The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months <i>NICE 2017 menu ID: NM154</i>	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months <i>NICE 2017 menu ID: NM155</i>	4	45-80%

CS indicator 005 (NICE 2017 menu ID: NM154)

The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months

CS indicator 006 (NICE 2017 menu ID: NM155)

The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months

CS005.1 and 006.1 Rationale

These indicators are designed to encourage and incentivise contractors to offer age appropriate cervical screening in line with the recommendations of the NHS Screening Programme and to continue to achieve high levels of uptake of this.

Specific requirements apply to these indicators in relation to the Personalised Care Adjustment. These are detailed in Section 6.

CS005.2 and CS006.2 Reporting and verification

See indicator wording for requirement criteria.

Commissioners may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number with a personalised care adjustment and the number who have had a cervical screening test performed at the appropriate time interval.

Women need to be sent a minimum of three invitations before the personalised care adjustment of not responding to invitations for care can be applied as described in Section 6 of this guidance. As of 2019, there will be a discrete SNOMED code to record that women have not responded to three invitations for cervical screening.

Section 5: Quality improvement domain

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

End of life care

Indicator	Points	Achievement thresholds
QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance	27	NA
QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.	10	NA

Rationale for inclusion of a QI domain

This is a new domain which seeks to fulfil the recommendation in the Report of the Review of QOF¹²⁶ to introduce a quality improvement domain. The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development

¹²⁶ <https://www.england.nhs.uk/wp-content/uploads/2018/07/quality-outcome-framework-report-of-the-review.pdf>

and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality¹²⁷.

NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement actions. Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement targets to address these. There are no deadlines given for the completion of the diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas identified for 2019/20 are prescribing safety and end of life care. These topics will change on an annual basis. Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules.

The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

All the supporting information and resources referred to in this guidance will be made available on NHS England's website by end of March 2019. Further information as to how to undertake quality improvement activities is available from a number of sources including:

NHS England Sustainable Improvement Team

(<https://www.england.nhs.uk/sustainableimprovement/>) - this is a national resource to support quality improvement activity in primary care and includes training, practical advice and support from quality improvement specialists.

NHS Improvement (<https://improvement.nhs.uk/improvement-hub>) - resources including improvement tools and case studies.

RCGP QI resources (www.rcgp.org.uk/qi) - resources including the RCGP QI Guide for General Practice and other quick guides to the use of quality improvement tools and techniques. These are available to both members and non-members.

¹²⁷ <https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf>

Health Foundation (<https://www.health.org.uk/publications/quality-improvement-made-simple>) - an easy to read and practical guide to undertaking QI

NICE Practical Steps [<https://intopractice.nice.org.uk/practical-steps-improving-quality-of-care-services-using-nice-guidance/index.html>] – online guide to putting NICE guidance into practice and tools to support this.

Institute for Health Improvement [<http://www.ihl.org/>] – a US site with a range of resources to support QI activity.

Prescribing safety

Indicator	Points	Achievement thresholds
QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.	27	NA
QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.	10	NA

Rationale

Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare ([NICE, 2015](#)). The number of prescribed medicines supplied in primary care in England has been increasing year on year. The Health Survey for England 2016 ([NHS Digital, 2017](#)) reported that 1,104 million prescription items were dispensed in 2016, an increase of 1.9% (20.5 million additional items) on the number dispensed in 2015. The average number of prescription items per head of the population in 2016 was 20.0, compared with 19.8 items in the previous year.

As primary care staff will be aware, the number of people with multiple conditions is increasing; 25% of all people in England live with 2+ conditions and 8% live with 4+ conditions ([Health Foundation, 2018](#)). Over a 2-year period, people with 4+ conditions visited their GP almost 25 times for face to face consultations and were prescribed over 20 different medications.

In May 2012, the GMC published its report *Investigating the prevalence and causes of prescribing errors in general practice* which found that 1 in 20 prescriptions contained an error in terms of medication or monitoring. Most were graded as mild or moderate severity but 1 in 550 was a severe error. Many such errors relate not just to a prescriber's clinical knowledge but also to communication between primary and

secondary care, communication with patients and carers, and safety monitoring systems in practices.

Through these QOF indicators practices are being encouraged to help meet the WHO challenge to reduce medication-related harm by 50% by December 2022 (*Medication Without Harm*, Third Global Patient Safety Challenge, WHO, 2017) and recently announced five-year action plan to reduce antimicrobial resistance (Tackling antimicrobial resistance 2019-2024, HM Government 2019).

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in the following aspects of prescribing safety:

- Reduce the rate of potentially hazardous prescribing, with a focus upon the safer use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at significant risk of complications such as gastro-intestinal bleeding.
- Better monitoring of potentially toxic medications and the creation of safe systems to support drug monitoring through a focus upon lithium prescribing (or another agreed medication if no patients on the registered list are currently being prescribed lithium).
- Better engagement of patients with their medication through a focus upon valproate and pregnancy prevention.
- Improve collaboration between practices, networks and community pharmacists to share learning and improve systems to reduce harm and improve safety.

Practices will need to:

- i. Evaluate the current quality of their prescribing safety and identify areas for improvement – this would usually include an baseline assessment of current prescribing (QI001)
- ii. Identify quality improvement activities and set improvement goals to improve performance in the three identified areas – see below (QI001)
- iii. Implement the improvement plan (QI001)
- iv. Participate in a minimum of 2 network peer review meetings (QI002)
- v. Complete the QI monitoring template in relation to this module (QI001 + QI002)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should undertake an audit of the current quality of their prescribing in relation to the following measures:

- Patients at significant risk of gastrointestinal adverse effects who have been prescribed a nonselective nonsteroidal anti-inflammatory drug (NSAID) without co-prescription of a proton-pump inhibitor (PPI) in the preceding 6 months.
- Patients receiving lithium and being monitored in primary care who have not had a recorded check of their lithium concentrations, estimated glomerular filtration rate, urea and electrolytes, serum calcium and thyroid function in the previous 6 months.
- Girls and women of childbearing potential currently being prescribed valproate have had an annual specialist medication review and are taking this in compliance with the pregnancy prevention programme as documented by a specialist in the annual risk acknowledgement form. This standard applies equally to unlicensed use for pain, migraine and other conditions.

Where practices do not have any patients being prescribed lithium they may select an alternative medication to focus on based on their prescribing data and professional judgement. It is recommended that the medication chosen reflects similar issues to lithium prescribing e.g. a requirement for systematic toxicity monitoring. Suggested alternatives include the appropriate monitoring of amiodarone, phenobarbital or methotrexate. As this is a quality improvement exercise, this should not lead to the removal of locally agreed shared care protocols, including any associated funding to deliver the activity. Any alternative to lithium should be agreed between the contractor and the commissioner.

Even if a practice does not have any girls of any age or women of childbearing potential who are currently prescribed valproate, they should ensure their practice has a robust system in place to identify and refer for annual specialist review any new at-risk patients being prescribed valproate and should ensure continuous measurement of this measure. The inclusion of valproate prescribing and monitoring seeks to further promote health care professional awareness of the appropriate monitoring actions whilst awaiting the report of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege.

These medications have been selected as they are linked to significant potential harm if prescribed and managed inappropriately. At a national level, progress against these measures will be monitored and used to inform any evaluation of this QI module.

Box 1. How to do a prescribing audit

A prescribing audit is considered to have five steps:

1. Choose a relevant topic (such as NSAID prescribing)
 2. Derive some standards from good quality guidelines (eg NICE)
 3. Measure your prescribing practice (through searches in the clinical system) and compare how you do against your chosen standards
 4. Plan any actions needed to make improvements or sustain good practice and implement them, setting clear goals to achieve
 5. Repeat the measurement of your prescribing practice against the standards to assess the impact of the changes you have made.
- Continue repeated cycles of these steps as you judge necessary.

An audit function is available on all GP software systems to identify and recall all women and girls being prescribed valproate who may be of child bearing potential. Contractors should use this tool in preference to developing their own bespoke searches.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the RCGP guide *How to get started in QI* (<https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx>). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

Following the initial baseline assessment, practices should develop a quality improvement plan which describes the actions they are going to take to address the prescribing safety improvements they are going to make. Evidence based improvement quality activities include:

- Audit of current prescribing against validated measures
- Review of patients identified as potentially at risk through the audit
- Review of practice systems to address organisational factors which contribute to medication related harm
- Ongoing measurement to demonstrate the impact of any changes^{128 129}

¹²⁸ Avery et al. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. *The Lancet* 2012;379(9823):1310-1319. [https://doi.org/10.1016/S0140-6736\(11\)61817-5](https://doi.org/10.1016/S0140-6736(11)61817-5)

¹²⁹ Dreischulte et al. Safer prescribing – a trial of education, informatics and financial incentives. *N Eng J Med* 2016;374:1053-1064. <https://doi.org/10.1056/NEJMsa1508955>

Objectives to support these plans should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Factors to consider when setting these targets include:

- The severity level of identified clinical risk to patients
- The urgency of the timescale to review patients and reduce the risk
- The availability and training of appropriate practice staff to review patients

Quality improvement activities can involve the whole practice team and specialist advice as necessary. In relation to prescribing safety, practices are encouraged to work with clinical and community pharmacists to consider potential improvements and how these may be realised.

There are many aspects of prescribing safety which would be suitable for quality improvement work, but practices should as a minimum address the aspects listed above. A number of external resources are available to support practices with improving prescribing safety such as the [RCGP Patient Safety toolkit](#). In addition, the Academic Health Sciences Network (AHSNs) are implementing the PINCER intervention between now and 2020. Practices are encouraged to engage with their AHSN to access this support.

Box 2: Examples of SMART objectives

Objective 1:

Baseline practice prescribing analysis identifies patients on regular NSAID prescriptions with a recorded contraindication.

SMART outcome: Repeat analysis after 3 months (and repeated at 3monthly interval thereafter) shows NO PATIENTS with a recorded contraindication have been prescribed NSAIDS.

Objective 2:

Baseline practice prescribing analysis shows only 5% of patients obtaining a regular (repeat) NSAID have had a clinical safety risk assessment clearly documented within the last 12months.

SMART outcome: Increase from 5% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people prescribed NSAIDs regularly have a documented clinical safety risk assessment (as part of their medication review) as per NICE advice within the preceding 12months.

Objective 3:

Baseline practice prescribing analysis shows 50% of patients prescribed lithium for more than one year and suitable (as per NICE guidance) for 6 monthly checks had had a recorded serum lithium level checked within the last 6 months.

SMART outcome: At a repeat analysis 6 months after the baseline analysis there is an increase from 50% to X% (practice to decide) of patients prescribed lithium for greater than a year who are suitable for 6 monthly checks who have a recorded serum lithium level within the last 6 months.

Objective 4

Baseline practice prescribing analysis shows no girls or women of childbearing potential are currently prescribed valproate without a highly effective pregnancy prevention plan in place as per MHRA guidelines. However no practice system is in place to routinely identify new potential at risk patients.

SMART outcome: Within one month the practice can demonstrate an appropriate repeated monthly search of the clinical system to identify all girls or women of childbearing potential who have been recommended to start valproate medication have had a clinical review to ensure compliance with the pregnancy prevention programme as recommended by the MHRA.

Guidance on specific elements of the quality improvement activity

NSAID prescribing

[NICE Clinical Knowledge Summary \(CKS\) on NSAID prescribing](#) (revised August 2018) provides advice on this topic including how to reduce harm from gastrointestinal side effects such as ulcer, perforation, obstruction or bleeding. Nonsteroidal anti-inflammatory drugs (NSAIDs) must not be prescribed to people with:

- active gastrointestinal (GI) bleeding, or active GI ulcer
- history of GI bleeding related to previous NSAID therapy, or history of GI perforation related to previous NSAID therapy
- history of recurrent GI haemorrhage (two or more distinct episodes), or history of recurrent GI ulceration (two or more distinct episodes).

The CKS advice also sets out how to assess risk of harm from NSAIDs in patients and then what appropriate prescribing decisions to take. This advice can be used as evidence-based standards against which to assess a practice's current prescribing.

Examples of the audit standards which practices could adopt are:

- No patients with a current clinical contraindication are currently being prescribed an NSAID medication.
- 100% of patients with an NSAID medication on regularly receiving a repeat prescription have had a documented clinical safety risk review in the last 12 months.
- 100% of patients identified as high risk and requiring ongoing treatment have been prescribed a selective NSAID.
- 100% of patients identified as moderate risk and requiring ongoing treatment have been prescribed an appropriate NSAID with proton pump inhibitor unless contraindicated.

Practices should then demonstrate the action they have taken to reduce risk to these patients, and the system or process they will continue to use to maintain safe NSAID prescribing.

Monitoring or potentially toxic medications – Lithium

[NICE guidance Bipolar disorder: assessment and management](#), NICE (2014) clearly sets out the requirements for monitoring lithium once a patient has been returned from secondary to primary care.

Analysis of the practice's prescribing data and searches within the practice's electronic clinical system will be able to identify individual patients prescribed lithium who are not being managed in line with NICE guidance. Practices are encouraged to review their process for following up a person who has not responded to invitations for monitoring or fails to order or collect prescriptions to ensure concordance with treatment plans and avoid clinical deterioration and crisis.

Practices can use the QI approach to ensure their processes for lithium monitoring are robust and comply with NICE guidance and take action to identify and reduce any risks to individual patients.

Valproate and pregnancy prevention programme – [MRHA alert April 2018, updated October 2018](#)

(see also *Drug Safety Update* volume 11 issue 10; May 2018)

During 2018, all practices and individual GPs will have been sent a pack of information advising them of the need to identify any girl or woman of childbearing potential (this is defined as a pre-menopausal woman who is capable of becoming pregnant) currently being prescribed valproate and setting out a series of actions for health professionals including GPs. Valproate use in pregnancy is associated with an increased risk of children with congenital abnormalities and developmental delay. Valproate is contraindicated in women of childbearing potential unless the conditions of the valproate pregnancy prevention programme are fulfilled. Whilst the rates of prescribing of valproate continue to decline slowly there are wide geographical variations in prescribing.

Clear actions have been set for general practices to identify and recall existing patients, provide them with a copy of the Patient Guide, to check they have had a specialist review in the last year and to have systems in place to identify and appropriately manage new patients who are prescribed valproate and are of child bearing potential.

The pregnancy prevention programme requires GPs to:

- Ensure continuous use of highly effective contraception* in all women of childbearing potential (consider the need for pregnancy testing if not a highly effective method).
- Check that all patients have an up to date, signed, Annual Risk Acknowledgment Form each time a repeat prescription is issued.
- Ensure the patient is referred back to the specialist for review, annually.
- Refer back to the specialist urgently (within days) in case of unplanned pregnancy or
where a patient wants to plan a pregnancy.

* The Summary of Product Characteristics for valproate states that 'Women of childbearing potential who are prescribed valproate must use effective contraception without interruption during the entire duration of treatment with valproate. These patients must be provided with comprehensive information on pregnancy prevention and should be referred for contraceptive advice if they are not using effective contraception. At least one effective method of contraception (preferably a user independent form such as an intra-uterine device or implant) or two complementary forms of contraception including a barrier method should be used. Individual circumstances should be evaluated in each case when choosing the contraception method, involving the patient in the discussion to guarantee her engagement and compliance with the chosen measures. Even if she has amenorrhea she must follow all the advice on effective contraception.'

For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and on the use of valproate during pregnancy to their parents/ caregiver/ responsible person and make sure they clearly understand the content.

The practice should regularly use the audit function on their clinical system to identify at risk patients and ensure timely recall for clinical review in line with the MHRA alert. Such continuous measurement can be used to demonstrate compliance with the MHRA alert.

This improvement programme offers general practice a further opportunity to ensure these actions have been completed and that ongoing systems to protect patients from harm have been put in place.

3. Implementing the plan

Practices should implement the improvement plan developed to support their objectives. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community pharmacy where practicable.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set themselves. These should focus upon necessary changes to practice systems and processes, staff roles, methods of recording and sharing information as well as reviewing care for individual patients.

Continuous measurement is recommended to demonstrate the impact of the changes being tested. The audit cycle should be closed by repeating the audit and clarifying the outcomes achieved.

Example case studies can be downloaded from
<https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/>.

4. Network peer review meetings

A key objective of the network peer review meetings is the establishment of a system to enable shared learning across Primary Care Networks. The aim of this is to share best practice in prescribing safety.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of

these meetings but we would recommend that the first meeting takes place early in the QI activity and the second towards the end.

Box 3. Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI process and focus upon:

- Sharing of the outputs of diagnostic work to understand the issues associated with prescribing safety
- Validation of practice improvement targets

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI process and should focus upon:

- Celebrating successes and sharing of key changes made in practice.
- How these changes can be embedded into practice.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity prescribing safety is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification – Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exception and unforeseen circumstances then they will need to demonstrate other active engagement in peer learning as review.

The reporting template is available from

<https://www.england.nhs.uk/gp/gpfp/investment/gp-contract/>. Patient identifiable information should not be included in this template or appended to it.

End of life care

Indicator	Points	Achievement thresholds
QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance	27	NA
QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.	10	NA

Rationale

In 2015 the National Palliative and End of Life Care Partnership published [*Ambitions for palliative and end of life care: a national framework for local action 2015-2020*](#).

This quality improvement activity is designed to support practices to respond to those ambitions and to build the foundations needed to provide excellent, holistic and individualised care for all.

Identifying patients in need of end of life care, assessing their needs and preferences, and proactively planning their care with them are key steps in the provision of high quality care at the end of life in general practice. There is evidence to suggest that there is the potential for the quality of this care to be improved¹³⁰. Increased use of healthcare services during this time also occurs often with limited clinical effectiveness and poor experiences for people. Better identification of people in the last year of their life followed by appropriate care planning and support for them are recognised as key elements of good medical practice as set out by the General Medical Council ([*Treatment and care towards the end of life: good practice in decision making*](#), 2010).

Involving, supporting and caring for all those important to the dying person is also recognised as a key foundation of good end of life care. As well as being individuals facing impending loss and grief, they often provide a key caring role for the dying person.

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. **Early identification and support for people** with advanced progressive illness who might die within the next twelve months.
2. **Well-planned and coordinated care** that is responsive to the patient's changing needs with the aim of improving the experience of care.
3. **Identification and support for family / informal care-givers**, both as part of the core care team around the patient and as individuals facing impending bereavement.

Practices will need to:

- vi. Evaluate the current quality of their end of life care and identify areas for improvement – this would usually include a retrospective death audit (QI003)
- vii. Identify quality improvement activities and set improvement goals to improve performance (QI003)
- viii. Implement the improvement plan (QI003)
- ix. Participate in a minimum of 2 GP network peer review meetings (QI004)
- x. Complete the QI monitoring template in relation to this module (QI003 + QI004)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

¹³⁰ National Audit Office. End of Life Care: Report by the Comptroller and Auditor General. 2008; available from <https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf>

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. Box 4 provides further information about how to do this. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care process then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?
- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency treatment preferences such as recording of decision on cardiopulmonary resuscitation (note evidence suggests that this should be part of the care planning process and not done in isolation).
- Main carer is identified with offer of assessment and support
- Anticipatory medicines are available in the place of care

We encourage practices, particularly those with well-established end of life care processes to seek the views of family members / informal carers which for example could be done through a **survey of carers** or a **structured interview with one carer or patient every six months** to evaluate how well the practice meets their needs and what improvements could be made.

Box 4: How to do a retrospective death baseline analysis (audit)

Practices should review a sample of X deaths over the previous 12 months to establish baseline performance on the areas of care listed above and to calculate their expected palliative care register size. A suggested template to support data collection for the audit can be downloaded from <https://www.england.nhs.uk/gp/gpfp/investment/gp-contract/>.

The number of deaths each year will vary between individual practices due to differences in the demographics of the practice population. Practices could use the number of deaths reported in their practice populations in the previous year to assess how well they are identifying patients who would benefit from end of life care. An audit standard against which to assess current practice would be that the practice was successfully anticipating approximately 60% of deaths.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the accompanying RCGP guide How to get started in QI (<https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx>). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

The identification of quality improvement activities should be informed by the results of the retrospective death baseline audit and analysis. Practices should focus their QI activities on delivering improvement across the following four **measures**:

1. An increase in the proportion of people who die from advanced serious illness who had been **identified** in a timely manner on a practice 'supportive care register', in order to enable improved end of life care, reliably and early enough for all those who may benefit from support.
2. An increase in the proportion of people who died from advanced serious illness who were sensitively **offered timely and relevant personalised care and support plan discussions; documented and shared electronically** (with appropriate data sharing agreements in place) to support the delivery of coordinated, responsive care in and out of hours with key cross-sector stakeholders.
3. An increase in the proportion of people who died from advanced serious illness where a family member / informal care-giver/ next-of-kin had been **identified**; with an increase in those who were **offered holistic support before and after death**, reliably and early enough for all those who may benefit from support.
4. A reliable system in place to monitor and enable improvement based on timely feedback of the **experience of care** from staff, patients and carer perspectives.

These measures will be used at a national level to assess the impact of the module.

Identification and care planning should be addressed in parallel. Improvement activity should focus on impact., and may include a dedicated focus on specific areas or patient groups e.g. the practice may perform well in relation to supporting patients with cancer at the end of life, but could improve in relation to other patient groups e.g. those with respiratory disease, children with life limiting illnesses or people with learning disabilities.

Practices may also wish to review the RCGP and Marie-Curie Daffodil standards: core Standards for advanced serious illness and end of life care in general practice (<https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical->

<resources/daffodil-standards.aspx>) and the NICE Quality Standards for End of Life Care in Adults (QS13) and Care of dying adults in the last days of life (QS144) for further suggestions of appropriate quality improvement activities.

For each of the measures, practices should identify and agree their own objectives which are *SMART* (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 5 for examples of SMART outcomes. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Box 5: Examples of SMART outcomes for each measure

Measure 1:

Baseline analysis from retrospective audit – 20% of people affected by serious illness and end of life care who died, had already been identified on a practice 'supportive care register'.

SMART outcome: Increase from 20% to X% of people **affected by serious illness and end of life care who died, to be identified** on a practice 'supportive care register', over the next 6 months.

Measure 2:

Baseline analysis from retrospective audit – 10% of people **affected by serious illness and end of life care who died**, had been sensitively offered timely and relevant personalised care and support plan discussions and these were **documented and shared electronically**.

SMART outcome: Increase from 10% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people **affected by serious illness and end of life care who died, to be** sensitively offered timely and relevant personalised care and support plan discussions and have these **documented and shared electronically**.

Measure 3:

Baseline analysis from retrospective audit – 10% **of family members / informal care-givers/ next-of-kin** identified on a practice 'supportive care register' were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.

SMART outcome: Increase from 10% to X% (practice to decide) of **family members / informal care-givers/ next-of-kin** identified on the practice 'supportive care register' to be contacted and offered information on dealing with grief and bereavement within X weeks /months (practice to decide) of the person on the register dying – within a 12-month period.

Measure 4:

SMART outcomes:

To support and reflect on retrospective death audit and practice-relevant QI planning within the 12-month period, achieving a minimum of:

- a) 2-5 family/care-giver or patient interviews (See Appendix 1) e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.

Optional and additional SMART OUTCOMES could include:

- Staff feedback to support the QI planning (See Appendix 1) e.g. survey
- MDT feedback to support the QI planning (See Appendix 1) e.g. survey, discussion at MDT

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set for themselves in relation to the measures they are focusing on.

Example case studies can be viewed at
<https://www.england.nhs.uk/gp/gpfp/investment/gp-contract/>.

4. GP Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from deaths and the provision of best practice end of life care. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 6.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but it is recommended that the first meeting takes place early in the QI activity and the second towards the end.

Box 6: Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the diagnostic work to understand the issues for each practice about end of life care.
- Validation of practice improvement targets.

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in end of life care is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been

unable to attend a meeting due to exceptional circumstances then they will need to demonstrate other active engagement in network peer learning and review.

The reporting template is available from

<https://www.england.nhs.uk/gp/gpfp/investment/gp-contract/>. Patient identifiable information should not be included in this template or appended to it.

Section 6: Personalised care adjustment

As of 1 April 2019, exception reporting is being replaced with a Personalised Care Adjustment (PCA). This will allow practices to differentiate between the following reasons for adjusting care and removing a patient from the indicator denominator:

- *unsuitability* for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy;
- *patient choice*, following a shared-decision making conversation;
- the patient *did not respond* to offers of care – recording of this will change to capture actual invitations sent to patients;
- the specific service is *not available* (in relation to a limited number of indicators only); or
- *newly diagnosed or newly registered* patients, as per existing rules.

As with exception reporting applying a PCA to the patient record will remove that patient from an indicator denominator if the QOF defined intervention has not been delivered. It will not result in patients being removed from the disease register or other target population.

This mechanism differs from ‘exclusions’ which refer to patients on a particular clinical register who are not included in an indicator denominator for definitional reasons. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

The associated changes to data recording and extraction should result in a redistribution of coding work away from year-end and provide better information about why patients are not receiving interventions.

Principles

When considering whether a PCA applies to an individual patient practices are reminded that:

- the duty of care remains for all patients,

- the decision to apply a personalised care adjustment should be based on clinical judgement, informed by patient preferences and underpinned by shared decision-making principles, with clear and auditable reasons coded or entered in free text on the patient record
- there should be no blanket personalised care adjustments: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set and this decision reviewed on a regular basis.

In each case where a personalised care adjustment is applied then in addition to what needs to be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the reason for the adjustment is fully recorded in a way that can facilitate both safe and effective patient care and audit of the patient record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient's record as well as a code to indicate intolerance.

Criteria for the personalised care adjustment

Personalisation of care can occur for the following reasons which are listed in the order in which they will be extracted in the Business Rules:

1. The investigative service or secondary care service is unavailable (where relevant to the indicator)
2. Intervention described in the indicator is clinically unsuitable
3. The patient has chosen not to receive the intervention described in the indicator
4. The patient has not responded to invitations for the intervention described in the indicator (a minimum of two invitations for the intervention in the preceding 12 months, except for the cervical screening indicators where women should receive a total of three invitations for screening)
5. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 3 months and has not received the defined clinical measurements e.g. blood pressure measurement
6. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards e.g. blood pressure control within target levels.

It is recognised that patients may meet more than one of these criteria and in these circumstances all reasons for personalisation should be recorded in the patient's record to facilitate safe and effective patient care. However, as a patient can only be acknowledged as having a personalised care adjustment once within the Business Rules for a given indicator, they will be allocated to the first criterion they meet in the hierarchy listed above. For example, where a patient is recorded as having registered with the practice in the preceding 3 months and has also chosen not to

receive the intervention described in the indicator they would be identified in the Business Rules as having chosen not to receive the care.

The hierarchy listed above seeks to prioritise clinical judgement and patient choice over other criteria. Applying this hierarchy consistently in the Business Rules in conjunction with the recording changes described below will support better attribution of the reason for care being personalised, allowing for more meaningful conversations between clinicians, commissioners and regulators.

Interpretation and recording of the personalised care adjustment

The interpretation of these categories and how they should be recorded is detailed further below.

The investigative service or secondary care service is unavailable

This care adjustment will apply only to the following indicators: HF002, AST002, COPD002, COPD008 and DM014.

Where one of these services is unavailable this should be recorded using specific codes which state that the service is unavailable. The contractor is expected to explore fully with their CCG, if a suitable investigative or secondary service could be commissioned for the patient prior to entering a service unavailable code in the patient record.

The frequency with which service unavailable codes should be added to the patient record is noted below and may vary between indicators. Some codes may need to be entered annually whereas others may only need to be entered once in the relevant timeframe stated in the indicator.

Table 2: Frequency of data entry

Indicator ID	Service unavailable may be recorded
HF002	Within 1 year of diagnosis of heart failure
AST002	Required annually
COPD002	Required annually
COPD008	Required each year the patient becomes eligible for pulmonary rehabilitation
DM014	Within 279 days of diagnosis of diabetes

Intervention described in the indicator is clinically unsuitable

We envisage this being the main reason for personalisation of care, recognising the importance of clinical judgement in determining the applicability of guideline recommendations to individual patients.

This category encapsulates the historical exception reporting criteria of 1) patients for whom it is not appropriate to review their chronic disease parameters due to particular circumstances e.g. receiving end of life care, 2) those who are on maximal tolerated doses of medication, 3) those who have an allergy, contraindication or adverse reaction to medication, 4) those who have not tolerated medications and 5) where the patient has a supervening condition which would make treatment of their condition inappropriate.

This criterion will be supported by both generic 'patient unsuitable' codes which will apply to all indicators in the clinical area and more specific codes which can be attributed to single indicators. Over time, more specific codes will be introduced which define the clinical reasons which might make the intervention clinically unsuitable for an individual patient.

Codes which indicate ongoing and permanent reasons for personalisation of care such as allergies to specified medication may be entered once in the medical record. Other codes will need to be recorded on an annual basis following an individual patient review of the applicability of the intervention described in the indicator.

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out and either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, this should be noted in the patient record. A personalised care adjustment may then be applied.

The patient has chosen not to receive the intervention described in the indicator

This criterion requires that there has been a personal contact or a discussion recorded in the patient record which ideally notes the reasons for the intervention being declined. This contact may be face-to-face, video conferencing or telephone contact between a health professional and the patient.

This criterion will be supported by both generic 'informed dissent' codes which will apply to all indicators in the clinical area and more specific codes which can be attributed to single indicators. Practices are encouraged to use more specific codes where they are available.

The decision to decline a QOF intervention should be reviewed with the patient on an annual basis and recorded annually if necessary. The exceptions to this are indicators CS005 and CS006 where the choice not to receive the intervention need only be entered once during the time-period stated in the indicator. However, as noted in the underpinning principles, good practice would be to revisit this decision

on a regular basis. Women who choose to withdraw from the cervical screening call/recall will receive no further offers of screening from the central screening service.

The patient has not responded to invitations for the intervention described in the indicator

To be removed from an indicator denominator using this criterion patients must have been sent a minimum of **two** invitations for QOF care at two unique time points in the QOF year i.e. 1 April to 31 March separated by a minimum of seven calendar days. The exceptions to this are indicators CS005 and CS006 where the patient should have been sent a minimum of **three** invitations at three unique time points during the timeframe stipulated in the indicator.

General standards and recording requirements for invitations

Many different methods of communication are already available to invite patients for QOF care and these are likely to expand with the ongoing development of digital technology. The NHS also has a legal duty to ensure that patients who have a disability, impairment or sensory loss get information that they can access and understand as set out in the Accessible Information Standard.¹³¹ The first step to making an effective invitation for care therefore is that it is made in a manner which is accessible to the patient. Therefore, practices should prospectively and opportunistically record individual patients preferred methods of communication, for example at the time of the next patient contact. Where a preferred contact method is recorded this would be used to make the first invitation for care. The second invitation may be via any method.

All invitations should be personalised to the patient i.e. use their name and specify what they are being invited for. Where invitations are being sent via letter or email these should also include information for the patient as to why this care is being offered and its importance for their health care.

Invitations should be coded at the time they are sent to the patient. For data extraction purposes, there should be a minimum of seven calendar days between each invitation, but practices should use their judgement in determining the optimal spacing between invitations for their practice population. A longer period may be more appropriate. Codes currently exist to indicate the communication method used to make the invitation and further codes will become available during 2019/20 to indicate that the patients preferred method was used. Both will be acceptable for QOF purposes.

Patients should be sent a minimum of two invitations for care within the QOF year i.e. 1 April – 31 March. If these invitations are correctly coded then they will be identified through the business rules and there will be no need to add additional codes at year-end to indicate that a patient has not responded to these invitations.

¹³¹ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

As at present, generic invitations such as messages added to the right-hand side of prescriptions or notices in the waiting room inviting groups of patients to attend clinics or make appointments will not be acceptable.

Invitations for cervical screening

As noted above, the requirement for women to be invited on three separate occasions will continue in line with national screening programme requirements. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation, or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitation.
- Where contractors have opted to run their own call/recall system then they are responsible for making all three invitations.

Where a woman does not respond to these three invitations then contractors will need to code that this has been the case. A specific code to do this has been requested and will become available during 2019/20. Each invitation should be recorded in the patient record as evidence of these may be required for assessment and audit purposes.

Women may choose to withdraw from the national screening programme. This should be undertaken with caution as women who withdraw from cervical screening call/recall will receive no further offers of screening from the central service. Where women actively decline cervical screening, this should be recorded as such.

The patient has registered with the practice or been newly diagnosed with the condition in the last 3 months of the QOF year and has not received defined clinical measurements

Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last three months of the QOF year (1 January – 31 March) this criterion applies automatically, unless the contractor has recorded the defined clinical measurements within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

The patient has registered with the practice or has been newly diagnosed with the condition in the last 9 months of the QOF year and has not achieved defined clinical standards

Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last nine months of the QOF year (1 July – 31 March) this criterion applies automatically, unless the contractor has achieved the defined clinical standards within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

Section 7: Indicators no longer in QOF (INLIQ)

There are minor changes to the INLIQ extraction from 1 April 2019 including the introduction of four new indicators and the removal of six existing indicators. The indicators included in INLIQ in 2019/20 are detailed below.

Indicator ID	Indicator description
CHD003	The percentage of patients with coronary heart disease whose last measured cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
CKD004	The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months
NM84	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists
CVD-PP002	The percentage of patients diagnosed with hypertension (diagnosed after or on 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
DM005	The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months
DM011	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
EP002	The percentage of patients 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
EP003	The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months
LD002	The percentage of patients on the learning disability register with Down's syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months
MH004	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months
MH005	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months

MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.
RA003	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months
RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months
SMOK001	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months
STIA005	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
THY001	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine
THY002	The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months

Section 8: Glossary of acronyms

Abbreviation	Definition
A&E	Accident and Emergency
ABPM	Ambulatory Blood Pressure Monitoring
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
ACR	Albumin Creatinine Ratio
AF	Atrial Fibrillation
APDF	Adjusted Practice Disease Factor
ARB	Angiotensin Receptor Blocker
AST	Asthma
ATC	Antithrombotic Trialists Collaboration
ATS/ERS	American Thoracic Society/European Respiratory Society
BMD	Bone Mass Density
BMI	Body Mass Index
BMA	British Medical Association
BMJ	British Medical Journal
BNF	British National Formulary
BP	Blood Pressure
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAN	Cancer
CAT	COPD Assessment Test
CCG	Clinical Commissioning Group
CG	Clinical guideline (NICE)
CHD	Coronary Heart Disease
CHADS ₂	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CHA ₂ DS ₂ -VASc	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke (prior stroke) Vascular Disease (peripheral artery disease) Age (65–74 years) Sex Category (ie female)
CKD	Chronic Kidney Disease

Abbreviation	Definition
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQRS	Calculating Quality Reporting Service
CRP	C-Reactive Protein
CS	Cervical Screening
CTV3	Clinical Terms Version 3
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DCCT	Diabetes Control and Complications Trial
DHSC	Department of Health and Social Care
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DMARD	Disease Modifying Anti-Rheumatic Drugs
DXA	Dual-Energy X-ray Absorptiometry
ED	Erectile Dysfunction
eGFR	Estimated Glomerular Filtration Rate
EOLC	End of Life Care
EP	Epilepsy
ES	Enhanced Service
ESR	Erythrocyte Sedimentation Rate
FBC	Full Blood Count
FEV ₁	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMC	General Medical Council
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner

Abbreviation	Definition
GPC England	General Practitioners Committee England
GPES	General Practice Extraction Service
GSF	Gold Standards Framework
HbA1c	Glycated Haemoglobin
HBPM	Home Blood Pressure Monitoring
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
INLIQ	Indicators no longer incentivised in QOF
IQ	Intelligence Quotient
JBS	Joint British Societies
JBS2	Joint British Society 2
JCVI	Joint Committee on Vaccination and Immunisation
KPa	KiloPascal
LD	Learning Disabilities
LDL	Low Density Lipoprotein
LVSD	Left Ventricular Systolic Dysfunction
MDT	Multi-disciplinary team
MH	Mental Health
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
MRC	Medical Research Council
NAO	National Audit Office
NCSI	National Cancer Survivorship Initiative
NEJM	New England Journal of Medicine
NG	NICE guideline (clinical guidelines update reference from 2015)
NHS	National Health Service
NHS CB	NHS Commissioning Board (NHS England)

Abbreviation	Definition
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapy
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
NSF	National Service Framework
NT-proBNP	N-terminal pro-B-type natriuretic peptide
OB	Obesity
OGTT	Oral Glucose Tolerance Test
ONS	Office for National Statistics
OST	Osteoporosis
PaO ₂	Partial Pressure of Oxygen in Arterial Blood
PAD	Peripheral Arterial Disease
PC	Palliative Care
PCA	Personalised Care Adjustment
PCRJ	Primary Care Respiratory Journal
PEF	Peak Expiratory Flow
PH	Public health
PPI	Proton pump inhibitor
PVD	Peripheral Vascular Disease
QI	Quality Improvement
QOF	Quality and Outcomes Framework
QS	Quality standard (NICE)
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCN	Royal College of Nurses
RCTs	Randomised Controlled Trials
SCR	Supportive Care Register
SFE	Statement of Financial Entitlements
SIGN	Scottish Intercollegiate Guidelines Network
SMOK	Smoking

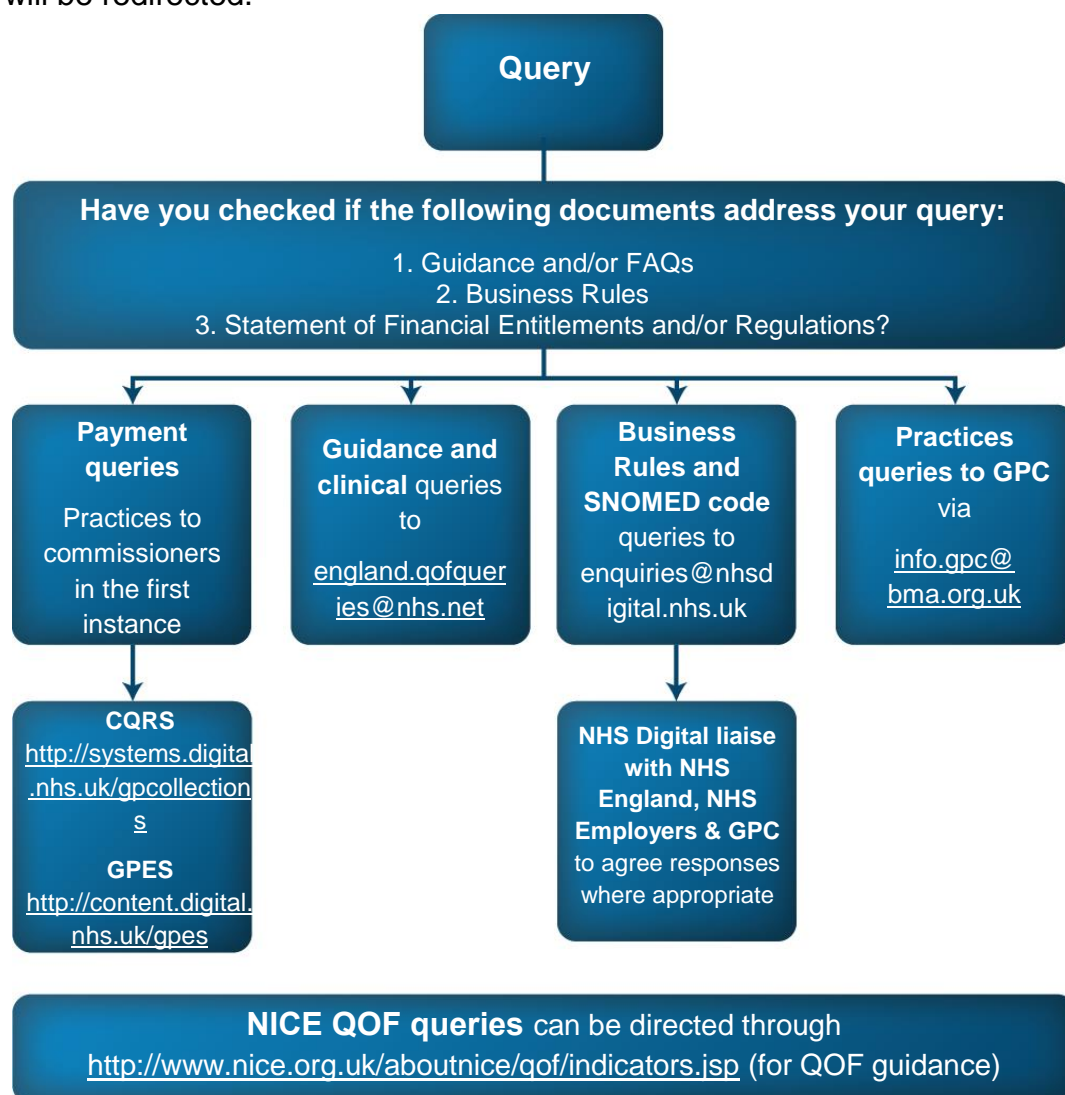
Abbreviation	Definition
SaO ₂	Arterial Oxygen Saturation
SpO ₂	Pulse Oximetry
SPICT	Supportive and Palliative Care Indicators Tool
SWOT analysis	Strengths, weaknesses, opportunities and threats analysis
STIA	Stroke or Transient Ischemic Attack
TA	Technology appraisal (NICE)
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
US	United States
WHO	World Health Organisation

Section 9: Queries

Queries fall into three main categories:

1. those which can be resolved by referring to guidance and/or FAQs
2. those requiring interpretation of the guidance or Business Rules¹³²
3. those not anticipated in guidance¹³³.

Queries may incorporate one or more of the following areas: Business Rules, coding, payment, CQRS, GPES, and clinical or policy issues. The recipient of the query will liaise with other relevant parties in order to respond and where necessary the query will be redirected.



¹³² NHS Digital. <http://content.digital.nhs.uk/qofesextractspecs>

¹³³ Where an issue relating to clinical indicators cannot be resolved with simple clarification of the guidance, this will fall in to the NICE process of reviewing QOF indicators.

Section 10: Summary of clinical indicator changes

New indicators

Fifteen new indicators are being introduced from 1 April 2019. These are listed in Table 3 below.

Table 3: New indicators for 2019/20

Indicator ID	Indicator wording	Points	Payment thresholds	Rationale for inclusion
CS005	The proportion of women eligible for screening and aged 25-49 years at the end of reporting period whose notes record that an adequate cervical screening test has been performed in the preceding 3 years and 6 months	7	45-80%	To achieve alignment with screening committee guidelines
CS006	The proportion of women eligible for screening and aged 50-64 years and the end of reporting period whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%	
COPD008	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme	2	40-90%	High impact intervention for patients with COPD
DM019	The percentage of patients with diabetes, on the register, without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	10	38-78%	Suite of changes to reduce the potential for over-treatment and iatrogenic harm to patients with moderate or severe frailty and to reduce the potential for under-treatment of
DM020	The percentage of patients with diabetes, on the register, without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.	17	35-75%	
DM021	The percentage of patients with diabetes, on the register, with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.	10	52-92%	
DM022	The percentage of patients with diabetes, on the register, aged 40 years and over, with no history of CVD and without moderate or severe frailty, who are	4	50-90%	

	currently treated with a statin. (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)			patients without moderate or severe frailty.
DM023	The percentage of patients with diabetes, on the register, and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin.	2	50-90%	
HYP003	The percentage of patients aged 79 years or under, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less.	14	40-77%	To achieve alignment with NICE guidance and introduce more clinically appropriate targets
HYP007	The percentage of patients aged 80 years and over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less	5	40-80%	
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4	50-90%	To maintain focus upon weight management in this patient group
CHD008	The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less	12	40-77%	To achieve alignment with NICE guidance and introduce more clinically appropriate targets
CHD009	The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less	5	46-86%	
STIA010	The percentage of patients aged 79 years or under, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3	40-73%	
STIA011	The percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2	46-86%	

Retired indicators

Twenty-eight indicators have been retired from April 2019. These are listed in Table 4 below.

Table 4: Indicators retired from April 2019

Indicator ID	Indicator wording	Points	Rationale for retirement
CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	17	Replacement with more clinically appropriate targets
CON001	The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS	4	Simple collection of prescribing data. No link to any other indicators
CON003	The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible contraception at the time or within one month of the prescription	3	Small numbers of patients at practice level leading to reliability issues. Achievement has plateaued.
COPD004	The percentage of patients with COPD with a record of FEV ₁ in the preceding 12 months	7	Not required on an annual basis to guide care coupled with issues with access to annual spirometry in general practice
COPD005	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months	5	Not in line with NICE guidance

CS001	The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates	7	Core professional responsibility
CS002	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	Replacement with indicators in line with screening recommendations
CS004	The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample takers at least every 2 years	2	Core professional responsibility
DEM005	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register	6	Small numbers at a practice level leading to reliability issues.
DM002	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	8	Replacement with indicators in which treatment targets are stratified according to whether the patient has moderate or severe frailty
DM003	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10	
DM004	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	
DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months	17	
DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	
DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	
HYP006	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	20	Replacement with more clinically appropriate targets
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	Replacement with an indicator

			focused upon BMI recording
MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years	5	Small numbers at a practice level leading to reliability issues. Also double payment of CS002.
MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1	Small numbers at a practice level leading to indicator reliability issues.
MH010	The percentage of patients on lithium therapy with lithium levels in the therapeutic range in the preceding 4 months	2	Small numbers at a practice level leading to reliability issues. Indicator timing not in line with clinical guidance.
OST002	The percentage of patients aged 50 or over, and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone sparing agent	3	Small number s at a practice level leading to reliability issues. Concerns about over-treatment.
OST005	The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with a bone sparing agent	3	Small number s at a practice level leading to reliability issues. Concerns about over-treatment.

PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2	Significant overlap with other CVD areas therefore not a priority for ongoing incentivisation.
PAD003	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken	2	
PC002	The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3	Issues with indicator assurance. Greater potential gain through a QI approach.
SMOK003	The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2	Core professional practice
STIA003	The percentage of patients with a history of a stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	Replacement with more clinically appropriate targets
STIA008	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA	2	Time for referral clinically inappropriate

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